FORM 10-K

TENET HEALTHCARE CORP - THC

Filed: March 08, 2005 (period: December 31, 2004)

Annual report with a comprehensive overview of the company

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

Form 10-K

☒ **Annual report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 for the fiscal year ended December 31, 2004**

OR

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

Commission file number 1-7293

TENET HEALTHCARE CORPORATION

(Exact name of Registrant as specified in its charter)

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

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 and Pacific Stock Exchange
6 3/8% Senior Notes due 2011	New York Stock Exchange
6 1/2% Senior Notes 2012	New York Stock Exchange
7 3/8% Senior Notes due 2013	New York Stock Exchange
9 7/8% Senor Notes due 2014	New York Stock Exchange
6 7/8% Senior Notes due 2031	New York Stock Exchange

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 ☒ No ☐

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

Indicate by check mark whether the Registrant is an accelerated filer (as defined in Exchange Act Rule 12b-2). Yes ☒ No ☐

As of June 30, 2004, there were 466,135,031 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, 2004, based on the closing price of the Registrant's shares on the New York Stock Exchange, was approximately $3,992,023,369. For the purpose of the foregoing calculation only, all directors and the executive officers who are SEC reporting persons of the Registrant have been deemed affiliates. As of February 28, 2005, there were

468,321,988 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's definitive proxy statement for the 2005 annual meeting of shareholders to be held on May 26, 2005 are incorporated by reference into Part III of this Form 10-K.

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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.") We are the second largest investor-owned health care services company in the United States. At December 31, 2004, our subsidiaries operated 80 general hospitals (two of which were classified as critical access hospitals) with 19,668 licensed beds, serving urban and rural communities in 13 states. Of those general hospitals, 64 were owned by our subsidiaries and 16 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, 2004, our subsidiaries also owned or leased various related health care facilities, including two rehabilitation hospitals, one specialty hospital, four skilled nursing facilities and 85 medical office buildings—each of which is located on the same campus as, or nearby, one of our general hospitals. In addition, our subsidiaries own or lease physician practices, captive insurance companies and various ancillary health care businesses, including outpatient surgery centers, occupational and rural health care clinics, and an interest in a health maintenance organization, 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 nurses and other employees, (5) reduce provisions for doubtful accounts 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

From March 2003 to February 2004, we organized our general hospitals and other related health care facilities into two divisions with five underlying regions. In February 2004, we announced a streamlining of our operational structure by eliminating our two divisions and having our five regions report directly to our newly appointed chief operating officer. In July 2004, we consolidated our operating regions from five to four in an effort to continue streamlining our operational structure. Our four regions are:

- California, which includes all of our hospitals in California, as well as our hospital in Nebraska;
- Central Northeast-Southern States, which includes all of our hospitals in Georgia, Missouri, North Carolina, Pennsylvania, South Carolina and Tennessee;
- Florida-Alabama, which includes all of our hospitals in Florida, as well as our hospital in Alabama; and
- Texas-Gulf Coast, which includes all of our hospitals in Louisiana and Texas, as well as our hospital in Mississippi.

All of our regions 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, non-core assets or excess capacity, or because of changing market conditions. From time to time, we make strategic acquisitions of, or enter into partnerships or affiliations with, general hospitals and related health care businesses.

In March 2003, we announced our intention to divest or consolidate 14 general hospitals that no longer fit our core operating strategy of building and maintaining competitive networks of hospitals that provide quality patient care in major markets. We sold 11 and closed two of the 14 hospitals by the end of 2003. The sale of the remaining hospital took place effective February 1, 2004. In November 2003, we announced we would not renew our leases on two additional hospitals and ceased operations at both of these hospitals in 2004. In addition, in December 2003, we announced our intention to close one more hospital and sell another, and we divested both hospitals in 2004. Also in December 2003, we acquired the USC Kenneth Norris Jr. Cancer Hospital, which one of our subsidiaries had managed since 1997; the hospital is a 60-bed facility specializing in cancer treatment on the campus of our USC University Hospital in Los Angeles, California.

In January 2004, we announced our intention to divest an additional 27 general hospitals, including 19 in California and eight in Louisiana, Massachusetts, Missouri and Texas. This decision was based on a comprehensive review of the near-term and long-term prospects of each of the hospitals, including a study of the capital expenditures required to comply with California's seismic regulations for hospitals. As of December 31, 2004, we had completed the divestiture of 18 of the 27 facilities and had entered into a definitive agreement to divest an additional four hospitals. We continue to work toward entering into definitive agreements to divest the remaining facilities in the plan, with transaction closings to take place as soon as possible.

In addition to the hospitals divested or to be divested as part of the restructuring program that we announced in January 2004, we sold our only foreign facility, a general hospital in Barcelona, Spain, in May 2004. During 2004, we also completed the divestiture of or entered into agreements to divest substantially all of the home health agencies owned and operated by our subsidiaries. In June 2004, we completed construction of and opened two new general hospitals, the 90-bed Saint Francis Hospital—Bartlett in Bartlett, Tennessee, a suburb of Memphis, and the 118-bed Centennial Medical Center in Frisco, Texas, a suburb of Dallas.

Going forward, we will focus our financial and management resources on the 69 general hospitals and related operations that will remain after all proposed divestitures are completed. Our general hospitals in continuing operations generated in excess of 96.0% of our net operating revenues for all periods presented in our consolidated financial statements. Factors that affect patient volumes and, thereby, our results of operations at our hospitals and related health care facilities include, but are not limited to (1) unemployment levels, (2) the business environment of local communities, (3) the number of uninsured and underinsured individuals in local communities, (4) seasonal cycles of illness, (5) climate and weather conditions, (6) physician recruitment, retention and attrition, (7) local health care competitors, (8) managed care contract negotiations or terminations, (9) unfavorable publicity, which impacts relationships with physicians and patients, and (10) factors that affect the timing of elective procedures.

Each of our general hospitals offers acute care services, operating and recovery rooms, radiology services, respiratory therapy services, clinical laboratories, and pharmacies; 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. Seven of our hospitals—Memorial Medical Center, USC University Hospital, Saint Louis University Hospital, Hahnemann University Hospital, Sierra Medical Center, Western Medical Center Santa Ana and St. Christopher's Hospital for Children —offer quaternary care in such areas as heart, lung, liver and kidney transplants. USC University Hospital, Sierra Medical Center and Good Samaritan Hospital also offer gamma-knife brain surgery and Saint Louis University Hospital, Hahnemann University Hospital and Memorial Medical Center offer bone marrow

transplants. Our hospitals also 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 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 two hospitals) 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 hospitals that are not accredited also participate in the Medicare program by otherwise meeting the Medicare Conditions of Participation.

The following table lists, by state, the general hospitals owned or leased and operated by our subsidiaries as of December 31, 2004:

Hospital	Location	Licensed Beds	Status
Alabama			
Brookwood Medical Center	Birmingham	586	Owned
California			
Alvarado Hospital Medical Center/SDRI	San Diego	311	Owned
Brotman Medical Center*	Culver City	420	Owned
Chapman Medical Center**	Orange	114	Leased
Coastal Communities Hospital**	Santa Ana	178	Owned
Community Hospital of Huntington Park*	Huntington Park	81	Leased
Community Hospital of Los Gatos	Los Gatos	143	Leased
Desert Regional Medical Center	Palm Springs	394	Leased
Doctors Hospital of Manteca	Manteca	73	Owned
Doctors Medical Center	Modesto	465	Owned
Encino-Tarzana Regional Medical Center*(1)	Encino	151	Leased
Encino-Tarzana Regional Medical Center*(1)	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	161	Owned
Los Alamitos Medical Center	Los Alamitos	167	Owned
Mission Hospital of Huntington Park*	Huntington Park	109	Owned
Placentia Linda Hospital	Placentia	114	Owned
San Dimas Community Hospital	San Dimas	93	Owned
San Ramon Regional Medical Center	San Ramon	123	Owned
Sierra Vista Regional Medical Center	San Luis Obispo	200	Owned
Twin Cities Community Hospital	Templeton	84	Owned
USC University Hospital(2)	Los Angeles	329	Leased
Western Medical Center Santa Ana**	Santa Ana	280	Owned
Western Medical Center Hospital Anaheim**	Anaheim	188	Owned
Florida			
Cleveland Clinic Hospital(3)	Weston	150	Owned
Coral Gables Hospital	Coral Gables	256	Owned
Delray Medical Center	Delray Beach	372	Owned
Florida Medical Center	Fort Lauderdale	459	Owned
Good Samaritan Hospital	West Palm Beach	341	Owned
Hialeah Hospital	Hialeah	378	Owned
Hollywood Medical Center	Hollywood	324	Owned
North Ridge Medical Center	Fort Lauderdale	332	Owned
North Shore Medical Center	Miami	357	Owned
Palm Beach Gardens Medical Center	Palm Beach Gardens	204	Leased
Palmetto General Hospital	Hialeah	360	Owned
Parkway Regional Medical Center	North Miami Beach	382	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			
Kenner Regional Medical Center	Kenner	203	Owned
Meadowcrest Hospital	Gretna	207	Owned
Lindy Boggs Medical Center	New Orleans	172	Owned
Memorial Medical Center	New Orleans	333	Owned
NorthShore Regional Medical Center	Slidell	174	Leased
Mississippi			
Gulf Coast Medical Center	Biloxi	189	Owned
Missouri			
Des Peres Hospital	St. Louis	167	Owned
Saint Louis University Hospital	St. Louis	356	Owned
Nebraska			
Creighton University Medical Center(5)	Omaha	358	Owned
North Carolina			
Central Carolina Hospital	Sanford	137	Owned
Frye Regional Medical Center	Hickory	355	Leased
Frye Regional Medical Center—Alexander Campus(4)	Taylorsville	25	Leased
Pennsylvania			
Graduate Hospital	Philadelphia	240	Owned
Hahnemann University Hospital	Philadelphia	618	Owned
Roxborough Memorial Hospital	Philadelphia	125	Owned
St. Christopher's Hospital for Children	Philadelphia	161	Owned
Warminster Hospital	Warminster	145	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	561	Owned
Saint Francis Hospital—Bartlett	Bartlett	90	Owned
Texas			
Centennial Medical Center	Frisco	118	Owned
Cypress Fairbanks Medical Center	Houston	146	Owned
Doctors Hospital	Dallas	232	Owned
Houston Northwest Medical Center	Houston	498	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(6)	Dallas	155	Leased
Shelby Regional Medical Center	Center	54	Owned
Sierra Medical Center	El Paso	351	Owned
Trinity Medical Center(6)	Carrollton	207	Leased

* We continue to work toward entering into definitive agreements to divest these facilities as part of the restructuring of our operations announced in January 2004.
** We have entered into a definitive agreement to divest these facilities as part of the restructuring of our operations announced in January 2004.
(1) Leased by a partnership in which Tenet subsidiaries own a 75% interest and of which a Tenet subsidiary is the managing general partner.
(2) Facility owned by us on land leased from a third party.
(3) Owned by a partnership in which a Tenet subsidiary owns a 51% interest and is the managing general partner. The partner owning the 49% interest, an affiliate of the Cleveland Clinic Foundation, has an option to acquire our interest at any time after July 2, 2006 pursuant to the terms of the related partnership agreement.
(4) Designated by CMS as critical access hospitals and, therefore, although not being divested, these facilities are not counted among the 69 general hospitals that will remain after all proposed divestitures are completed.
(5) Owned by a limited liability company in which a Tenet subsidiary owns a 74% interest and is the managing member.
(6) Leased from the Metrocrest Hospital Authority under a lease that expires in August 2007.

As of December 31, 2004, the largest concentrations of our licensed beds were in California (27.0%), Florida (23.2%) and Texas (15.1%). Strong concentrations of hospital beds within geographic 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 or other development occur within these states, our business, financial position, results of operations or cash flows could be materially adversely affected.

The following table shows certain information about the hospitals operated domestically by our subsidiaries for the years ended December 31, 2004 and 2003, for the seven-month transition period ended December 31, 2002 and for the fiscal year ended May 31, 2002.

	Years ended December 31		Seven months ended December 31, 2002	Year ended May 31, 2002
	2004	2003		
Total number of facilities (at end of period)(1)	80	101	114	116
Total number of licensed beds (at end of period)(2)	19,668	25,116	27,870	28,667

(1) Includes nine facilities at December 31, 2004, 32 facilities at December 31, 2003 and 45 facilities at December 31, 2002 and May 31, 2002, 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 55.

PROPERTIES

At December 31, 2004, our administrative offices were located in Los Angeles, Santa Ana and Santa Barbara, California; Ft. Lauderdale, Florida; Atlanta, Georgia; St. Louis, Missouri; Philadelphia, Pennsylvania; and Dallas, Texas. We moved our corporate headquarters from Santa Barbara to Dallas effective January 3, 2005.

Our subsidiaries lease the space for our offices in Los Angeles, Santa Ana, Ft. Lauderdale, Atlanta, St. Louis and Philadelphia under operating lease agreements. We own our Santa Barbara office building, which is on land that is leased by one of our subsidiaries under a long-term ground lease that expires in 2068. We plan to close this office in June 2005, then sell the building and assign the ground lease to the buyer. Another one of our subsidiaries leases the space for our Dallas office under an operating lease agreement that terminates in 2010 subject to our ability to exercise of one or both of two five-year renewal options under the lease agreement.

Our subsidiaries operated 85 medical office buildings at December 31, 2004; most of these office buildings are adjacent to our general hospitals. The number of licensed beds and locations of our general hospitals at December 31, 2004 are described in the table beginning on page 4.

As of December 31, 2004, we had approximately $34 million of outstanding loans secured by property and equipment, and we had approximately $31 million of capitalized lease obligations. We believe that all of our properties, as well as the administrative and medical office buildings described above, are suitable for their intended purposes.

MEDICAL STAFF AND EMPLOYEES

Our hospitals are staffed by licensed physicians who have been admitted to the medical staff of individual hospitals. 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 staff and the administrative staff 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, ability and experience of our employees and the physicians on the medical staffs of our hospitals. Our future growth depends on our ability to (1) attract and retain skilled employees, (2) attract and retain physicians and other health care professionals, and (3) manage growth successfully. Therefore, our success, in part, depends upon the quality, quantity and specialties of physicians on our hospitals' medical staffs, most of whom have no long-term contractual relationship with us. In some of our markets, physician recruitment and retention are affected by a shortage of physicians in certain specialties and the difficulties that physicians are experiencing in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance.

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 position, results of operations or cash flows.

At December 31, 2004, the approximate number of our employees (of which approximately 29% were part-time employees) was as follows:

General hospitals and related health care facilities(1)	90,649
Corporate offices	984
Total	91,633

(1) Includes employees whose employment relates to the operations of our general hospitals, rehabilitation hospitals, specialty hospital, outpatient surgery centers, managed services organizations, physician practices, in-house collection agency and other health care operations.

The largest concentrations of our employees are in those states where we have the largest concentrations of licensed hospital beds:

	% of employees	% of licensed beds
California	30.7%	27.0%
Florida	15.8%	23.2%
Texas	13.3%	15.1%

At December 31, 2004, approximately 14% 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 seeing an increase in the amount of union activity, particularly in California. In May 2003, we entered into an agreement with the Service Employees International Union and the American Federation of Federal, State, County and Municipal Employees with respect to all of our California hospitals and two hospitals in Florida; in December 2003, we entered into an agreement with the California Nurses Association with respect to all of our California hospitals. The agreements are expected to streamline the organizing and contract negotiation process, with minimal impact on and disruption to patient care, if a hospital's employees choose to organize into collective bargaining units. The agreements also provide a framework for pre-negotiated salaries and benefits at the related hospitals. As of December 31, 2004, there were approximately 10,899 unionized employees in our California hospitals who were covered by these agreements. In 2005, labor union contracts at five hospitals in Pennsylvania and California, representing 2% of our employees, will expire, but we do not expect renegotiations to have a material adverse effect on our business, financial position, results of operations or cash flows.

Factors that adversely affect our labor costs include the nationwide shortage of nurses and the enactment of state laws regarding nurse-staffing ratios. The nursing shortage is more serious in certain specialties and in certain geographic areas than others, including several areas in which we operate hospitals, such as Southern California, South Florida and Texas. The nursing shortage has become a significant operating issue to health care providers, including us, and has resulted in increased costs for nursing personnel.

State-mandated nurse-staffing ratios adversely 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 that went into effect on January 1, 2004. We have, however, gradually improved our monthly compliance and strive to make continued improvements into 2005.

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 wage and benefit pressures created by the current nursing shortage throughout the country and escalation in state-mandated nurse-staffing ratios, particularly in California (even though, in November 2004, California delayed its next increase in the mandated ratios until at least 2008). We may be required to enhance wages and benefits to recruit and retain nurses. We may also be required to increase our use of temporary personnel, which is typically more expensive. Significant efforts are being invested in workforce development with local schools of nursing and in recruitment of 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 from sales, property and income taxes.

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 should help to position us competitively to meet these challenges. The C2Q initiative is designed to (1) improve patient safety and evidence-based practice, (2) support physician excellence, (3) improve the practice and leadership of nursing, and (4) facilitate improved patient flow and care delivery. A year has passed since we formally launched our C2Q initiative with a series of hospital-based pilot programs. At December 31, 2004, 42 of our hospitals had completed the initial eight-week "transformation" phase and 10 hospitals were in process. We plan to complete the full initial implementation of our C2Q initiative by the end of 2005. At most hospitals that have completed the initial eight-week transformation phase, we have seen various levels of reductions in emergency room wait times, increases in on-time starts in the operating rooms, and improved bed management and care coordination.

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 charges and effective reimbursement rates for services. The laws, rules and regulations governing the health care industry are extremely complex, and the industry often 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 position, results of operations or cash flows could be materially adversely affected.

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 Amendments") 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 Amendments include criminal penalties and civil sanctions, 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 Amendments, 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.

In addition to addressing other matters, as discussed below, the Health Insurance Portability and Accountability Act of 1996 also amends Title XI (42 U.S.C. Section 1301 et seq.) to broaden the scope of current 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 and radiology 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 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.

On January 4, 2001, U.S. Department of Health and Human Services ("HHS") issued final regulations, subject to comment, intended to clarify parts of the Stark law and some of the exceptions to it. These regulations were considered the first phase of a two-phase process. The "phase II" regulations were issued on March 26, 2004, and became effective on July 26, 2004. These regulations clarified existing definitions and exceptions, and added new regulatory exceptions.

The federal government has also issued regulations that describe some of the conduct and business relationships that are permissible under the Anti-kickback Amendments. 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 Amendments. Rather, such conduct and business arrangements risk increased scrutiny by government enforcement authorities and should be reviewed on a case-by-case basis. We have a regulatory compliance department that systematically reviews all of our operations to determine the extent to which they comply with federal and state laws related to health care, such as the Anti-kickback Amendments, the Stark law and similar state statutes.

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), HHS and the U.S. Department of Justice are scrutinizing, among other things, the terms of acquisitions of physician practices and the coding practices related to certain clinical laboratory procedures and inpatient procedures. We believe that we, and the health care industry in general, will continue to be subject to increased government scrutiny and investigations such as this, which could have a material adverse effect on our business, financial position, 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 allow private individuals to bring actions on behalf of the government, alleging that a hospital or health care provider has defrauded a federal 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 of between $5,500 and $11,000 for each false claim submitted to the government. As part of the resolution of a qui tam case, the party filing the initial complaint may share in a portion of any settlement or judgment. If the government does not intervene in the action, the qui tam plaintiff may 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 impact of such actions on our business, financial position, results of operations or cash flows.

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 44). Further changes in the regulatory framework affecting health care providers could have a material adverse effect on our business, financial position, results of operations or cash flows.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The Health Insurance Portability and Accountability Act, or HIPAA, mandates the adoption of industry standards for the exchange of health information in an effort to encourage overall administrative simplification and enhance the effectiveness and efficiency of the health care industry. HIPAA requires that health providers and other "covered entities," such as insurance companies and other third-party payers, adopt uniform standards for the electronic transmission of medical records, billing statements and insurance claims forms. HIPAA also establishes new federal rules protecting the privacy and security of personal health information. The privacy and security regulations address the use and disclosure of individual health care information and the rights of patients to understand and control how such 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. In 2001, in response to concerns by many health care providers about their ability to comply with impending HIPAA deadlines, Congress extended until October 2003 the original deadline for compliance with the electronic data transmission (transaction and code set) standards that health care providers must use when transmitting certain health care information electronically. In October 2003, under authority given by HHS, CMS implemented a plan that allows providers and other electronic billers to continue to submit pre-HIPAA format electronic claims for periods after October 16, 2003, provided they can show good faith efforts to become HIPAA compliant. We continue to work toward full and complete compliance with the electronic data transmission standards.

All covered entities, including those we operate, were required to comply with the privacy requirements of HIPAA by April 14, 2003. We were in material compliance with the privacy regulations by that date and remain so, as we continue to develop training and revise procedures to address ongoing compliance. The HIPAA security regulations require health care providers to implement administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of patient information. We are required to comply with the security regulations by April 20, 2005, and are on target to complete our implementation plan by that 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 the existing and proposed regulations, we believe that the cost of our compliance with HIPAA will not have a material adverse effect on our business, financial position, 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 hygiene. 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 health care facility, are overseen by each health care facility's local governing board, the members of which primarily are community members and physicians, and are reviewed by our quality assurance 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, 2004, 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, as well as our purchases and sales of facilities, 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, results of operations or competitive position.

COMPLIANCE PROGRAM

We maintain a multifaceted corporate and hospital-based compliance program that strives to meet or exceed applicable standards established by federal guidance and industry practice. On January 14, 2004, our board of directors approved a new 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.

We have restructured our compliance department as a separate and independent body. To further ensure the independence of the compliance department, the following measures have been implemented: (1) the compliance department has its own operating budget, (2) the compliance department has the authority to hire outside counsel, to access any Tenet document and to interview any of our personnel, and (3) according to the new structure, the chief compliance officer reports directly to the quality, compliance and ethics committee of our board of directors.

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, we have 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.

We are working toward creating a fully integrated compliance communications and data infrastructure. This tool will support the compliance staff in ensuring accountability at all levels within Tenet with measurable criteria for the effectiveness of the compliance program. Furthermore, it will help ensure that we are able to effectively address and resolve all compliance-related issues.

On March 23, 2004, Tenet entered into a five-year Corporate Integrity Agreement ("CIA") with the Office of the Inspector General of HHS related to North Ridge Medical Center ("NRMC"), one of our Florida hospitals; however, certain provisions of the CIA impose obligations on Tenet and our subsidiaries. The CIA is structured to assure the federal government of our federal health care program compliance and specifically covers physician relations. Under the CIA, we have an affirmative obligation to report probable violations of applicable federal health care laws and regulations. This obligation could result in greater scrutiny by regulatory authorities. Breach of the CIA could subject us to substantial monetary penalties and/or affect NRMC's participation in the Medicare and Medicaid programs. We have agreed, during the five-year term of the CIA, to operate our compliance program as it pertains to NRMC in a manner that meets the requirements of the CIA.

ETHICS PROGRAM

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

All of our employees, including our chief executive officer, chief financial officer, 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 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 training sessions to every employee, as well as our board of directors. 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 ethics and business conduct 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 of our corporate secretary.

PROFESSIONAL AND GENERAL LIABILITY INSURANCE

Through May 31, 2002, we insured substantially all of our professional and general liability risks in excess of self-insured retentions through Hospital Underwriting Group ("HUG"), our majority-owned insurance subsidiary, under a mature claims-made policy with a 10-year extended reporting period. (HUG became a wholly owned subsidiary effective May 31, 2003.) Our hospitals' self-insured retentions were $1 million per occurrence for fiscal years ended May 31, 1996 through May 31, 2002. HUG's retentions covered the next $2 million per occurrence. Claims in excess of $3 million per occurrence were, in turn, reinsured with major independent insurance companies. In earlier policy periods, the self-insured retentions varied by hospital and by policy period from $500,000 to $5 million per occurrence.

For the periods June 1, 2000 through May 31, 2001, and June 1, 2001 through May 31, 2002, the policies written by HUG provided a maximum of $50 million of coverage for each policy period. As of December 31, 2004, HUG's retained reserves for losses for the policy period ended May 31, 2001 were substantially close to reaching $50 million and for the policy period ended May 31, 2002, the retained reserves for losses reached the $50 million limit. However, the $50 million coverage limit each year is based on paid claims, and the payments for each year have not reached the limit; therefore, the policies remain in effect. If the $50 million maximum amount is exhausted in either of these periods, we will be responsible for the first $25 million per occurrence for any subsequent claim paid that was applicable to the exhausted policy period before any excess professional and general liability insurance coverage would apply. Based on an actuarial review, we have provided for losses that exceed our self-insured retentions that will not be covered by the HUG policies.

Effective June 1, 2002, our hospitals' self-insured retention per occurrence was increased to $2 million. In addition, a new wholly owned insurance subsidiary, The Healthcare Insurance Corporation, was formed to insure substantially all of these risks. This subsidiary insures these risks under a claims-made policy with retentions per occurrence for the periods June 1, 2002 through May 31, 2003, and June 1, 2003 through May 31, 2004, of $3 million and $13 million, respectively. Risks in excess of these retentions are reinsured with major independent insurance companies. For the policy period June 1, 2004 through May 31, 2005, The Healthcare Insurance Corporation retains 17.5%

of the first $10 million layer for reinsurance claims in excess of $15 million resulting in a maximum retention per occurrence of $14.75 million.

As of December 31, 2004, we had purchased claims-made excess professional and general liability insurance policies from major independent insurance companies with a total aggregate limit of $275 million, which policies provide coverage if a claim exceeds $25 million. All reinsurance applicable to HUG or The Healthcare Insurance Corporation and any excess professional and general liability insurance we purchase are subject to policy aggregate limitations. If such policy aggregate limitations should be partially or fully exhausted in the future, our financial position, results of operations or cash flows could be materially adversely affected.

In addition to the reserves recorded by the above insurance subsidiaries, we maintain self-insured retention reserves based on actuarial estimates for the portion of our professional and general liability risks, including incurred but not reported claims, for which we do not have insurance coverage (i.e., self-insured retentions). Reserves for losses and related expenses are estimated using expected loss-reporting patterns and are discounted to their present value under a risk-free rate approach using a Federal Reserve seven-year maturity composite rate of 3.8% at December 31, 2004 and a Federal Reserve 10-year maturity composite rate of 4.0% at December 31, 2003 based on our estimated claims payout period. If actual payments of claims materially exceed projected estimates of claims, our financial position, results of operations or cash flows could be materially adversely affected. Also, we provide letters of credit to our insurers as security under a selected number of programs to collateralize the deductible and self-insured retentions under our professional and general liability insurance programs, which can be drawn upon under certain circumstances.

EXECUTIVE OFFICERS

The names, positions and ages of our executive officers, as of March 8, 2005, are:

	Position	Age
Trevor Fetter	President and Chief Executive Officer	45
Reynold J. Jennings	Chief Operating Officer	58
Stephen D. Farber	Chief Financial Officer	35
E. Peter Urbanowicz	General Counsel and Secretary	41
W. Randolph Smith	President, Western Division	56
Timothy L. Pullen	Executive Vice President and Chief Accounting Officer	49

Mr. Fetter was elected president effective November 7, 2002 and was named chief executive officer in September 2003. He also was elected to the board of directors of Tenet in September 2003. From March 2000 to November 2002, Mr. Fetter was chairman and chief executive officer of Broadlane, Inc. He continues to serve as chairman of Broadlane. From October 1995 to February 2000, he served in several senior management positions at Tenet, including executive vice president and chief financial officer, and chief corporate 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 also serves as a director of the Tenet Healthcare Foundation.

Mr. Jennings was named chief operating officer on February 9, 2004. Prior to that, he served as president of our former eastern division, and, from 1997 to March 2003, he served as executive vice president of our former southeast division. Mr. Jennings rejoined Tenet in 1997 from Ramsay Health Care Inc., where he was president and chief executive officer from 1993 to 1996. Before that, he served as senior vice president, operations, responsible for National Medical Enterprises, Inc.'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 has 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 and a board member of the Federation of American Hospitals.

Mr. Farber was elected chief financial officer on November 7, 2002. Prior to his current position, Mr. Farber served as Tenet's senior vice president, corporate finance, and treasurer. Mr. Farber rejoined Tenet in May 1999 from J.P. Morgan & Co. in New York, where he served as vice president, health care investment banking. He previously served Tenet as vice president, corporate finance, from February 1997 to October 1998. From 1993 to 1997, Mr. Farber worked as an investment banker in the Los Angeles office of Donaldson, Lufkin & Jenrette. Mr. Farber has a bachelor of science degree in economics from the University of Pennsylvania's Wharton School of Business and completed the Advanced Management Program at Harvard Business School. Mr. Farber also serves as a director of the Tenet Healthcare Foundation. On March 10, 2005, Robert S. Shapard will succeed Mr. Farber as our chief financial officer.

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 of arts degree in English and political science from Tulane University. He is a member of the American Law Institute and a board member of the Federation of American Hospitals.

Mr. Smith was promoted to president of our former western division on March 10, 2003; in February 2004, we announced that Mr. Smith would be responsible for managing the transition of the 27 hospitals slated for divestiture as part of the restructuring program that we announced in January 2004. Prior to March 2003, Mr. Smith was executive vice president of our former central-northeast division. Before joining Tenet in 1995, he served as executive vice president, operations, for American Medical International, where he held various positions over 16 years. Mr. Smith has a master's degree in health care administration from Duke University and a bachelor's degree in business administration from Furman University. He has served in leadership and board positions for a variety of health care and community organizations, including the Federation of American Hospitals, Esoterix, Inc. and Epic Healthcare Corporation.

Mr. Pullen was appointed executive vice president and chief accounting officer in August 2003. Prior to his current position, he 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, in 1983 and served in various executive positions, including vice president, finance. Mr. Pullen has a bachelor of science degree in accounting from the Rochester Institute of Technology and an M.B.A. from Seattle University. He also completed the Advanced Management Program at Harvard Business School.

Effective March 10, 2005, Robert S. Shapard, 49, will succeed Stephen Farber as our chief financial officer. Mr. Shapard joined Tenet on March 1, 2005 from Exelon Corporation, one of the nation's largest electric utilities, where he had served as executive vice president and chief financial officer since the fall of 2002. Before joining Exelon, Mr. Shapard served as vice president and chief financial officer of Covanta Energy Corporation, which held energy investments domestically and internationally. From 2000 to 2001, he was executive vice president and chief financial officer of Ultramar Diamond Shamrock, a leading North American refining and marketing company. Earlier in his career, Mr. Shapard spent 20 years with TXU Corporation, a Dallas-based gas and electric utility, serving in a range of finance and general management positions. His final role at TXU was as chief executive

officer of TXU Australia. Mr. Shapard holds a bachelor's degree in accounting from Texas Tech University and is a Certified Public Accountant.

FORWARD-LOOKING STATEMENTS

The information in this Form 10-K 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 following:

- Changes in the Medicare and Medicaid programs or other government health care programs, including modifications to patient eligibility requirements, funding levels or the method of calculating payments or reimbursements.
- Any removal or exclusion of us, or one or more of our subsidiaries' hospitals, from participation in the Medicare or Medicaid program or another government health care program.
- The ability to enter into managed care provider arrangements on acceptable terms.
- The outcome of known and unknown litigation, government investigations, and liabilities and other claims asserted against us.
- Competition.
- Changes in, or our ability to comply with, laws and governmental regulations.
- Changes in business strategies or development plans.
- Our ability to satisfactorily and timely collect our patient accounts receivable, particularly in light of increasing numbers of underinsured and uninsured patients.
- Settlement of professional liability claims and the availability of professional liability insurance coverage at current levels and terms.
- Technological and pharmaceutical improvements that increase the cost of providing, or reduce the demand for, health care.
- National, regional and local economic and business conditions.
- Demographic changes.
- The ability to attract and retain qualified management and other personnel, including physicians, nurses and other health care professionals, and the impact on our labor expenses resulting from a shortage of nurses and other health care professionals.
- The amount and terms of our indebtedness.
- The timing and payment, if any, of any final determination of potential liability as a result of an Internal Revenue Service examination.
- The availability of suitable acquisition and divestiture opportunities, and our ability to accomplish proposed acquisitions and divestitures.

- The availability and terms of debt and equity financing sources to fund the needs of our business.
- Changes in the distribution process or other factors that may increase our costs of supplies.
- Other factors referenced in this Form 10-K and our other public filings.

When considering forward-looking statements, you should keep in mind the foregoing risk factors and other cautionary statements in this Form 10-K. Should one or more of the risks and uncertainties described above or elsewhere in this Form 10-K 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.

COMPANY INFORMATION

We file annual, transition, 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, transition, quarterly and current reports (and amendments to such reports) and other filings made with, or furnished to, the SEC.

ITEM 2. PROPERTIES

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

ITEM 3. LEGAL PROCEEDINGS

Tenet and our subsidiaries are subject to a significant number of claims and lawsuits. We are also the subject of federal and state agencies' heightened and coordinated civil and criminal investigations and enforcement efforts, and have received subpoenas and other requests for information relating to a variety of subjects. In the present environment, we expect that these enforcement activities will take on additional importance, that government enforcement activities may intensify, and that additional matters concerning us and our subsidiaries may arise. We also expect new claims and lawsuits to be brought against us from time to time.

The results of these claims and lawsuits cannot be predicted, and it is possible that the ultimate resolution of these claims and lawsuits, individually or in the aggregate, may have a material adverse effect on our business (both in the near and long term), financial position, results of operations or cash flows. Although we defend ourselves vigorously against claims and lawsuits and cooperate with investigations, 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.

- Could cause us to close or sell hospitals or otherwise modify the way we conduct business.

We recognize that, where appropriate, our interests may be best served by resolving certain matters without litigation. To that end, we have been and continue to be engaged in general discussions with federal law enforcement agencies regarding the possibility of reaching a non-litigated resolution of certain outstanding issues with the federal government. We are not able to predict whether such a resolution will in fact occur on any terms, project a timeline for resolution or quantify the economic impact of any non-litigated resolution; therefore, we have not recorded reserves for such a resolution. However, if we do reach a non-litigated resolution, it is possible that the resolution could be significant and may require us to incur additional debt or other financing. If a non-litigated resolution does not occur, we will continue to defend ourselves vigorously against claims and lawsuits. As stated above, any resolution of significant claims against us, whether as a result of litigation or negotiation, could have a material adverse impact on our business, liquidity, financial position or results of operations.

We record reserves for claims and lawsuits when they are probable and reasonably estimable. However, we presently cannot determine the ultimate resolution of all investigations and lawsuits. For matters where the likelihood or extent of a loss is not probable or cannot be reasonably estimated, we have not recognized in our consolidated financial statements all potential liabilities that may result. If adversely determined, the outcome of some of these matters could have a material adverse effect on our business, liquidity, financial position or results of operations.

Currently pending legal proceedings and investigations that are not in the ordinary course of business are principally related to the subject matters 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. We undertake no obligation to update the following disclosures for any new developments.

Physician Relationships

We and certain of our subsidiaries are under heightened scrutiny with respect to our hospitals' relationships with physicians. We believe that all aspects of our relationships with physicians are potentially under review. Proceedings in this area may be criminal, civil or both.

***United States v. Weinbaum, Tenet HealthSystem Hospitals, Inc. and Alvarado Hospital Medical Center, Inc*., Case No. 03CR1587L (U.S. District Court for the Southern District of California)**

On June 5, 2003, a federal grand jury in San Diego, California returned an eight-count indictment against Barry Weinbaum, who was at that time the chief executive officer of Alvarado Hospital Medical Center, Inc., a hospital owned by one of our subsidiaries and located in San Diego. The indictment alleged conspiracy to violate the federal anti-kickback statute and included substantive counts alleging the payment of illegal remuneration related to physician relocation, recruitment and consulting agreements.

On July 17, 2003, the grand jury returned a superseding indictment adding Tenet HealthSystem Hospitals, Inc. and Alvarado Hospital Medical Center as defendants. (Tenet HealthSystem Hospitals, Inc. is the legal entity that was doing business as Alvarado Hospital Medical Center during some of the period of time covered by the indictment.) The superseding indictment charged one count of conspiracy to violate the anti-kickback statute and 16 substantive counts of payment of illegal remunerations.

On September 25, 2003, the grand jury returned a second superseding indictment that added the hospital's director of business development, Mina Nazaryan, as a defendant. The second superseding indictment charged the defendants with conspiracy to violate the anti-kickback statute and 19

substantive counts of paying illegal remunerations. Additionally, Ms. Nazaryan was charged with one count of obstruction of a health care offense investigation and two counts of witness tampering.

On April 15, 2004, the grand jury returned a third superseding indictment, adding four counts of filing a false tax return solely against Ms. Nazaryan.

On July 22, 2004, the grand jury returned a fourth superseding indictment against Barry Weinbaum, Mina Nazaryan, Alvarado Hospital Medical Center and Tenet HealthSystem Hospitals. The fourth superseding indictment added details and allegations to the previously identified counts.

Prior to trial, all of the defendants pleaded not guilty. Trial proceedings commenced on October 20, 2004 in U.S. District Court in San Diego. In January 2005, Ms. Nazaryan entered into a plea agreement with the U.S. Attorney for the Southern District of California to plead guilty to one count of conspiracy. Several other counts against Ms. Nazaryan were dismissed as part of her plea agreement. At the conclusion of the prosecution's case-in-chief, the defendants filed a Rule 29 Motion for Judgment of Acquittal. The defendants then rested. On February 17, 2005, the trial judge declared a mistrial after the members of the jury indicated that they were unable to reach a verdict in the case. At a subsequent hearing, the judge set March 29, 2005 as the date a second trial in the matter would commence (although he later indicated he would instead set May 3, 2005 as the commencement date). At the hearing, the judge did not issue a ruling on our previously filed Rule 29 Motion, but pointed out that he would deny the portion of the motion regarding the single count of conspiracy against all the defendants and reserved his ruling on the other counts in the indictment related to substantive violations of the federal anti-kickback statute. If convicted following a second trial, the two defendant subsidiaries could be subject to monetary penalties and exclusion from participation in the Medicare program and other federal and state health care programs.

Southern California Investigations

On July 3, 2003, we and several of our subsidiaries received administrative subpoenas from the U.S. Attorney's Office for the Central District of California seeking documents from 1997 to 2003 related to physician relocation agreements at seven Southern California hospitals owned by our subsidiaries during that period, as well as summary information about physician relocation agreements related to all of our hospital subsidiaries. Specifically, the subpoenas, issued in connection with a criminal investigation, seek information from us, three intermediary corporate subsidiaries and subsidiaries that own or owned the following Southern California hospitals: Centinela Hospital Medical Center in Inglewood, Daniel Freeman Memorial Hospital in Inglewood, Daniel Freeman Marina Hospital in Marina del Rey, John F. Kennedy Memorial Hospital in Indio, Brotman Medical Center in Culver City, Encino-Tarzana Regional Medical Center in Encino and Tarzana, and Century City Hospital in Los Angeles. We sold Centinela Hospital Medical Center, Daniel Freeman Memorial Hospital and Daniel Freeman Marina Hospital in November 2004, and we ceased operating Century City Hospital in April 2004. We are cooperating with the government with respect to this investigation.

Physician arrangements at three of these hospitals—Century City Hospital, Brotman Medical Center and Encino-Tarzana Regional Medical Center—are also the subject of an ongoing federal civil investigation.

In addition, we are cooperating with the U.S. Attorney's Office in Los Angeles regarding its investigation into physician agreements, coronary procedures and billing practices at three hospitals in Southern California—Centinela Hospital Medical Center, Daniel Freeman Memorial Hospital and USC University Hospital. We have received a number of voluntary document requests from the government seeking information from 1998 to June 2004 concerning various aspects of this investigation.

Women's Cancer Center

In April 2003, we received an administrative subpoena duces tecum from the Office of the Inspector General ("OIG") of the U.S. Department of Health and Human Services seeking documents relating to any agreements with the Women's Cancer Center, a physician's group not owned by us practicing in the field of gynecologic oncology, and certain physicians affiliated with that group. The subpoena seeks documents from us as well as four California hospitals—Community Hospital of Los Gatos, Doctors Medical Center of Modesto, San Ramon Regional Medical Center and St. Luke Medical Center in Pasadena (which is now closed)—and Lake Mead Hospital Medical Center in North Las Vegas, Nevada (which we sold in February 2004). We are cooperating with the government with respect to this investigation.

Florida Medicaid Investigation

In June 2003, the Florida Medicaid Fraud Control Unit ("FMFCU") issued an investigative subpoena to us seeking employee personnel records and contracts with physicians, physician assistants, therapists and management companies, including loan agreements and purchase and sale agreements, from January 1, 1992 to June 27, 2003 related to the Florida hospitals owned by our subsidiaries. Since that time, we have received additional requests for information related to the foregoing topics, as well as coding at our Florida hospitals, and we are cooperating with the FMFCU's investigation.

El Paso Investigation

On January 23, 2004, we learned that the OIG had issued subpoenas to various physicians who have financial arrangements with our hospitals in El Paso, Texas. The subpoenas request documents relating to financial arrangements between these physicians and us or our subsidiaries. On March 3, 2004, as anticipated, we received from the Civil Division of the U.S. Department of Justice a request for documents in connection with this inquiry. We are cooperating with the government with respect to this matter.

New Orleans Investigation

On July 30, 2004, we received a subpoena from the U.S. Attorney's Office in New Orleans, Louisiana requesting documents relating to physician relationships and financial arrangements at three New Orleans area hospitals—Memorial Medical Center, Kenner Regional Medical Center and St. Charles General Hospital (which we sold in December 2004). We are cooperating with the government with respect to this matter.

St. Louis Investigation

On August 3, 2004, we received a voluntary request from the U.S. Attorney's Office in St. Louis, Missouri seeking documents relating to physician relocation agreements entered into from 1994 to August 2004 at four hospitals we own or owned during that period in the St. Louis area—Saint Louis University Hospital, Des Peres Hospital, Forest Park Hospital (which we sold in December 2004), and Saint Alexius Hospital, Jefferson Campus (formerly SouthPointe Hospital) (which we also sold in December 2004)—as well as Twin Rivers Regional Medical Center in Kennett, Missouri, which we sold in November 2003. We are cooperating with the government with respect to this matter.

San Ramon Regional Medical Center

On August 31, 2004, we received a subpoena from the U.S. Attorney's Office in San Francisco, California requesting documents relating to medical directorships entered into from January 1, 2000 to August 31, 2004 at San Ramon Regional Medical Center in San Ramon, California, as well as a small

number of physician relocation agreements at that hospital. We are cooperating with the government with respect to this matter.

Pricing

We and certain of our subsidiaries are currently subject to government investigations and civil lawsuits arising out of pricing strategies at facilities owned or formerly owned by our subsidiaries.

Outlier Investigation

On January 2, 2003, the U.S. Attorney's Office for the Central District of California issued an administrative investigative demand subpoena seeking production of documents related to Medicare outlier payments by us and 19 hospitals owned by our subsidiaries.

On January 14, 2003, we received an additional subpoena requesting information concerning outlier payments and our corporate integrity agreement that expired in 1999.

On October 15, 2003, we received another subpoena from the U.S. Attorney's Office seeking medical and billing records from January 1998 to October 15, 2003 for certain identified patients who were treated at two Los Angeles-area facilities owned by our subsidiaries —Encino-Tarzana Regional Medical Center in Tarzana and USC University Hospital. Additionally, the subpoena seeks personnel information concerning certain managers at those facilities during that period, as well as information about the two hospitals' gross charges for the same time period.

The investigation is focused on whether our receipt of outlier payments violated federal law and whether we omitted material facts concerning our outlier revenue from our public filings. We are cooperating with the government with respect to this investigation.

Pricing Litigation

We have been sued in class actions in a number of states regarding the pricing of pharmaceuticals and other products and services at hospitals owned and operated by our subsidiaries. The cases have been brought primarily on behalf of uninsured patients, who were billed at the hospitals' undiscounted gross charge rates. While the specific allegations and relief sought vary from case to case, the plaintiffs generally allege violations of state consumer protection statutes, breach of contract and other state law claims, and seek to enjoin us from continuing the alleged unfair pricing practices and to recover all sums obtained by those practices, including compensatory and punitive damages, restitution, and attorneys' fees and costs. At December 31, 2004, we had accrued $30 million as a minimum liability to address the potential resolution of these cases.

In California, the following actions have been coordinated into one proceeding entitled *Tenet Healthcare Cases II*, J.C.C.P. No. 4289, now pending in the Los Angeles County Superior Court:

(1) *Bishop v. Tenet Healthcare Corp.*, Case No. 2002-074408 (Superior Court of California, County of Alameda, filed December 2, 2002);

(2) *Castro v. Tenet Healthcare Corp.*, Case No. C03-00460 (Superior Court of California, County of Contra Costa, filed February 24, 2003);

(3) *Colon v. Tenet Healthcare Corp.*, Case No. BC 290360 (Superior Court of California, County of Los Angeles, filed February 13, 2003);

(4) *Congress of California Seniors v. Tenet Healthcare Corp.*, Case No. BC 287130 (Superior Court of California, County of Los Angeles, filed December 17, 2002);

(5) *Delgadillo v. Tenet Healthcare Corp.*, Case No. BC 290056 (Superior Court of California, County of Los Angeles, filed February 7, 2003);

(6) *Geller v. Tenet Healthcare Corp.*, Case No. BC 292641 (Superior Court of California, County of Los Angeles, filed March 21, 2003);

(7) *Jervis v. Tenet Healthcare Corp.*, Case No. BC 289522 (Superior Court of California, County of Los Angeles, filed January 30, 2003);

(8) *Moran v. Tenet Healthcare Corp.*, Case No. CV 030070 (Superior Court of California, County of San Luis Obispo, filed February 5, 2003);

(9) *Plocher v. Tenet Healthcare Corp.*, Case No. BC 293236 (Superior Court of California, County of Los Angeles, filed April 2, 2003);

(10) *Vargas v. Tenet Healthcare Corp.*, Case No. BC 291303 (Superior Court of California, County of Los Angeles, filed March 3, 2003);

(11) *Walker v. Tenet Healthcare Corp.*, Case No. BC 03082281 (Superior Court of California, County of Alameda, filed February 7, 2003);

(12) *Watson v. Tenet Healthcare Corp.*, Case No. 147593 (Superior Court of California, County of Shasta, filed December 20, 2002); and

(13) *Yslas v. Tenet Healthcare Corp.*, Case No. BC 289356 (Superior Court of California, County of Los Angeles, filed January 28, 2003).

On December 24, 2003, after the court overruled most of our demurrers to plaintiffs' First Amended and Consolidated Complaint, plaintiffs in the coordinated California action filed a Second Amended and Consolidated Class Action and Representative Complaint against us and all of our California hospitals on behalf of plaintiffs and a purported class consisting of certain uninsured, self-insured and Medicare patients who allegedly paid excessive or unfair prices for prescription drugs or medical products or procedures at hospitals or other medical facilities owned by us or our subsidiaries. The complaint asserts claims for violation of California's unfair competition law, violation of California's Consumers' Legal Remedies Act, breach of contract, breach of the implied covenant of good faith and fair dealing, and unjust enrichment. Plaintiffs seek to enjoin us from continuing the alleged unfair pricing policies and practices, and to recover all sums wrongfully obtained by those policies and practices, including compensatory damages, punitive damages, restitution, disgorgement of profits, treble damages, and attorneys' fees and costs. On January 20, 2004, we answered the Second Amended and Consolidated Complaint and filed counterclaims against the majority of the named plaintiffs for failure to pay the outstanding balances on their respective patient bills. The case is in the class discovery phase, and no due date has been set for plaintiffs' motion for class certification. A status conference is scheduled for March 11, 2005.

In addition to the California coordinated cases, similar class actions have been filed in Tennessee, Louisiana, Florida, South Carolina, Pennsylvania, Texas, Missouri and Alabama.

- *Wade v. Tenet Healthcare Corporation, et al.*, No. Ct-000250-03, was filed in Circuit Court in Memphis, Tennessee on January 15, 2003. The complaint asserts claims for violation of the Tennessee Consumer Protection Act, unjust enrichment, fraudulent concealment, declaratory relief and breach of contract. These claims are based on allegations that we excessively inflated our charges for medical products, medical services and prescription drugs at our hospitals. Plaintiffs seek compensatory and punitive damages, attorneys' fees, and equitable and other relief. On April 28, 2003, we filed a motion to dismiss the complaint. On November 13, 2003, the court accepted our challenges to the sufficiency of the complaint and granted plaintiffs leave to amend to allege certain matters with more specificity. Plaintiffs filed an amended complaint on March 12, 2004. In response to plaintiffs' amended complaint, we plan to file a motion to dismiss and a motion for summary judgment.

- *Wright v. Tenet Healthcare Corp., et al.*, No. 2003 6262, Civil District Court, Orleans Parish, was filed on April 22, 2003 in Louisiana. The court granted our exception to the *Wright* complaint for failure to state a cause of action and gave plaintiff 30 days to amend her petition. On November 14, 2003, plaintiff filed an amended petition, alleging claims against us under the Louisiana Unfair Practices Act, as well as claims for unjust enrichment, fraud and misrepresentation. Another class action was filed in Louisiana on May 5, 2003, entitled *Miranda v. Tenet Louisiana, Tenet Healthcare Corp.*, No. 03 6893, Civil District Court, Orleans Parish. The class action complaint, filed on behalf of all uninsured and partially insured residents of Louisiana who were treated at hospitals affiliated with us in Louisiana since February 1, 1999, alleges that the hospitals charged excessive prices for health care and pharmaceuticals. Plaintiff asserts claims for unjust enrichment, negligent misrepresentation, fraud and misrepresentation, and breach of contract, and seeks compensatory and punitive damages, attorneys' fees and equitable, injunctive and other relief. We filed exceptions seeking to have the complaint dismissed. Plaintiffs then moved to consolidate the *Wright* and *Miranda* actions, and the court granted the unopposed motion. We filed exceptions to the consolidated amended petition, which were denied on July 30, 2004. Discovery has commenced, and a class certification hearing is currently scheduled to begin on December 12, 2005.

- *Garcia v. Tenet Healthcare Corp., et al.*, No. 03 008646 CA 18b, which was filed on May 16, 2003 in Broward County, is pending in Florida. Plaintiffs allege, on behalf of themselves and a purported class of uninsured and partially insured patients, that we and/or our affiliated hospitals charged excessive and unlawful prices for medical products, services and pharmaceuticals. The complaint alleges a violation of Florida's Deceptive and Unfair Trade Practices Act and also asserts claims for unfair competition and unjust enrichment, and seeks damages, attorneys' fees, and injunctive and other equitable relief. We filed a motion to dismiss the complaint, which was heard on April 29, 2004. On December 13, 2004, the court entered an order granting in part and denying in part our motion to dismiss. Plaintiffs were given an extension to file their second amended complaint, but have not yet done so.

- *Comer v. Tenet Healthcare Corporation*, No 03-CP-46-1688, Court of Common Pleas, Sixth Judicial Circuit, York County, was filed in South Carolina on June 19, 2003. The class action has been amended and renamed *Atherton v. Tenet Healthcare Corp. & AMISUB of South Carolina*, Case No. 03-CP-46-1688. The amended complaint alleges, on behalf of plaintiffs and all "uninsured or self-pay patients" treated at Piedmont Medical Center in York County, South Carolina since January 1, 1997, that the charges at Piedmont Medical Center are excessive and in breach of a contract between York County and the defendant and trustees of the hospital to limit charges at the hospital. In addition to this breach of contract claim, plaintiffs also have alleged claims for unjust enrichment and implied contract for value of goods and services received and seek compensatory and punitive damages, injunctive and other relief. We filed a motion for summary judgment on all claims, which was heard on March 1, 2004. On March 29, 2004, the court granted our motion for summary judgment in its entirety as to all claims asserted by plaintiff. On May 10, 2004, plaintiffs appealed the trial court's summary judgment ruling to the Court of Appeals of the State of South Carolina. A hearing on the appeal has not yet been scheduled.

  A second similar class action was filed in South Carolina on September 13, 2004, entitled *Grubb v. Tenet South Carolina, Inc. d/b/a Hilton Head Regional Medical Center, East Cooper Regional Medical Center and Piedmont Medical Center*, No 04-CP-07-1660, Court of Common Pleas, Fourteenth Judicial Circuit, Beaufort County. The plaintiff purports to bring this action on behalf of himself and all uninsured patients who received treatment from Tenet South Carolina hospitals and were charged an undiscounted rate during a period of three years prior to the commencement of the action, and "uninsured patients who will receive medical treatment from

any of these hospitals in the future." Plaintiff alleges three causes of action for breach of contract, unjust enrichment, and declaratory and injunctive relief, and seeks compensatory and other damages, restitution, an injunction, attorneys' fees, and other relief. The action has been removed to the U.S. District Court for South Carolina, where we filed a motion to dismiss on October 22, 2004. The motion is pending. The plaintiff recently moved to amend his complaint in such a way that will eliminate the basis for the federal court's diversity jurisdiction; therefore, we expect the case will be remanded to state court in March 2005.

Two additional similar class actions were filed in the Court of Common Pleas, Charleston County, South Carolina on October 7, 2004, entitled *Robert A. Singletary, Sr. v. Tenet HealthSystem Medical, Inc., et al.*, No. 04-CP-10-4212, and *Allen Singletary, Jr. v. Tenet HealthSystem Medical Inc., et al.*, No. 04-CP-10-4211. In each case, the plaintiffs purport to bring the action on behalf of themselves and all other patients of the defendant who did not receive a statutory discount to which plaintiffs and class members were allegedly entitled under S.C. Code Ann. § 38-71-120. More specifically, the *Allen Singletary* action is asserted on behalf of uninsured patients who would be entitled to the discount; the *Robert Singletary* case is asserted on behalf of insured patients allegedly eligible for the discount. These lawsuits are virtually identical to actions that have been filed against various hospitals throughout South Carolina. The construction of the state statute at issue will be a matter of first impression.

- *Wright v. Tenet Healthcare Corp.*, No. 002365, Court of Common Pleas, Philadelphia County, was filed on December 17, 2003 on behalf of all Pennsylvania residents who allegedly paid unlawful or unfair prices for prescription drugs or medical products or procedures at hospitals or other medical facilities owned by us and/or our subsidiaries. The complaint alleges causes of action for violation of the Pennsylvania Unfair Trade Practices Act, breach of contract, breach of the covenant of good faith and fair dealing, and unjust enrichment, and seeks damages, restitution, injunctive relief and attorneys' fees. We filed a motion to dismiss the action on February 26, 2004. In response, plaintiff filed an amended complaint and, subsequently, filed a motion for leave to amend to add a new plaintiff and several additional defendant entities. Plaintiff's second amended complaint was filed on June 28, 2004. The second amended complaint adds a new representative plaintiff to the putative class and adds as defendants seven Philadelphia hospitals that were affiliated with us during the relevant time period and their parent corporation, Tenet HealthSystem Philadelphia, Inc. Plaintiffs voluntarily dismissed from the case Tenet HealthSystem HealthCorp. and Tenet HealthSystem Hospitals. We filed preliminary objections to the second amended complaint on July 22, 2004. On December 2, 2004, the court issued an order dismissing plaintiffs' claim for intentional interference with contract, but otherwise denying our preliminary objections. We expect to file our answer to plaintiffs' second amended complaint on or about March 11, 2005. Plaintiffs have begun discovery related to class certification, and must move for certification by April 30, 2005.

- *Fernandez v. Park Plaza Hospital and Tenet Healthcare Corporation*, No. 2004-45486, District Court of Harris County, was filed in Texas on August 24, 2004. The complaint is brought on behalf of a purported class of uninsured patients and alleges causes of action for violation of the Texas Deceptive Trade Practices Act, breach of contract, unjust enrichment, and breach of the duty of good faith and fair dealing. The complaint alleges that the defendants charge uninsured patients unreasonable or unconscionable rates that are significantly higher than those paid by insured patients for the same services. On behalf of the purported class, the plaintiff seeks declaratory and injunctive relief, compensatory and punitive damages, restitution and disgorgement, and attorneys' fees. An answer denying the material allegations has been filed, and discovery has commenced.

- *Zimmerly v. Tenet HealthSystem SL, Inc.,* Case No. 042-09386, Circuit Court for the City of St. Louis, was filed in Missouri, and we were served with a complaint on January 11, 2005. The

complaint is brought on behalf of a purported class of uninsured patients treated at St. Louis University Hospital during the period January 1, 2000 through the date of trial. The complaint alleges that the hospital's practice of charging uninsured patients higher rates than those paid by insured patients is unlawful. Specifically, the complaint alleges claims for breach of contract, declaratory judgment, breach of the duty of good faith and fair dealing, violation of the Missouri Merchandising Practices Act, unjust enrichment, constructive trust, and injunctive relief. The complaint seeks compensatory and punitive damages, injunctive and declaratory relief, and a constructive trust.

- *Sims v. Brookwood Medical Center Hospital, et al.,* Case No. CV 05 900, Circuit Court of Jefferson County, was filed in Alabama, and we were served with a complaint on February 17, 2005. The complaint is brought on behalf of a purported class of Alabama uninsured patients treated at Brookwood Hospital during the six years prior to the filing of the complaint. The complaint alleges that the hospital's practice of charging uninsured patients higher rates than those paid by insured patients is unlawful. Specifically, the complaint seeks compensatory damages and restitution on plaintiff's breach of contract and unjust enrichment claims, as well as declaratory and injunctive relief. A responsive pleading is due to be filed on or about March 19, 2005.

***State of Florida, Office of the Attorney, Department of Legal Issues, et al. v. Tenet Healthcare Corporation,* Case No. 05-20591-CIV (U.S. District Court for the Southern District of Florida, filed March 2, 2005)**

The Attorney General of the State of Florida and 13 Florida county hospital districts, systems and non-profit corporations filed a civil action in federal district court in Miami on March 2, 2005 alleging that Tenet's past pricing policies and receipt of Medicare outlier payments violated federal and Florida state Racketeer Influenced and Corrupt Organizations (RICO) Acts, causing harm to the plaintiffs. The civil complaint asserts claims of RICO violations and unjust enrichment on behalf of the plaintiff hospital systems. The complaint also asserts a claim for violation of the Florida Deceptive and Unfair Trade Practices Act on behalf of the State of Florida and the plaintiff hospital systems. The complaint seeks unspecified amounts of damages (including treble damages under RICO), restitution and disgorgement. We were served with this suit on March 4, 2005. We are vigorously defending the company in this matter.

***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 this civil action 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, alleging that Tenet's past pricing policies and receipt of Medicare outlier payments violated the federal Racketeer Influenced and Corrupt Organizations (RICO) Act, causing harm to plaintiffs. The civil complaint asserts claims of RICO violations, as well as claims of fraud, unjust enrichment and violation of the California Unfair Competition Law. The complaint seeks unspecified amounts of damages (including treble damages under RICO), restitution, disgorgement and punitive damages. We were served with this suit on March 2, 2005. We are vigorously defending the company in this matter.

Securities and Shareholder Matters

***In Re Tenet Healthcare Corporation Securities Litigation*, Case No. CV-02-8462-RSWL (U.S. District Court for the Central District of California, Consolidated Second Amended Complaint filed January 15, 2004)**

From November 2002 through January 2003, 20 securities class action lawsuits were filed against Tenet and certain of our officers and directors in the U.S. District Court for the Central District of California and the Southern District of New York on behalf of all persons or entities who purchased our securities during the various class periods specified in the complaints. All of these actions have been consolidated under the above-listed case number in the U.S. District Court for the Central District of California. The procedures of the Private Securities Litigation Reform Act apply to these cases.

On February 10, 2003, the State of New Jersey was appointed "lead" plaintiff in the consolidated actions and its counsel, the law firm of Schiffrin & Barroway, was appointed as lead class counsel.

On January 15, 2004, after the court granted in November 2003 defendants' motion to dismiss plaintiffs' first amended complaint for failure to plead fraud with the required particularity, plaintiffs filed their second amended complaint. The named defendants are Tenet Healthcare Corporation, Jeffrey Barbakow, David Dennis, Thomas Mackey, Raymond Mathiasen, Barry Schochet and Christi Sulzbach. Plaintiffs allege that Tenet and the individual defendants made or were responsible for false and misleading statements concerning the company's receipt of Medicare outlier payments and allegedly medically unnecessary heart surgeries at Redding Medical Center, a hospital we owned in Redding, California until July 16, 2004. Plaintiffs have not specified an amount of monetary damages. Defendants' motions to dismiss were filed on March 1, 2004.

On May 24, 2004, the court heard, and denied, defendants' motions to dismiss. The matter is proceeding with the following claims against the following defendants: (1) securities fraud under Section 10(b) of and Rule 10b-5 under the Securities Exchange Act of 1934 (the "Exchange Act") against Tenet and defendants Barbakow, Dennis and Mackey, (2) control person liability pursuant to Section 20(a) of the Exchange Act against defendants Barbakow, Dennis, Mackey, Mathiasen, Schochet and Sulzbach, (3) insider trading under Section 10(b) of and Rule 10b-5 under the Exchange Act against defendants Barbakow and Mackey, and (4) making false statements in registration statements for our debt offerings under Section 11 of the Securities Act of 1933 and control person liability pursuant to Section 15 of the Securities Act against Tenet and defendants Barbakow, Mackey, Dennis and Mathiasen. On July 6, 2004, all defendants filed answers to the second amended complaint denying all allegations of wrongdoing, setting forth various affirmative defenses and denying any liability for any and all of the causes of action set forth.

On December 21, 2004, the court granted plaintiffs' motion to certify the following class and subclass: (1) all persons and entities who purchased or otherwise acquired our securities between January 11, 2000 and November 7, 2002, including all persons and entities who purchased or otherwise acquired notes pursuant to our registration statements dated September 13, 2000, November 29, 2001 and December 6, 2001, and who were damaged thereby (the "class"); and (2) all persons and entities who purchased our common stock contemporaneously with defendants Barbakow and Mackey's sales of stock between January 11, 2000 and November 7, 2002 (the "subclass"). Discovery has commenced, and the court has set May 2, 2006 as the date the jury trial will begin.

Shareholder Derivative Actions

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

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

The above-listed cases are shareholder derivative actions filed against members of our board of directors and senior management by shareholders purporting to pursue their actions on behalf of Tenet and for our benefit. No pre-lawsuit demand to investigate the allegations or bring the action was made on the board of directors. Tenet is also named as a nominal defendant in each of the cases.

In the California derivative litigation, which involves 10 cases that have been consolidated, the lead plaintiff filed a Consolidated Amended Complaint on March 3, 2003. On May 1, 2003, defendants filed a motion to stay the California derivative litigation in favor of the federal derivative litigation and filed demurrers to all of the causes of action alleged in the Consolidated Amended Complaint. The complaint alleges claims for breach of fiduciary duty, abuse of control, gross mismanagement, waste of corporate assets, unjust enrichment, indemnification and insider trading under California law. The complaint alleges 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 us. The lead plaintiff further alleges that the defendants violated the California insider trading statute because they allegedly knew, but did not disclose, that (1) physicians at hospitals owned by our subsidiaries were routinely performing unnecessary procedures in order to take advantage of Medicare outlier reimbursement, (2) we deliberately raised our prices to take advantage of Medicare outlier reimbursement, (3) our growth was dependent primarily on our continued receipt of Medicare outlier payments, and (4) the rules and regulations related to Medicare outlier payments were being reformed to limit outlier payments, which would have a material negative effect on our revenues and earnings going forward. Plaintiff seeks a declaration that the individual defendants violated their fiduciary duties, compensatory damages plus interest, treble damages under Section 25502.5(a) of the California Corporations Code for insider trading, restitution and disgorgement of profits. On July 22, 2003, the California Superior Court entered an order overruling defendants' demurrer, and granting the motion to stay.

On June 17, 2004, the court, following a motion by the lead plaintiff to lift the stay, ordered that documents produced in the federal derivative action be produced to the plaintiff upon its request and at its expense. Also on June 17, 2004, the court denied defendants' motion to strike the lead plaintiff's writ of mandate seeking documents and discovery under California Corporations Code Section 1601, and ordered us and the plaintiff to meet and confer regarding a discovery referee to determine the permissible scope of plaintiff's inspection. On January 27, 2005, the court denied another motion to lift the stay filed by the lead plaintiff. The action remains stayed until further order of the court. The next case management conference is scheduled for September 15, 2005.

In addition to the derivative litigation pending in the California Superior Court, four derivative cases have also been filed in federal court. These four cases have been consolidated in the U.S. District Court for the Central District of California. Dr. Bernard Stern, North Border Investments and the City of Philadelphia have been appointed lead plaintiffs. Plaintiffs served their First Consolidated Amended Complaint on March 28, 2003, which was dismissed by the court, with leave to amend, pursuant to defendants' motion to dismiss in November 2003.

Plaintiffs filed their amended complaint on January 15, 2004. In addition to common law claims for breach of fiduciary duty, abuse of control, waste of corporate assets, indemnification, insider trading and unjust enrichment, the Second Consolidated Amended Complaint alleges violations of Sections 14(a) and 10(b) of and Rules 14a-9 and 10b-5 under the Exchange Act. Plaintiffs have alleged that the court has diversity jurisdiction over the state law claims. Plaintiffs seek declarations that (1) the directors violated Section 14(a) of the Exchange Act, (2) Jeffrey Barbakow violated Section 10(b) of

and Rule 10b-5 under the Exchange Act, (3) defendants are liable for contribution and indemnification under Section 10(b) of and Rule 10b-5 under the Exchange Act, (4) defendants committed insider trading, and (5) defendants breached their fiduciary duties, were unjustly enriched and must indemnify us under common law. The action also seeks an order that defendants refrain from further breaches of fiduciary duty. Plaintiffs further seek compensatory damages in an unstated amount, recovery of "millions of dollars" of profit from alleged insider trading and imposition of an equitable lien to secure recovery, repayment of salaries and other compensation, statutory treble damages and punitive damages. Defendants filed motions to dismiss this complaint on March 1, 2004.

On May 24, 2004, the court heard all motions to dismiss and granted them in part and denied them in part. As to defendant Barbakow, the court denied the motion to dismiss the claims for alleged violations of Sections 10(b) and 14(a) of and Rules 14a-9 and 10b-5 under the Exchange Act. The court further denied defendant Barbakow's motion to dismiss plaintiffs' claims for breach of fiduciary duty, common law insider trading and misappropriation, unjust enrichment, waste of corporate assets, common law indemnification and abuse of control. The court granted defendant Barbakow's motion to dismiss the claim for contribution under Section 10(b) of the Exchange Act. As to all other defendants, the court granted the motions to dismiss in their entirety.

On June 16, 2004, plaintiffs filed a Third Consolidated Amended Shareholder Derivative Complaint. The third amended complaint sets forth claims for: (1) alleged breach of fiduciary duty against 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, Bratter, Cloud, DeWald, Focht, Honeycutt, Kerrey, Korn, 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 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.

On July 14, 2004, all defendants moved to dismiss the third amended complaint. After a hearing held on September 13, 2004, the court entered an order denying the motions to dismiss as to all claims except one; the court dismissed with prejudice the claim for insider trading and misappropriation against defendants Bratter, Cloud, DeWald, Focht, Honeycutt, Kerrey and Korn. The matter will thus proceed with the following claims against the following defendants: (1) alleged breach of fiduciary duty against defendants Barbakow, Bratter, Cloud, DeWald, Focht, Honeycutt, Kerrey, Korn, Mackey, Mathiasen and 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 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. Defendants' filed answers to the third amended complaint on October 20, 2004. Discovery has commenced, and the court has set July 11, 2006 as the date the trial will begin.

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 securities law provisions

implicated include Sections 10(b) and 17(a) of the Exchange Act, Rules 12b-20, 13a-1 and 13a-13 under the Exchange Act, and regulations associated with those statutes and rules.

The SEC has 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 our independent auditors, and we are cooperating with the government with respect to the investigation.

Redding Medical Center

Redding OIG Administrative Action

On August 4, 2003, following an investigation by federal government agencies regarding whether two physicians, who were independent contractors with medical staff privileges at Redding Medical Center, performed medically unnecessary invasive cardiac procedures at the hospital, we reached a settlement with the United States and the State of California in the amount of $54 million. This settlement resolved all civil and monetary administrative claims that the United States may have had under the False Claims Act, the Civil Monetary Penalties Law, the Program Fraud Civil Remedies Act and/or common law theories of payment by mistake, unjust enrichment, breach of contract and fraud arising out of the performance of, and billings for, allegedly medically unnecessary cardiac procedures at Redding Medical Center from January 1, 1997 through December 31, 2002. In addition, the settlement resolves all civil and monetary administrative claims the State of California may have had under California Government Code Section 12650-54 and/or common law theories of payment by mistake, unjust enrichment, breach of contract and fraud arising out of this same alleged conduct. We were informed by the U.S. Attorney's Office for the Eastern District of California that it would not initiate any criminal charges against Redding Medical Center, Tenet HealthSystem Hospitals or us for the conduct covered by the settlement. The settlement had no effect on the civil litigation described below.

On September 3, 2003, the OIG issued a notice of its intent to exclude Redding Medical Center from participation in the Medicare and Medicaid programs and all other federal health care programs. Subsequently, on December 11, 2003, the OIG agreed to stay further exclusion proceedings against Redding Medical Center, conditioned upon our sale of Redding Medical Center's hospital assets. On July 16, 2004, we sold certain hospital assets of Redding Medical Center to Hospital Partners of America Inc. Redding Medical Center, Inc., our subsidiary that formerly owned the hospital, retained substantially all of its pre-closing liabilities.

Civil Litigation

A significant number of civil cases on behalf of approximately 700 to 800 patients were filed following the announcement in October 2002 that the government was investigating whether two physicians, who had staff privileges at Redding Medical Center, had performed medically unnecessary coronary procedures. Although the specific claims varied from case to case, the complaints generally alleged that the physician defendants knowingly performed medically unnecessary coronary procedures on patients and that we knew or should have known that such medically unnecessary procedures were being performed. The actions were coordinated for pretrial purposes in Shasta County, California.

After a series of pleadings, the court ruled that the plaintiffs were permitted to pursue a negligence claim against us, and also were permitted to pursue their fraud, breach of fiduciary duty, battery and elder abuse claims, but based only upon derivative theories of aiding and abetting and ratification. In addition, although the plaintiffs were permitted to seek compensatory damages, the court struck without prejudice the plaintiffs' requests for punitive damages and attorneys' fees.

On December 21, 2004, we announced that we had reached an agreement in principle to settle substantially all of the patient litigation against us and our subsidiaries arising out of the allegations set forth in the plaintiffs' complaints. We agreed to, and did, establish a settlement fund by December 31, 2004 of $395 million to be allocated among more than 750 plaintiffs who had filed suit. Substantially all of the individual plaintiffs have ratified the settlement, and the court has held that the settlement was entered into in good faith. A small number of cases relating to this matter remain pending, including:

(1) *Corapi v. Chae Moon, M.D., et al.,* Case No. 147223 (Superior Court of California, County of Shasta, filed November 27, 2002);

(2) *Boyd, et al. v. Redding Medical Center, et al.,* Case No. 149035 (Superior Court of California, County of Shasta, filed June 13, 2003);

(3) *Reynolds v. Tenet Healthcare Corp., et al.,* Case No. 150756 (Superior Court of California, County of Shasta, filed January 20, 2004);

(4) *Duffaut v. Tenet Healthcare Corp., et al*., Case No. 151946 (Superior Court of California, County of Shasta, filed June 24, 2004);

(5) *Case v. Tenet Healthcare Corp., et al*., Case No. 152909 (Superior Court of California, County of Shasta, filed October 28, 2004); and

(6) *Giannotti v. Tenet Healthcare Corp., et al*., Case No. 152911 (Superior Court of California, County Shasta, filed October 28, 2004).

We have sought recovery under our excess professional and general liability insurance policies for up to $275 million of our settlement of the Redding claims, but our insurance carriers have raised objections to coverage under our policies. We are pursuing all means available against the insurance carriers in seeking coverage, including, where permitted, filing arbitration demands. Our excess professional and general liability insurance policies covering occurrences prior to June 1, 2003 and having total limits of $275 million with three carriers, are single aggregate policies. Any limits paid, in whole or in part, could deplete or reduce the excess limits available to pay any other serious claims applicable to this policy period.

California Qui Tam Action

***State of California ex rel. John Corapi, et al. v. Tenet Healthcare Corporation, et al.* (Superior Court of California, County of Shasta, filed under seal November 5, 2002, First Amended Complaint filed January 25, 2005)**

This qui tam action was brought under California Insurance Code Section 1871.7 et seq., which allows "interested persons" to file sealed complaints for allegedly fraudulent billings to private insurers. The complaint generally alleges that false claims for payments were made to private insurers for allegedly medically unnecessary procedures performed at Redding Medical Center. Both the California Department of Insurance and the District Attorney of Shasta County, California have declined to intervene in this action. The action was unsealed in October 2004 and, subsequently, was served on the defendants. The plaintiff filed a first amended complaint on January 25, 2005. On February 1, 2005, the court denied our motion to stay the action until completion of the federal criminal proceedings pending against the individual physician co-defendants, but granted a complete stay to those co-defendants. We filed demurrers to plaintiff's first amended complaint on February 18, 2005, and a hearing on the demurrers is scheduled for April 18, 2005. No discovery has taken place, and no trial date has been set.

Medicare Coding

***United States v. Tenet Healthcare Corp., et al*, Case Nos. CV-03-206-GAF, CV-04-857-GAF and CV-04-859-GAF (U.S. District Court for the Central District of California)**

The U.S. Department of Justice, in conjunction with the OIG, has been investigating certain hospital billings to Medicare for inpatient stays reimbursed pursuant to diagnosis-related groups ("DRG") 79 (pneumonia), 415 (operating room procedure for infectious and parasitic diseases), 416 (septicemia), and 475 (respiratory system diagnosis with mechanical ventilator). The investigation is believed to have stemmed initially from the government's nationwide pneumonia "upcoding" initiative and focuses on 103 acute care hospitals owned or acquired by our subsidiaries during the period September 1992 through December 1998. On January 9, 2003, the government filed a lawsuit in the U.S. District Court for the Central District of California in regard to this matter, alleging violations of the federal False Claims Act and various common law theories of liability. The government seeks treble damages and other relief, including punitive damages. At December 31, 2004, we had an accrual of $34 million, recorded in prior years, for this matter.

On November 19, 2003, the District Court (1) granted our motion to dismiss for failure to plead fraud with the requisite particularity, with leave to amend, (2) granted, in part, our motion to sever, with leave to amend, and (3) dismissed, with prejudice, the government's claims for unjust enrichment, disgorgement and recoupment. Pursuant to the District Court's order, on February 6, 2004, the government filed a Second Amended Complaint and two additional related complaints against us and various subsidiaries alleging successor liability for claims submitted by the hospitals' prior owners. On July 19, 2004, we answered the complaints relating to Case Nos. CV-03-206-GAF and CV-04-859-GAF, and, on November 1, 2004, we answered the complaint relating to Case No. CV-04-857-GAF. Discovery has commenced and the trials are set to begin March 6, 2007.

Desert Regional Medical Center Comprehensive Cancer Center

In April 2004, we received a voluntary document request from the U.S. Attorney's Office for the Central District of California seeking, among other items, information from 1993 to April 12, 2004 about coding and billing practices at the Comprehensive Cancer Center at our Desert Regional Medical Center in Palm Springs, California. The request seeks specific information related to 353 patient records. Salick Health Care Inc., an entity not owned by us, manages the Comprehensive Cancer Center. We have operated Desert Regional Medical Center since June 1997 under a long-term lease with the Desert Healthcare District. We are cooperating with the document request.

Other Matters

David L. Dennis Arbitration

On October 27, 2003, David L. Dennis, our former chief financial officer and chief corporate officer, filed a demand for arbitration alleging that he is entitled to payments under a severance benefit plan that our board of directors adopted in January 2003. Our position is that the severance benefit plan does not apply to Mr. Dennis, who resigned in November 2002. The parties are currently in the discovery phase of the arbitration process.

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. We will now be defending in a single court this proposed class action lawsuit alleging

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 not included certain payments in the regular rate of pay that is used for purposes of calculating overtime, and that we have not paid a double time premium when employees work in excess of 12 hours in a day. The plaintiffs seek to certify this action on behalf of virtually all nonexempt employees of our California subsidiaries.

We will argue that certification of a class in the action is not appropriate because there are no uniform policies that fail to comply with the applicable Labor Code and Wage Orders. To the contrary, since 2000, when the applicable California law regarding missed meal and rest periods first went into effect, we have implemented policies consistent with the law that are intended to ensure that (1) employees who miss a rest period or meal break on any given day are appropriately paid and (2) all appropriate forms of compensation are included in the regular rate for overtime calculations and all appropriate overtime premiums are paid. In addition, it is our position that each of these claims must be addressed individually based on its particular facts and, therefore, should not be subject to class certification.

People's Health Network Investigation

In October 2003, People's Health Network, or PHN, an unconsolidated New Orleans health plan management services provider in which one of our subsidiaries holds a 50% membership interest, received two subpoenas from the U.S. Attorney's office in New Orleans seeking certain records from January 1, 1999 to October 9, 2003. The first subpoena, received October 3, 2003, seeks documents including articles of incorporation and bylaws, membership data, agendas and minutes of meetings, and policy manuals from PHN and additional documents related to several New Orleans-area independent physician associations that also hold membership interests in PHN. The second subpoena, received on October 14, 2003, seeks information on patients who were admitted to a rehabilitation unit and members for whom inpatient rehabilitation services were ordered, recommended or requested, and subsequently denied. On November 21, 2003, PHN received two additional subpoenas from the U.S. Attorney's Office in New Orleans. One of the subpoenas to PHN seeks documents and information from January 1, 1999 to October 9, 2003 related to payments to and contractual matters related to physicians and others, as well as third-party reviews of denials of services. The second subpoena to PHN seeks various documents, including agendas, minutes, bylaws, membership data and policies, from June 1, 2002 to November 19, 2003, related to certain medical staff committees and other medical staff entities. On September 9, 2004, PHN received an additional subpoena from the U.S. Attorney's Office in New Orleans seeking various documents, including medical policies and practice guidelines.

On November 21, 2003, the U.S. Attorney's Office in New Orleans also issued a related subpoena to Memorial Medical Center, a New Orleans hospital owned by one of our subsidiaries. That subpoena seeks various documents, including agendas, minutes, bylaws, membership data and policies, from June 1, 2002 to November 19, 2003, related to certain medical staff committees and other medical entities.

We are cooperating with the government with respect to this matter, and continue to provide certain information requested by the government.

Centinela Home Health Care Investigation

On April 13, 2004, we received a voluntary document request from the U.S. Attorney's Office for the Central District of California that primarily seeks information from January 1, 2003 to April 13, 2004 about the relationship between Centinela Hospital Medical Center in Inglewood, California, which

we sold in November 2004, and Allied Homecare Consultants Inc., an independent home health placement service. We are cooperating with the request.

Retained Liabilities

We were notified in mid-2004 that subpoenas had been issued to the buyer of two of our former hospitals, Twin Rivers Regional Medical Center in Missouri and John W. Harton Regional Medical Center in Tennessee. We retained certain liabilities in connection with the sale of these hospitals in November 2003. The Twin Rivers subpoena seeks documents for the period from 1999 through 2003 pertaining to a number of cardiac care patients. The Harton subpoena seeks a variety of documents, primarily financial, for the period from June 2000 through 2003.

On August 3, 2004, we received a voluntary request from the U.S. Attorney's Office in St. Louis, Missouri seeking, among other things, documents regarding physician relocation agreements at four St. Louis area hospitals—two of which we no longer own—as well as Twin Rivers Regional Medical Center. The voluntary request also seeks additional information regarding certain admissions and medical procedures at Twin Rivers. We are cooperating with the government with respect to this matter.

Congressional Investigations

On September 5, 2003, Senator Charles E. Grassley, chairman of the Senate Finance Committee, notified us that the Committee is investigating Tenet and requested documents relating to Redding Medical Center, Medicare outlier payments, patient care and other matters. Since such time, we have received additional requests from the Senate Finance Committee, including requests for quality reviews at certain hospitals. We are cooperating with the Committee with respect to this investigation.

Twenty large health care systems in the United States, including us, received a letter dated July 16, 2003 from the U.S. House of Representatives, Committee on Energy and Commerce, seeking documents related to hospital billing practices and their impact on the uninsured. Specifically, the Committee, through its Subcommittee on Oversight and Investigations, is conducting an investigation into the "sophisticated and complicated forces driving health care financing, including government entitlements, managed care, rising costs, and shrinking public funds." The Subcommittee is seeking input from each of the major health care systems to analyze the impact these competing forces have on the uninsured patient population. To that end, the Subcommittee conducted a hearing on the issues on June 24, 2004. Trevor Fetter, our president and chief executive officer, provided testimony to the Subcommittee at that hearing, and then provided responses to additional questions posed by the Subcommittee in writing after the hearing. We continue to cooperate with the Subcommittee with respect to this investigation, and have provided the Subcommittee with additional information since the June 2004 hearing.

Internal Revenue Service

The Internal Revenue Service has completed an examination of our federal income tax returns for the fiscal years ended May 31, 1995, 1996 and 1997, and has issued a Revenue Agent's Report in which it proposes to assess an aggregate tax deficiency for the three-year audit period of $157 million plus interest of approximately $138 million through December 31, 2004, before any federal or state tax benefit. The Revenue Agent's Report contains several disputed adjustments, including the disallowance of a deduction for a portion of the civil settlement we paid to the federal government in June 1994 related to our discontinued psychiatric hospital business and a disputed adjustment with respect to the timing of the recognition of income for tax purposes pertaining to Medicare and Medicaid net revenues. We have filed a protest with the Appeals Division of the Internal Revenue Service. In the event that these issues cannot be resolved successfully with the Appeals Division, we may further

appeal the findings by filing a petition for redetermination of a deficiency with the Tax Court or by filing a claim for refund in U.S. District Court or in the Court of Federal Claims. In order to file a claim for refund in U.S. District Court or in the Court of Federal Claims, all disputed taxes plus interest must be paid prior to filing the claim. We believe we have adequately provided for all tax matters in dispute related to the Revenue Agent's Report for the fiscal years ended May 31, 1995, 1996 and 1997 as of December 31, 2004.

In addition, the Internal Revenue Service has commenced an examination of our tax returns for the fiscal years ended May 31, 1998 through the seven-month transition period ended December 31, 2002. We presently cannot determine the ultimate resolution of this examination.

Florida Medical Center

Following a January 26, 2005 survey of our Florida Medical Center hospital in Ft. Lauderdale by the Florida Department of Children and Families (DCF) and Florida's Agency for Health Care Administration (AHCA), on February 14, 2005, DCF suspended the hospital's authority to receive involuntary psychiatric patient admissions under the Baker Act, a Florida state law that governs the involuntary admission of psychiatric patients to a hospital. Reports issued by DCF and AHCA cited hospital deficiencies in two principal areas: (1) the transportation of Baker Act patients; and (2) completion of medical record documentation and forms required by the Baker Act. On March 1, 2005, we received a voluntary request for documents from the Florida Attorney General's Medicaid Fraud Control Unit Office in Ft. Lauderdale. The request seeks medical records and billing information for Medicaid patients admitted to Florida Medical Center's psychiatric unit from January 2004 to the present, as well as certain information concerning patients admitted to the hospital under the Baker Act. We are cooperating with all of these state agencies in connection with their reviews, and we are working with DCF to have Baker Act receiving authority reinstituted at Florida Medical Center.

Managed Care Insurance Disputes

We recently resolved our disputes with several managed care plans regarding charges at facilities owned by our subsidiaries and the impact of those charges on stop-loss and other payments. In particular, as announced on February 14, 2005, we resolved a payment dispute involving our California hospitals by entering into a settlement agreement with Health Net, Inc. We and our subsidiaries continue to be engaged in disputes with managed care plans, although our charges and their influence on contract provisions are less frequently the focus of these disputes. For the most part, 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, we are subject to claims and lawsuits in the ordinary course of business. The largest category of these relate to medical malpractice. While most medical malpractice claims arise as separate legal actions, more than 100 individual lawsuits were filed by one law firm in Palm Beach County Circuit Court against Palm Beach Gardens Medical Center in Florida, claiming damages arising as a result of alleged postoperative infections. On December 23, 2004, we announced that our subsidiary that operates Palm Beach Gardens Medical Center had agreed in principle to settle all of these lawsuits, and, by the end of December, we paid $31 million into a settlement fund for the plaintiffs and their counsel. All of the plaintiffs have since executed individual settlement agreements, and we expect dismissal of all of the suits by the end of March 2005.

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

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

	High	Low
Year Ended December 31, 2004		
First Quarter	$ 18.73	$ 9.15
Second Quarter	13.43	10.43
Third Quarter	13.41	9.85
Fourth Quarter	12.45	9.95
Year Ended December 31, 2003		
First Quarter	$ 19.25	$ 16.30
Second Quarter	17.47	11.47
Third Quarter	16.40	11.32
Fourth Quarter	16.20	12.35

On February 28, 2005, the last reported sales price of our common stock on the New York Stock Exchange composite tape was $10.91 per share. As of that date, there were approximately 9,296 holders of record of our common stock.

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 one-year letter of credit facility contains provisions that may have the effect of limiting or prohibiting the payment of dividends from time to time.

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

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 table presents selected audited consolidated financial data for Tenet Healthcare Corporation and its wholly owned and majority-owned subsidiaries for the years ended December 31, 2004 and 2003, the seven-month transition period ended December 31, 2002, and the years ended May 31, 2002 through 2000.

The selected financial data presented below are not necessarily indicative of our future financial position or results of operations. Reasons for this include, but are not limited to (1) our voluntary adoption of a new method for calculating Medicare outlier payments effective January 1, 2003, and subsequent new regulations governing the calculation of such payments, (2) future changes in Medicare regulations, (3) the timing and magnitude of negotiations and resolutions of disputes with managed care companies, (4) fluctuations in revenue allowances and discounts, including the impact of phasing in the discounting components of our *Compact with Uninsured Patients*, (5) the increase in the number of patients who are uninsured, (6) our ability to collect our accounts receivable, particularly in light of recent trends in patient accounts receivable collectibility and associated increases in provisions for doubtful accounts, (7) levels of malpractice expense and settlement trends, (8) the ultimate resolution of investigations and lawsuits and (9) changes in interest rates, tax rates, occupancy levels and patient volumes. Other items include the effects of impairment and restructuring charges, losses from early extinguishment of debt, and other disposals of facilities and other assets, all of which have also occurred during some or all of the periods presented in the below table.

	Years ended December 31		Seven months ended December 31, 2002	Years ended May 31		
	2004	2003		2002	2001	2000
	(In Millions, Except Per-Share Amounts)					
Net operating revenues	**$ 9,919**	**$ 10,146**	**$ 6,069**	**$ 9,734**	**$ 8,419**	**$ 8,054**
Operating expenses:						
Salaries and benefits	4,325	4,239	2,341	3,837	3,332	3,242
Supplies	1,724	1,602	870	1,371	1,174	1,149
Provision for doubtful accounts	1,205	1,135	478	710	596	619
Other operating expenses	2,231	2,108	1,211	1,909	1,756	1,748
Depreciation	368	360	206	347	319	316
Goodwill amortization	—	—	—	85	83	79
Other amortization	20	20	13	23	20	22
Impairment of long-lived assets and goodwill	1,236	1,278	9	76	55	216
Restructuring charges	36	106	13	23	88	95
Costs of litigation and investigations	74	282	—	—	—	—
Loss from early extinguishment of debt	13	—	4	383	56	—
Operating income (loss)	**(1,313)**	**(984)**	**924**	**970**	**940**	**568**
Interest expense	(333)	(294)	(144)	(324)	(452)	(477)
Investment earnings	20	16	13	31	35	22
Minority interests	3	(21)	(10)	(24)	(6)	(14)
Net gains on sales of facilities, long-term investments and subsidiary common stock	10	16	—	—	28	49
Impairment of investment securities	—	(5)	(64)	—	—	—
Income (loss) before income taxes	**(1,613)**	**(1,272)**	**719**	**653**	**545**	**148**
Income tax (expense) benefit	(184)	228	(289)	(319)	(238)	(101)
Income (loss) from continuing operations, before discontinued operations and cumulative effect of accounting change	**$ (1,797)**	**$ (1,044)**	**$ 430**	**$ 334**	**$ 307**	**$ 47**
Basic earnings (loss) per common share from continuing operations	**$ (3.85)**	**$ (2.24)**	**$ 0.89**	**$ 0.68**	**$ 0.64**	**$ 0.10**
Diluted earnings (loss) per common share from continuing operations	**$ (3.85)**	**$ (2.24)**	**$ 0.87**	**$ 0.66**	**$ 0.63**	**$ 0.10**

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

BALANCE SHEET DATA

	December 31			May 31		
	2004	2003	2002	2002	2001	2000
	(In Millions)					
Working capital (current assets minus current liabilities)	$ 1,862	$ 1,854	$ 1,385	$ 829	$ 1,060	$ 1,682
Total assets	10,078	12,298	13,796	13,803	12,995	13,161
Long-term debt, net of current portion	4,395	4,039	3,872	3,919	4,202	5,668
Shareholders' equity	1,732	4,361	5,824	5,697	5,153	4,142

CASH FLOW DATA

	Years ended December 31		Seven months ended December 31, 2002	Years ended May 31		
	2004	2003		2002	2001	2000
	(In Millions)					
Net cash provided by (used in) operating activities	$ (82)	$ 838	$ 1,126	$ 2,315	$ 1,818	$ 869
Net cash used in investing activities	(12)	(333)	(389)	(1,227)	(574)	(36)
Net cash provided by (used in) financing activities	129	(96)	(565)	(1,112)	(1,317)	(727)

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 the Company, 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 earnings and cash flows. 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

SIGNIFICANT CHANGES AND INITIATIVES

During 2004, we continued to focus on the development and execution of our operating strategies, including initiatives we introduced during the year ended December 31, 2003. Management is dedicated to improving our patients', shareholders' and other stakeholders' confidence in us. We believe we will do that by providing quality care and generating positive growth and earnings at our hospitals.

Key initiatives and developments during 2004 included:

- *Proposed Divestitures*—In January 2004, we announced a major restructuring of our operations involving the proposed divestiture of 27 general hospitals (19 in California and eight others in Louisiana, Massachusetts, Missouri and Texas). As of December 31, 2004, we had completed the divestiture of 18 of the 27 hospitals and entered into a definitive agreement for the sale of four more. We continue to work toward entering into definitive agreements to divest the remaining facilities in the plan, with transaction closings to take place as soon as possible. In addition to the restructuring program we announced in January 2004, we completed several other hospital divestitures in 2004 including our general hospital in Barcelona, Spain, certain hospital assets of Redding Medical Center in Redding, California and Medical College of Pennsylvania Hospital ("MCPH") in Philadelphia, Pennsylvania. We also allowed our leases at Century City Hospital in Los Angeles, California and Suburban Medical Center in Paramount, California to expire and closed Northshore Psychiatric Hospital in Slidell, Louisiana. Our continuing operations, beginning in the fourth quarter of 2004, include only our core group of 69 general hospitals that will remain after all previously announced divestitures are completed. By focusing our financial and management resources on the 69 general hospitals that will remain, we expect to create a stronger company with greater potential for long-term growth.

- *Settlement of Litigation*—In December 2004, we reached an agreement to settle substantially all of the patient litigation against us and our subsidiaries arising out of the allegations of medically unnecessary coronary procedures performed at Redding Medical Center for $395 million. We also settled all of the patient litigation against us arising as a result of alleged postoperative infections at Palm Beach Gardens Medical Center for $31 million, which we paid in December 2004. These settlements demonstrate the progress we have made to put some of our legal challenges related to past events behind us.

- *Discounts for Uninsured Patients*—In March 2004, we announced that, where permitted by state law, we would be implementing managed care-style discounts for most of our uninsured patients under our *Compact with Uninsured Patients* ("Compact"). The discounts for uninsured patients began to be phased in during the second quarter of 2004 at many of our hospitals and were in effect at 40 of our 69 general hospitals at the end of the year. Of the remaining 29 hospitals, 17 implemented the Compact during the first quarter of 2005; however, we are still evaluating and addressing legal and other issues that may limit our ability to implement the discounting components of the Compact at our hospitals in Texas.

- *Corporate Headquarters Relocation*—On May 6, 2004, we announced that we would move our corporate headquarters to Dallas, Texas as part of our ongoing effort to improve organizational effectiveness. Effective January 3, 2005, our headquarters were officially moved to Dallas; however, certain functions continue to be systematically transferred to Dallas from our Santa Barbara offices, which will close by the end of June 2005.

- *Opening of Two New Hospitals*—In June 2004, we completed construction of and opened two new hospitals, the 90-bed Saint Francis Hospital—Bartlett in Bartlett, Tennessee, a suburb of Memphis, and the 118-bed Centennial Medical Center in Frisco, Texas, a suburb of Dallas.

- *Appointment of New Members to our Board of Directors*— In March and June 2004, respectively, we announced that Richard R. Pettingill and James A. Unruh had joined the company's board of directors as independent members. Mr. Pettingill was also appointed to the compensation and quality, compliance and ethics committees of the board, and Mr. Unruh was appointed to the audit and nominating and corporate governance committees of the board. Mr. Pettingill currently serves as the president and chief executive officer of Allina Hospitals & Clinics, a not-for-profit network of hospitals, clinics and other health care services based in Minneapolis. He also serves as a director for Allina, Minnesota Hospital Association, Safest in America and Minnesota Business Partnership. Mr. Unruh currently serves as principal of Alerion Capital Group, a private equity firm based in Phoenix. He also serves as a director of Prudential Financial Inc.

- *Consolidation of Operating Regions*— In July 2004, we consolidated our operating regions from five to four in an effort to continue streamlining our operational structure as we build our future around 69 hospitals. Our four regions are California, Central Northeast-Southern States, Florida-Alabama and Texas-Gulf Coast, all of which report directly to our chief operating officer.

SIGNIFICANT CHALLENGES

We believe we made progress this year in building a foundation for sustainable future growth, but our results were disappointing in the areas of volume and provision for doubtful accounts. Our performance was impacted by a combination of challenges specific to us and significant industry trends. Below is a summary of these items:

Company Specific Challenges

Volume decline—Admissions and outpatient visits decreased from the prior year on a total-hospital and same-hospital basis. A portion of the decrease was attributable to the sale or closure of certain home health agencies, hospices, clinics and skilled nursing and rehabilitation units during 2004, and the impact of various hurricanes in the southeastern United States. We believe other reasons for the volume declines include a milder flu season this year compared to last year, the impact of our litigation and government investigations, physician attrition and managed care contract negotiations or terminations.

Litigation and investigations—We continue to defend against a significant amount of litigation and are cooperating with a number of governmental investigations; however, we also seek to resolve certain matters without litigation when appropriate and cost effective. See Note 14 to the Consolidated Financial Statements for a summary of these matters and Part I, Item 3, Legal Proceedings, for more detailed information.

Effective Reimbursement Rates—Pressure from payers also affects our business. We strive to ensure that we are appropriately compensated for the services we provide, but third-party payers continue to ask us to accept lower rates of payment even in the face of rising medical costs. While government regulations determine the amounts we receive for care provided through government programs, we continue to negotiate with managed care payers for adequate and timely reimbursement for our services. We continue to strive to reduce the impact of gross charges on our contractual rates; however, certain payers are unwilling to accept such a change without a reduction in overall net reimbursement to unacceptable levels. Also, we have disputes with a number of third-party payers over payment for past services.

Impairments of long-lived assets and goodwill— 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 $1.2 billion during the fourth quarter of 2004.

Significant Industry Trends

Provision for doubtful accounts— Like others in the health care industry, we also have experienced an adverse change in our business mix and operating results as the level of uninsured and underinsured patients continued to grow. We believe this trend is due to a combination of broad economic factors, including unemployment levels, reductions in state Medicaid budgets, increasing numbers of individuals and employers who choose not to purchase insurance, and an increased burden of co-payments and deductibles to be made by patients instead of insurers. Additionally, many of these patients, who delay or do not seek routine medical care because of the costs, are being admitted through the emergency department and often require more costly care, resulting in higher billings, which are the least collectible of all accounts. Although our Compact is expected to reduce our accounts receivable and provision for doubtful accounts recorded in our consolidated financial statements, it is not expected to mitigate the net economic effects of treating such patients. In addition, we cannot predict how the Compact will affect the collectibility of those accounts.

Providing quality patient care in a competitive and highly regulated environment— The 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 should help to position us competitively to meet these challenges. The initiative is designed to (1) improve patient safety and evidence-based practice, (2) support physician excellence, (3) improve the practice and leadership of nursing, and (4) facilitate improved patient flow and care delivery. A year has passed since we formally launched our C2Q initiative with a series of hospital-based pilot programs. At December 31, 2004, 42 of our hospitals had completed the initial eight-week "transformation" phase and 10 hospitals were in process. We plan to complete the full initial implementation of our C2Q initiative by the end of 2005. At most hospitals that have completed the initial eight-week transformation phase, we have seen various levels of reductions in emergency room wait times, increases in on-time starts in the operating rooms, and improved bed management and care coordination.

Cost Pressures—A significant cost pressure facing us and the industry in general is the ongoing increase in labor costs due to a nationwide shortage of nurses and the enactment of state laws regarding nurse-staffing ratios. The nursing shortage is more serious in certain specialties and in certain geographic areas than others, including several areas in which we operate hospitals, and has resulted in increased costs for nursing personnel. State-mandated nurse-staffing ratios adversely 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 that went into effect on January 1, 2004. We have, however, gradually improved our monthly compliance and strive to make continued improvements into 2005.

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 wage and benefit pressures created by the current nursing shortage throughout the country and escalation in state-mandated nurse-staffing ratios. In November 2004, California delayed its next increase in the mandated ratios until at least 2008, which will abate some of the anticipated cost increases in 2005. Nevertheless, we may be required to enhance wages and benefits to recruit and retain nurses. We may also be required to increase our use of temporary personnel, which is typically more expensive. Significant efforts are being invested in workforce development with local schools of nursing and in recruitment of experienced nurses.

RESULTS OF OPERATIONS—OVERVIEW

Our results of operations for the last two years reflect the challenges we have faced in restructuring our operations to focus on a smaller group of general hospitals. We believe the actions we have taken will help to return us to profitability; however, the process will take time and our turnaround timeframe is hampered by industry trends that negatively affect our revenue growth and operating expenses. Our future profitability depends significantly on volume growth, reimbursement levels and cost control. Below are some of the highlights from 2004 compared to 2003:

- Net inpatient revenue per patient day and per admission increased by 0.7% and 1.2%, respectively, despite the implementation, during the last half of the year, of our discounting of self-pay charges under the Compact.

- Net outpatient visits and outpatient revenue decreased by 4.3% and 4.7%, respectively.

- Two material patient litigation matters (Redding and Palm Beach Gardens) were settled in the fourth quarter of 2004, resulting in charges to our operations.

- We refinanced debt and increased liquidity through private placements of debt, pushing our next major maturity out to December 2011, after various debt extinguishments in the first quarter of 2005.

- Cash used in operating activities was $82 million (prior to capital expenditures and asset sale proceeds), which included payments for restructuring, litigation and settlement costs of $280 million and a use of cash in our discontinued operations of $408 million, which included a $395 million legal settlement related to Redding Medical Center.

- Loss per diluted share from continuing operations increased $1.61 to $(3.85), reflecting lower revenues due to lower volumes and the closure or sale of certain home health agencies, hospices, clinics and skilled nursing facilities and rehabilitation units and establishing a valuation allowance on deferred tax assets associated with continuing operations of $480 million.

Results of operations—Year ended December 31, 2003 compared to the fiscal year ended May 31, 2002

- Net inpatient revenue per admission was $9,401 in the year ended December 31, 2003 compared to $9,449 in the year ended May 31, 2002. This decrease is primarily due to the lower outlier revenue beginning January 1, 2003.

- Patient days and admissions increased by 4.2% and 5.4%, respectively, in 2003.

- Loss per diluted share from continuing operations was $(2.24) in the year ended December 31, 2003 compared to earnings per share of $0.66 in the year ended May 31, 2002. This decrease reflects lower outlier revenue and increased charges recorded for impairment and restructuring and litigation and investigations.

- We recorded a loss from early extinguishment of debt of $383 million during the year ended May 31, 2002 in connection with the repurchases of $3.7 billion of debt.

- Cash flow from operations decreased to $838 million in the year ended December 31, 2003 from $2.3 billion in the year ended May 31, 2002, primarily due to lower net revenues and declining cash flow performance from our hospitals included in discontinued operations.

The table below shows the pretax and after-tax impact on continuing operations of (1) additional provision for doubtful accounts, (2) goodwill amortization, (3) impairment of long-lived assets and goodwill, (4) restructuring charges, (5) costs of litigation and investigations, (6) loss from early extinguishment of debt, (7) net gains on sales of facilities, long-term investments and subsidiary

common stock, and (8) impairment of investment securities for the years ended December 31, 2004 and 2003, the seven months ended December 31, 2002, and the year ended May 31, 2002:

	Years ended December 31		Seven months ended December 31, 2002	Year ended May 31, 2002
	2004	2003		
	(In Millions, Except Per-Share Amounts)			
Additional provision for doubtful accounts	$ (196)	$ (166)	$ —	$ —
Goodwill amortization	—	—	—	(85)
Impairment of long-lived assets and goodwill	(1,236)	(1,278)	(9)	(76)
Restructuring charges	(36)	(106)	(13)	(23)
Costs of litigation and investigations	(74)	(282)	—	—
Loss from early extinguishment of debt	(13)	—	(4)	(383)
Net gains on sales of facilities, long-term investments and subsidiary common stock	10	16	—	—
Impairment of investment securities	—	(5)	(64)	—
Pretax impact	$ (1,545)	$ (1,821)	$ (90)	$ (567)
Deferred tax asset valuation allowance	$ (480)	$ —	$ —	$ —
Total after-tax impact	$ (1,731)	$ (1,385)	$ (56)	$ (380)
Diluted per-share impact of above items	$ (3.71)	$ (2.97)	$ (0.11)	$ (0.76)
Diluted earnings (loss) per share, including above items	$ (3.85)	$ (2.24)	$ 0.87	$ 0.66

LIQUIDITY AND CAPITAL RESOURCES—OVERVIEW

Net cash used in operating activities was $82 million in the year ended December 31, 2004 compared to net cash provided by operating activities of $838 million in the year ended December 31, 2003. The principal reasons for the change were increased net losses, the payment of litigation settlements and the impact of changes in certain working capital components.

Proceeds from the sales of facilities, long-term investments and other assets during the year ended December 31, 2004 aggregated $431 million. The proceeds from the actual and anticipated divestitures of our domestic hospitals and our hospital in Barcelona, Spain in the year ended December 31, 2004 and any anticipated tax benefits associated with such divestitures should further bolster our liquidity. We expect a significant portion of the proceeds to be received in the form of tax refunds from anticipated tax losses that will result from these divestitures.

In June 2004, we issued $1 billion of senior notes due in 2014 and subsequently used a portion of the $954 million of net proceeds, after deducting discounts and related expenses, to repurchase $552 million of senior notes due in 2006 through 2008.

On December 31, 2004, we terminated our then-existing credit agreement and replaced it with a new $250 million, one-year secured letter of credit facility. The new facility provides for the issuance of up to $250 million in letters of credit and does not provide for any cash borrowings. The new facility is secured by the stock of certain of our subsidiaries and cash collateral equal to 105% of the facility amount (approximately $263 million reflected as restricted cash on the consolidated balance sheet). In January 2005, we sold $800 million of unsecured $9^{1}/_{4}$% senior notes with registration rights in a private placement. The net proceeds from the sale of the senior notes were approximately $773 million after deducting discounts and related expenses. We used the proceeds in February 2005 to redeem our remaining $400 million outstanding senior notes due in 2006 and 2007, and for general corporate purposes. 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 the time.

We are currently in compliance with all covenants in our letter of credit facility and the indentures governing our senior notes. (See Note 6 to the Consolidated Financial Statements.) At December 31, 2004, we had approximately $216 million of letters of credit outstanding under the letter of credit facility, which was fully collateralized by the $263 million of restricted cash. In addition, we had $654 million of unrestricted cash and cash equivalents on hand.

OUTLOOK

We have implemented a variety of programs and initiatives, previously announced and discussed herein, in an effort to address the various challenges that we presently face. However, we do not anticipate significant improvement in operating performance to be achievable in 2005 because overcoming many of these challenges will require time. These challenges include, but are not limited to, ongoing issues resulting from our prior pricing strategy, provisions for doubtful accounts, reduced net cash flow from operations, and the need to resolve a number of government investigations and legal actions. We believe that our decision to divest all but 69 of our hospitals, the consolidation of our regions, our ongoing program to reduce costs and enhance operating performance, and our clinical quality initiatives will ultimately position us to report improved results of operations. Our hospitals that have already been sold or that are scheduled for divestiture are expected to generate negative cash flow, excluding sales proceeds, in the aggregate, during the entire sale process time period, and the expected long-term benefits of our cost-saving initiatives will be temporarily offset by restructuring costs, costs to implement our planned initiatives, and other costs. In the long term, however, we believe the prospects for the 69 hospitals that we will continue to operate are positive as a whole, relative to their current levels, and the restructuring and other initiatives we have undertaken will position us to improve our future financial performance.

SOURCES OF REVENUE

We receive revenues for patient services from a variety of sources, primarily, the federal Medicare program, state Medicaid programs, managed care payers (including preferred provider organizations and health maintenance organizations), 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			Seven months ended December 31, 2002	Year ended May 31, 2002
	2004	2003	Increase (Decrease)(1)		
Medicare	26.1%	25.1%	1.0%	28.5%	29.6%
Medicaid	7.4%	7.7%	(0.3)%	6.4%	6.5%
Managed care(2)	49.7%	51.0%	(1.3)%	50.0%	47.4%
Indemnity, self-pay and other	16.8%	16.2%	0.6%	15.1%	16.5%

(1) The change is the difference between the 2004 and 2003 amounts shown.
(2) Includes Medicare Advantage and Medicaid managed care.

GOVERNMENT PROGRAMS

The Medicare program, the nation's largest health insurance program, is administered by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services ("CMS"). Medicare is a health insurance program primarily for individuals 65 years of age and older, certain disabled individuals, and people with end-stage renal disease, and is provided without regard to

income or assets. Medicaid is a program that pays for medical assistance 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 individuals with limited income.

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 government program payments in the future, as well as affect the cost of providing services to patients and the timing of payments to facilities. We are unable to predict the effect of future government health care funding policy changes on our operations. If the rates paid or the scope of services covered by governmental payers are reduced, if we are required to pay substantial amounts in settlement pertaining to government programs, or if we, or one or more of our subsidiaries' hospitals, are excluded from participation in the Medicare, Medicaid or other government health care programs, there could be a material adverse effect on our business, financial position, results of operations or cash flows. The government is investigating various matters, including Medicare outlier payments we received in prior years, as discussed under Part I, Item 3, Legal Proceedings, of this report.

Medicare

Medicare offers beneficiaries different ways to obtain their medical benefits. One option, the Traditional Medicare Plan is a fee-for-service payment system. The other option, called Medicare Advantage (formerly Medicare + Choice), includes managed care and private fee-for-service plans. The major components of our net patient revenues for services provided to patients enrolled in the Traditional Medicare Plan for the years ended December 31, 2004 and 2003, the seven months ended December 31, 2002 and the year ended May 31, 2002 are set forth in the table below:

Revenue Descriptions	Years ended December 31		Seven months ended December 31, 2002	Year ended May 31, 2002
	2004	2003		
			(In Millions)	
Diagnosis-related group—operating	$ 1,407	$ 1,387	$ 727	$ 1,256
Diagnosis-related group—capital	149	147	85	169
Outlier	64	101	304	454
Outpatient	418	410	234	385
Disproportionate share	215	189	97	168
Direct Graduate and Indirect Medical Education	129	108	65	121
Inpatient psychiatric	76	75	44	73
Inpatient rehabilitation	123	141	83	115
Skilled nursing facilities and other	17	28	70	44
Adjustments for valuation allowance and prior-year cost report settlements	(33)	(62)	(9)	27
Total Medicare net patient revenues	**$ 2,565**	**$ 2,524**	**$ 1,700**	**$ 2,812**

Acute Care Hospital Inpatient Prospective Payment System

Diagnosis-Related Group Payments—Sections 1886(d) and 1886(g) of the Social Security Act (the "Act") set forth a system of payments for the operating and capital costs of acute care hospital stays based on a prospective payment system ("PPS"). Under the PPS, Medicare payments for hospital inpatient operating and capital-related costs are made at predetermined rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"), which group patients with similar clinical characteristics that are expected to require similar amounts of

hospital resources. CMS assigns to each DRG a relative weight that represents the average resources required to care for cases in that particular DRG, relative to the average resources used to treat cases in all DRGs. Effective October 1, 2004, the federal DRG classification system includes 543 categories.

The base payment amount for operating costs is comprised of an average standardized amount that is divided into a labor-related share and a nonlabor-related share. Both the labor-related share of the operating base payments and the capital base payments are adjusted by the geographic variations in labor and capital costs. These base payments are multiplied by the relative weight of the DRG assigned to each case. Although these payments are adjusted for area labor and capital cost differentials, the adjustments do not take into consideration an individual hospital's operating and capital costs. The DRG operating and capital base rates are updated annually, giving consideration to the increased cost of goods and services purchased by hospitals. The rate increases that became effective on October 1, 2004 and October 1, 2003 were 3.3% and 3.4%, respectively.

Outlier Payments—Outlier payments, which were established by Congress as part of the DRG prospective payment system, are additional payments made to hospitals for treating Medicare patients who are costlier to treat than the average patient in the same DRG. To qualify as a cost outlier, a hospital's billed (or gross) charges, adjusted to cost, must exceed the payment rate for the DRG by a fixed threshold established annually by CMS. The Medicare fiscal intermediary calculates the cost of a claim by multiplying the billed charges by the cost-to-charge ratio from the hospital's most recent filed cost report. If the computed cost exceeds the sum of the DRG payment plus the fixed threshold, the hospital receives 80% of the difference as an outlier payment.

Under the Act, CMS must project aggregate annual outlier payments to all PPS hospitals to be not less than 5% nor more than 6% of total DRG payments ("Outlier Percentage"). The Outlier Percentage is determined by dividing total outlier payments by the sum of DRG and outlier payments. CMS annually adjusts the fixed threshold to bring expected outlier payments within the mandated limit. A change to the fixed threshold affects total outlier payments by changing (1) the number of cases that qualify for outlier payments, and (2) the dollar amount hospitals receive for those cases that still qualify. The most recent change to the cost outlier threshold that became effective on October 1, 2004 was a decrease from $31,000 to $25,800, which CMS projects will result in an Outlier Percentage of 5.1%. In August 2004, CMS estimated that the actual Outlier Percentage for Federal Fiscal Year ("FFY") 2004 will be 3.5%, 1.6 percentage points lower than the 5.1% CMS projected in setting outlier policies for FFY 2004.

On January 6, 2003, in response to concerns raised by CMS regarding the level of outlier payments we were receiving, we voluntarily submitted a proposal to CMS that would reduce outlier payments to our hospitals retroactive to January 1, 2003. During 2003, CMS issued new regulations governing the calculation of outlier payments to hospitals. Those regulations, which became effective August 8, 2003, included several significant changes, many of which were contemplated in our proposal.

Our proposal to CMS included a provision to reconcile the payments we would receive under our proposed interim arrangement to those we would have received if the new CMS regulations had gone into effect on January 1, 2003 up to the effective date of the final rules and regulations (the "Reconciliation Period"). Effective August 8, 2003, outlier payments to our hospitals began to be calculated by the fiscal intermediary in accordance with the final rule, which applies to all hospitals. The final determination and outcome of outlier payments under the reduction arrangement continues to be the subject of further review and approval by CMS. The final outcome could result in an additional material increase to the ultimate amount of outlier revenue we could potentially recognize for the Reconciliation Period, but this remains unknown at this point.

Also, in July 2004 we were informed that CMS is reviewing the application of their rules concerning the use of the statewide ratio of cost to charges for calculating outlier payments for prior years principally related to the acquisition of our Philadelphia-area hospitals in 1998. This matter is

unresolved at this time and we cannot predict the final outcome. An adverse final determination could result in a material decrease to outlier revenue recorded in prior years.

Additionally, on December 20, 2002, CMS issued Program Memorandum A-02-126 that instructed Medicare fiscal intermediaries to identify hospitals that "appear, through data analysis, to present the greatest risk to the program." Based on the results of the data analysis, the Program Memorandum instructed the fiscal intermediaries to perform certain audit and review steps of cost reports, charges and medical records. Shortly after the Program Memorandum was issued, we were informed that the required audits and reviews of any of our hospitals would be postponed until CMS issued further guidance to our fiscal intermediary in this regard. In October 2004, we were informed that CMS had instructed our fiscal intermediary to proceed with the required audits and reviews, and we were also advised that 16 of our hospitals, including nine hospitals that are part of our divestiture plan, have been identified as meeting the criteria for audit and/or review. We cannot predict what impact, if any, the results of these audits and reviews will have on Medicare revenue recorded in the current or prior years.

Hospital Outpatient Prospective Payment System

Under the outpatient prospective payment system, hospital outpatient services, except for certain services that are reimbursed on a fee schedule, are classified into groups called ambulatory payment classifications ("APC"). Services in each APC are similar clinically and in terms of the resources they require, and a payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. CMS periodically updates the APCs and annually adjusts rates paid for each APC.

Disproportionate Share Payments—If a Medicare-participating hospital serves a disproportionate share of low-income patients, it receives a percentage add-on to the DRG payment for each case. This percentage varies, depending on several factors that include the percentage of low-income patients served. During 2004, 54 of our hospitals in continuing operations qualified for disproportionate share payments.

Direct Graduate and Indirect Medical Education—The Medicare program provides additional reimbursement to approved teaching hospitals for additional expenses incurred by such institutions. This additional reimbursement, which is subject to certain limits, including intern and resident full-time equivalent ("FTE") caps established in 1996, is made in the form of Direct Graduate Medical Education ("GME") and Indirect Medical Education ("IME") payments. During 2004, 25 of our hospitals in continuing operations were affiliated with academic institutions and were eligible to receive such payments. Medicare rules permit hospitals to enter into Medicare GME Affiliation Agreements for the purpose of applying the FTE limits on an aggregate basis, and some of our hospitals have entered into such agreements.

Inpatient Psychiatric Prospective Payment System

Effective January 1, 2005, CMS implemented a new system of reimbursement for hospital inpatient psychiatric services to replace a cost-based payment system. The inpatient psychiatric facility prospective payment system ("IPF-PPS") applies to psychiatric hospitals and psychiatric units located within acute care hospitals that have been designated as exempt from the hospital inpatient prospective payment system. The IPF-PPS includes several provisions to ease the transition to the new payment system. For example, CMS is phasing in the IPF-PPS for existing hospitals and units over a three-year period to avoid disrupting the delivery of inpatient psychiatric services. Full payment under the IPF-PPS begins in the fourth year. The IPF-PPS, which is based on prospectively determined per diem rates, includes a stop-loss provision to protect providers against significant losses during the transition period, and an outlier policy that authorizes additional payments for extraordinarily costly cases.

At December 31, 2004, 21 of our hospitals in continuing operations operated Medicare-certified psychiatric units. Because of the aforementioned three-year transition and stop-loss provisions of the IPF-PPS, we do not believe the new payment system will have a material impact on our 2005 inpatient psychiatric payments.

Inpatient Rehabilitation Reimbursement

Medicare payments to qualifying inpatient rehabilitation facilities are generally higher than those paid under the Medicare acute hospital prospective payment system for similar services. Rehabilitation hospitals and rehabilitation units within acute care hospitals that are designated as exempt from the acute hospital PPS are paid according to the inpatient rehabilitation facility prospective payment system ("IRF-PPS"). Among the criteria established by CMS that a hospital or unit must satisfy to qualify for the exemption from the acute hospital PPS is the ability to demonstrate that a significant percentage of the patients admitted to the rehabilitation hospital or unit have medical conditions requiring rehabilitation as specified in the CMS regulations. Failure to satisfy this requirement could result in the rehabilitation hospital or unit losing its exemption from the acute hospital PPS.

On April 30, 2004, CMS released a final rule that revises the medical condition criteria rehabilitation hospitals and units must meet. The new regulations make it possible for facilities treating a broader range of patients who require intensive rehabilitation to qualify for payments as inpatient rehabilitation facilities. It does so by, among other things, increasing the number of qualifying medical conditions from 10 to 13. The final rule also replaced the current 75% compliance threshold with a three-year transition compliance threshold of 50%, 60% and 65% for years one, two and three, respectively, that commences with cost reporting periods beginning on or after July 1, 2004. At the end of the three-year transition period, the compliance threshold will be 75% if CMS does not take further regulatory action.

At December 31, 2004, we operated two inpatient rehabilitation hospitals and 20 of our hospitals in continuing operations operated inpatient rehabilitation units. Based on our preliminary analysis, approximately 50% of these 20 hospital units and two inpatient rehabilitation facilities do not meet the first year 50% compliance threshold. With respect to the compliance threshold, the final rule contains a 12-month review period, which for 10 of our units and facilities commenced on September 1, 2004; the review period for the remaining 12 units and facilities commenced on February 1, 2005. The results of the 12-month review will determine the facility's or unit's eligibility for payment under the IRF-PPS for the first cost reporting period that begins after the end of the review period.

In accordance with the Consolidated Appropriations Act, 2005 enacted on December 8, 2004, CMS may not use the revised requirements to change the classification of inpatient rehabilitation facilities or units that were classified as such until CMS either: (1) determines that the current regulations are not inconsistent with a soon-to-be-released Government Accountability Office ("GAO") inpatient rehabilitation facility ("IRF") study; or (2) issues an interim final rule revising the regulations used to classify a facility as an inpatient rehabilitation facility in accordance with the provisions of the GAO IRF study.

If our rehabilitation hospitals and units fail to continue to qualify as inpatient rehabilitation facilities, our business, financial position, results of operations or cash flows could be materially adversely affected.

Cost Reports

The final determination of certain Medicare payments to our hospitals, such as IME, GME, disproportionate share, and bad debt expense, are retrospectively determined based on our hospitals' cost reports. The final determination of these amounts often takes many years to resolve because of

audits by the program representatives, providers' rights of appeal, and the application of numerous technical reimbursement provisions.

Prior to the fourth quarter of 2003, we recorded estimates for contractual allowances and cost report settlements based on amounts generated from information accumulated from various accounting and information systems. Adjustments to these accruals were generally made upon the final settlement of Medicare and Medicaid cost reports. In the fourth quarter of 2003, we completed the implementation of a new system and estimation process for recording Medicare net revenue and estimated cost report settlements. This resulted in a refinement in recording the accruals to more closely reflect the expected final settlements on our cost reports. For filed cost reports, we now record the accrual based on those cost reports and subsequent activity, and record a valuation allowance against those cost reports based on historical settlement trends. The accrual for periods for which a cost report is yet to be filed is now recorded based on estimates of what we expect to report on the filed cost reports and a corresponding valuation allowance is recorded as previously described. Cost reports must be filed generally within five months after the end of the annual cost report reporting period. After the cost report is filed, the accrual and corresponding valuation allowance may need to be adjusted.

Medicaid

Medicaid programs are funded by both the federal government and state governments. These programs and the reimbursement methodologies are administered by the states and vary from state to state.

Estimated payments under various state Medicaid programs, excluding state-funded managed care programs, constituted approximately 7.4% of net patient revenues at our continuing general hospitals for the year ended December 31, 2004. These payments are typically based on fixed rates determined by the individual states. We also receive disproportionate-share payments under various state Medicaid programs. For the years ended December 31, 2004 and 2003, our disproportionate-share payments and other state-funded subsidies were approximately $78 million and $76 million, respectively.

Many states in which we operate are facing budgetary challenges that pose a threat to Medicaid funding levels to hospitals and other providers. We expect these challenges to continue; however, we cannot predict the extent of the impact of the states' budget reductions on our hospitals. Also, any changes to federal Medicaid funding methodologies or levels to the states could materially adversely impact Medicaid payments to our hospitals.

Legislative and Regulatory Changes

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") (P.L. 108-173), which was signed into law on December 18, 2003, includes several provisions affecting hospital Medicare and Medicaid reimbursement. Below is a summary of the significant provisions affecting our hospitals' reimbursement:

Medicare—Medicare inpatient prospective payment system payments were increased by 3.3% in FFY 2004, a rate equal to the full market basket index. For FFYs 2005, 2006 and 2007, hospitals will receive an inpatient update equal to the full market basket rate if they submit quality performance data to the U.S. Department of Health and Human Services ("HHS"). Those hospitals not submitting quality performance data for 10 quality measures will receive an increase equal to the market basket rate minus 0.4 percentage points. The update reduction is a one-year adjustment and does not affect the base amount inflated from year to year. Hospitals not submitting quality data in FFY 2005 may choose to submit data in 2006 or 2007 and would then receive a full inflationary update. In order to

qualify for the full market basket update, hospitals must submit performance data on all patients on the 10 quality measures that are a subset of common hospital performance measures developed and aligned by CMS and the Joint Commission on Accreditation of Healthcare Organizations and endorsed by the National Quality Foundation. All of our hospitals currently participate in the National Voluntary Initiative and will, as required by CMS, report the quality data on all 10 measures to receive the full market basket update.

The indirect medical education adjustment decreases from 6.0% at the end of FFY 2004 to 5.8% in FFY 2005 then to 5.55% in FFY 2006 and down to 5.35% in FFY 2007. It increases to 5.5% for FFY 2008 and beyond.

Medicaid—The reduction in Medicaid Disproportionate Share hospital funding (referred to as the "DSH cliff") in FFY 2004 was eliminated and the DSH allotment increased 16% over FFY 2003 levels. Subsequent years are frozen at 2004 levels until the allotment level intersects with where it would have been absent relief from the Balanced Budget Act. Increases thereafter are tied to the change in the Consumer Price Index.

Annual Update to the Medicare Inpatient Prospective Payment System

Under Medicare law, CMS is required annually to update certain rules governing prospective payments for acute, rehabilitation and skilled nursing facilities. The updates generally become effective October 1, the beginning of the federal fiscal year. On August 11, 2004, CMS issued the final inpatient hospital prospective payment rules for FFY 2005. The final rules implement major provisions of the MMA pertaining to hospital payments. CMS projects that the combined impact of the changes will yield an average 5.4% increase in inpatient payments for large urban (populations over one million) hospitals. Significant changes include:

- An inflation update for DRG operating payments equal to the hospital market basket percentage of 3.3% for hospitals reporting specified quality data.
- A decrease in the cost outlier threshold from $31,000 to $25,800.
- An increase in the number of DRGs subject to the post-acute transfer policy from 29 to 30.

Other changes include:

- Replacing the Metropolitan Statistical Areas and New England County Metropolitan Areas with the new Core Based Statistical Area definitions for purposes of determining hospital geographic classification.
- A 0.7% inflation update for DRG capital payments.
- Implementing a provision of the MMA that redistributes unused residency slots to teaching hospitals for purposes of calculating Medicare payments for direct and indirect graduate medical education.
- Incorporating 10% of the Occupational Mix Adjustment to the prospective payment wage index that is used to account for geographic differences in labor costs. Section 1886(d)(3)(E) of the Social Security Act requires CMS to collect data every three years on the occupational mix of employees for each acute care hospital participating in the Medicare program in order to construct an occupational mix adjustment to the wage index.

Annual Update to the Medicare Outpatient Prospective Payment System

On November 15, 2004, CMS issued the final changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2005 Payment Rates. CMS projects that the combined impact of the proposed changes will yield an average 3.9% increase in outpatient payments for large urban (populations over one million) hospitals.

Medicare Payment Advisory Commission Recommendation

The Medicare Payment Advisory Commission ("MedPAC"), an independent federal body established by the Balanced Budget Act of 1997, advises the U.S. Congress on issues affecting the Medicare program, including payments to providers and health plans participating in Medicare, and analyzes access to care, quality of care and other issues affecting Medicare. On January 12, 2005, the MedPAC Commissioners approved a recommendation calling for a FFY 2006 payment update for inpatient and outpatient payments of market basket minus 0.4%. Current forecasts project that the market basket of hospital goods and services will increase 3.1% in FFY 2006.

The MedPAC Commissioners also voted unanimously to recommend that Congress extend until January 1, 2007 an existing moratorium that prohibits the development of new limited-service facilities, such as specialty hospitals in which the physicians have an ownership interest, and recommended a number of payment policy changes designed to address the payment inequities created by limited-service facilities.

On March 1, 2005, the MedPAC released its March 2005 *Report to Congress: Medicare Payment Policy* ("March Report"). Included in the March Report are the following recommendations:

- Medicare should pay more for higher quality performance from hospitals, home health agencies and physicians.
- For hospital inpatient and outpatient prospective payment systems, payment updates equal a market basket index minus 0.4 percent.

The March Report also states that in a forthcoming Congressional report on physician owned specialty hospitals, MedPAC is recommending several refinements to the acute inpatient PPS that will improve the accuracy of payments at the case level. These include:

- Refining the current DRGs to more fully capture differences in severity of illness among patients;
- Basing the DRG relative weights on the estimated cost of providing care, rather than on charges;
- Basing the weights on the national average of hospitals' relative costs in each DRG; and
- Adjusting the DRG relative weights to account for differences in the prevalence of high-cost outlier cases.

We cannot predict what action Congress or HHS will take on these recommendations or the impact, if any, these recommendations will have on our hospitals.

2006 Federal Budget Proposal

On February 7, 2005, the White House released its FFY 2006 budget proposal to Congress. The President's budget proposal assumes: (1) a full market basket increase for hospital inpatient and outpatient services as specified under current law and (2) expansion of the Medicare transfer payment policy for hospital inpatients transferred to post acute settings. The budget proposal also includes (1) an endorsement of the MedPAC proposal to address the payment inequities between acute care hospitals and limited-service specialty facilities in which physicians have an ownership interest and (2) a number of reform measures to the Medicaid program, which could reduce federal Medicaid spending, as well as proposed new spending initiatives designed to improve access to health insurance. We cannot predict the final outcome of the President's budget proposal or the effect it may have on our hospitals and facilities.

PRIVATE INSURANCE

Managed Care

We currently have thousands of managed care contracts with various health maintenance organizations ("HMOs") and Preferred Provider Organizations ("PPOs"). HMOs generally maintain a full-service health care delivery network comprised of physician, hospital, pharmacy and ancillary service providers that HMO members must access through an assigned "primary care" physician. The member's care is then managed by his or her primary care physician and other network providers in accordance with the HMO's quality assurance and utilization review guidelines so that appropriate health care can be efficiently delivered in the most cost-effective manner. HMOs typically provide no benefit or reimbursement to their members who use non-contracted health care providers.

PPOs generally offer limited benefits to members who use non-contracted health care providers. PPO members who use contracted health care providers receive a preferred benefit, typically in the form of lower co-payments or deductibles. As employers and employees have demanded more choice, managed care plans have developed hybrid products that combine elements of both HMO and PPO plans.

The amount of our net patient revenue under managed care contracts during the years ended December 31, 2004 and 2003 was $4.8 billion and $5.0 billion, respectively, and is anticipated to be approximately $5 billion for our continuing operations in 2005. Approximately 34% of our managed care net patient revenues during 2004 related to our top five managed care payers. At December 31, 2004 and 2003, approximately 55% and 45%, respectively, of our net accounts receivable related to continuing operations are due from managed care providers. A majority of our managed care contracts are "evergreen" contracts. Evergreen contracts extend automatically every year, but may be renegotiated or terminated by either party after giving 90 to 120 days notice. In the past several years, we have renewed or renegotiated over 90% of these agreements. National payers generate in excess of 40% of our total net managed care revenues, although these agreements are often negotiated on a local or regional basis. The remainder comes from regional or local payers.

Generally, managed care plans prefer fixed, predictable rates in their contracts with health care providers. Managed care plans seeking to pay fixed and predictable rates frequently pay for hospital services on a capitation, DRG or per diem basis. Capitation is the least common of the three fixed payment methods. Under capitation, the hospital is paid a fixed amount per HMO member each month for all the hospital care of a specific group of members. Managed care plans also pay hospitals a fixed fee based upon the DRG assigned to each patient. The DRG is a health care industry code that is based upon the patients' diagnosis at time of discharge. HMOs and PPOs may also reimburse hospitals on a "per day" or "per diem" basis. Under a per diem payment arrangement, the hospital is reimbursed a fixed amount for every day of hospital care delivered to a member. Per diem payment arrangements generally represent less financial risk to a hospital than capitation payment arrangements because the amount paid varies with the number of days of care provided to each patient. The financial risk of per diem agreements is further mitigated by the fact that most contracts with per diem payment arrangements also contain some form of "stop-loss" provision that allows for higher reimbursement rates in difficult medical cases where the hospital's billed charges exceed a certain threshold amount. The majority of our managed care contracts are based on per diem payments with a stop-loss payment component as well.

With mixed success, we have been working to transition key managed care payers to contracts that use fixed, predictable market-based per diems that are less dependent on stop-loss payments, and that provide for market-based rate escalators and terms and conditions designed to help us reduce our provision for doubtful accounts.

In the past, our managed care policy was developed and implemented almost exclusively at the local hospital or regional level. However, we now have a team at the corporate level to develop a strategy to support our hospitals in their managed care relationships and provide a more consistent message to payers that will focus on performance management and assessment.

Our new approach to managed care is built around the development of key competencies in the following areas: (1) strategy, policy and initiatives; (2) individualized key payer strategies; (3) managed care economics; (4) regional contracting support for our hospital regions; and (5) centralized data base management, which will enhance our ability to effectively model contract terms and conditions for negotiations, and improve the efficiency and accuracy of our billing procedures.

Indemnity

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

SELF-PAY PATIENTS

Self-pay patients are patients who do not qualify for government programs payments, such as Medicare and Medicaid, or who do not have some form of private insurance, and are, therefore, responsible for their own medical bills. We have seen an increase in the number of self-pay patients at our hospitals. A significant portion of this patient volume is being admitted through the emergency department and often requires high-acuity treatment. High-acuity treatment is more costly to provide and, therefore, results in higher billings, which are the least collectible of all accounts. We believe this trend is due to a combination of broad economic factors, including unemployment levels, reductions in state Medicaid budgets, increasing numbers of individuals and employers who choose not to purchase insurance, and an increased burden of co-payments and deductibles to be made by patients instead of insurers.

Self-pay accounts pose significant collectibility problems. At December 31, 2004 and 2003, approximately 8% and 18%, respectively, of our net accounts receivable related to continuing operations are due from self-pay patients. This reduction was primarily due to the additional provision for doubtful accounts discussed in Note 3 to the Consolidated Financial Statements. The majority of our provision for doubtful accounts relates to self-pay patients. We are taking multiple actions in an effort to mitigate the effect on us of the rapid growth in uninsured patients and the related economic impact. These initiatives include conducting detailed reviews of intake procedures in hospitals facing the greatest pressures, and enhancing and updating intake best practices for all of our hospitals. Hospital-specific reports detailing collection rates by type of patient were developed to help the hospital management teams better identify areas of vulnerability and opportunities for improvement. Also, we have completely redesigned our self-pay collection workflows, enhanced technology and improved staff training to increase collections.

Over the longer term, several other initiatives we have previously announced and begun to implement should also help address this emerging challenge. For example, our Compact, which is discussed above, is enabling us to offer lower rates to uninsured patients who historically have been charged standard gross charges.

We provide care without charge to certain patients and, for other charity care patients who meet certain financial or economic criteria, we discount the amount of gross charges whereby the amount billed is substantially lower than our established charges. Our policy is to not pursue collection of amounts determined to qualify as charity care; accordingly, we do not report them in net operating revenues or in provision for doubtful accounts. For the year ended December 31, 2004, gross charges of $573 million in charity care were excluded from operating revenues and provision for doubtful accounts compared to $740 million in 2003 (see Note 2C to the Consolidated Financial Statements).

RESULTS OF OPERATIONS

The following two tables show a summary of our net operating revenues, operating expenses and operating income or loss from continuing operations, both in dollar amounts and as percentages of net operating revenues, for the years ended December 31, 2004 and 2003, the seven months ended December 31, 2002 and the year ended May 31, 2002:

	Years ended December 31		Seven months ended December 31, 2002	Year ended May 31, 2002
	2004	2003		
			(In Millions)	
Net operating revenues:				
General hospitals	$ 9,680	$ 9,837	$ 5,880	$ 9,392
Other operations	239	309	189	342
Net operating revenues	9,919	10,146	6,069	9,734
Operating expenses:				
Salaries and benefits	4,325	4,239	2,341	3,837
Supplies	1,724	1,602	870	1,371
Provision for doubtful accounts	1,205	1,135	478	710
Other operating expenses	2,231	2,108	1,211	1,909
Depreciation	368	360	206	347
Amortization	20	20	13	108
Impairment and restructuring charges	1,272	1,384	22	99
Costs of litigation and investigations	74	282	—	—
Loss from early extinguishment of debt	13	—	4	383
Operating income (loss)	**$ (1,313)**	**$ (984)**	**$ 924**	**$ 970**

	Years ended December 31		Seven months ended December 31, 2002	Year ended May 31, 2002
	2004	2003		
			(% of Net Operating Revenues)	
Net operating revenues:				
General hospitals	97.6%	97.0%	96.9%	96.5%
Other operations	2.4%	3.0%	3.1%	3.5%
Net operating revenues	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Operating expenses:				
Salaries and benefits	43.6%	41.8%	38.6%	39.4%
Supplies	17.4%	15.8%	14.3%	14.1%
Provision for doubtful accounts	12.2%	11.2%	7.8%	7.3%
Other operating expenses	22.5%	20.8%	20.0%	19.6%
Depreciation	3.7%	3.5%	3.4%	3.6%
Amortization	0.2%	0.2%	0.2%	1.1%
Impairment and restructuring charges	12.8%	13.6%	0.4%	1.0%
Costs of litigation and investigations	0.7%	2.8%	—	—
Loss from early extinguishment of debt	0.1%	—	0.1%	3.9%
Operating income (loss)	**(13.2)%**	**(9.7)%**	**15.2%**	**10.0%**

Net operating revenues of our continuing general hospitals include inpatient and outpatient revenues, as well as nonpatient revenues (primarily rental income, management fee revenue and income from services such as cafeteria, gift shops and parking) and other miscellaneous revenue. Net

operating revenues of other operations consist primarily of revenues from (1) physician practices, (2) rehabilitation hospitals, long-term-care facilities and specialty hospitals located on or near the same campuses as our general hospitals, and (3) equity in earnings of unconsolidated affiliates that are not directly associated with our general hospitals.

Net operating revenues from our other operations were $239 million and $309 million for the years ended December 31, 2004 and 2003, respectively, $189 million for the seven months ended December 31, 2002 and $342 million for the year ended May 31, 2002. The decrease for the year ended December 31, 2004 is primarily attributable to Broadlane, Inc. (a 46% affiliate) no longer being consolidated, effective June 28, 2003. The decrease for the year ended December 31, 2003 is due to the sale or closure of facilities other than general hospitals, including a subsidiary that offered managed care and indemnity products. As we continue to focus on our general hospital operations, the revenue attributable to our other operations may continue to decrease.

The table below shows certain selected historical operating statistics for our continuing general hospitals:

	Years ended December 31			Seven months ended December 31, 2002	Year ended May 31, 2002
	2004	2003	Increase (Decrease)		
Net inpatient revenues (in millions)(2)	$ 6,546	$ 6,558	(0.2)%	$ 3,897	$ 6,256
Net outpatient revenues (in millions)(2)	$ 2,999	$ 3,148	(4.7)%	$ 1,907	$ 3,010
Number of general hospitals (at end of period)	69	67	2(1)	67	69
Licensed beds (at end of period)	17,902	17,771	0.7 %	17,827	18,549
Average licensed beds	17,861	17,772	0.5 %	17,713	18,541
Utilization of licensed beds(5)	54.5%	55.5%	(1.0)%(1)	53.6%	51.0%
Patient days	3,565,672	3,598,270	(0.9)%	2,029,946	3,452,334
Equivalent patient days(4)	4,971,323	4,998,583	(0.5)%	2,844,120	4,876,670
Net inpatient revenue per patient day	$ 1,836	$ 1,823	0.7 %	$ 1,920	$ 1,812
Admissions(3)	687,857	697,588	(1.4)%	391,590	662,086
Equivalent admissions(4)	967,093	977,078	(1.0)%	554,777	945,160
Net inpatient revenue per admission	$ 9,517	$ 9,401	1.2 %	$ 9,952	$ 9,449
Average length of stay (days)	5.2	5.2	— (1)	5.2	5.2
Net outpatient revenue per visit	$ 529	$ 532	(0.6)%	$ 560	$ 513
Outpatient visits	5,664,357	5,919,981	(4.3)%	3,403,688	5,868,306

(1) The change is the difference between 2004 and 2003 amounts shown.
(2) Net inpatient revenues and net outpatient revenues are components of net operating revenues.
(3) Self-pay admissions represented 3.6% and 3.2% of total admissions for the years ended December 31, 2004 and 2003, respectively.
(4) Equivalent admissions/patient days represents actual admissions/patient days adjusted to include outpatient and emergency room services by multiplying actual admissions/patient days by the sum of gross inpatient revenues and outpatient revenues and dividing the result by gross inpatient revenues.
(5) Utilization of licensed beds represents patient days divided by average licensed beds divided by number of days in the period.

The table below shows certain selected historical operating statistics for our continuing general hospitals on a same-hospital basis as of December 31, 2004 (excludes one cancer treatment facility acquired in December 2003, USC Kenneth Norris Jr. Cancer Hospital, located on the campus of USC

University Hospital, which is a facility owned by us on land leased from a third party, and two general hospitals, Centennial Medical Center and St. Francis Hospital—Bartlett, which both opened in 2004):

	Years ended December 31		
	2004	2003	Increase (Decrease)
Net inpatient revenues (in millions)	$ 6,491	$ 6,557	(1.0)%
Net outpatient revenues (in millions)	$ 2,931	$ 3,146	(6.8)%
Number of general hospitals (at end of period)	67	67	—
Average licensed beds	17,679	17,767	(0.5)%
Patient days	3,541,990	3,597,643	(1.5)%
Net inpatient revenue per patient day	$ 1,833	$ 1,823	0.5%
Admissions	683,474	697,488	(2.0)%
Net inpatient revenue per admission	$ 9,497	$ 9,401	1.0%
Average length of stay (days)	5.2	5.2	—
Net outpatient revenue per visit	$ 526	$ 532	(1.1)%
Outpatient visits	5,573,644	5,917,276	(5.8)%

REVENUES

During the year ended December 31, 2004, we reported net operating revenues from continuing operations of $9.9 billion compared to $10.1 billion in the year ended December 31, 2003, $6.1 billion in the seven months ended December 31, 2002 and $9.7 billion in the year ended May 31, 2002. Outpatient visits, admissions and patient days from our continuing general hospitals were lower during the year ended December 31, 2004 compared to the year ended December 31, 2003 by 4.3%, 1.4% and 0.9%, respectively. We believe the following factors are contributing to the decline in our inpatient and outpatient volume levels: (a) loss of volume to competing health care providers, (b) physician recruitment, retention and attrition, (c) managed care contract negotiations or terminations, (d) the negative impact from various hurricanes in the southeastern United States, (e) a milder flu season in 2004 compared to 2003 and (f) negative publicity about us as a result of lawsuits and government investigations, which impacts our relationships with physicians and patients. Our inpatient and outpatient volume levels were also impacted by the sale or closure of certain home health agencies, hospices, clinics, and skilled nursing and rehabilitation units during 2004.

Net inpatient revenue during the year ended December 31, 2004, on an overall basis, declined slightly (0.2%) compared to 2003; this change was attributable to various positive and negative factors that essentially offset each other. Net inpatient revenue per admission during the year ended December 31, 2004 compared to the prior year increased 1.2% and net inpatient revenue per patient day was up 0.7%. Net inpatient revenue was impacted negatively in 2004 by a decline in inpatient volume levels as described above, the phase-in of the discounting components of the Compact, and a decline in managed care net revenues.

Partially offsetting the negative factors above was an increase in our indemnity, self-pay and other payer revenue category, which primarily consists of self-pay revenue, as the mix of self-pay patients grew. We believe this trend was due to a combination of broad economic factors, including unemployment levels, reductions in state Medicaid budgets, and increasing numbers of individuals and employers who choose not to purchase insurance. Self-pay revenue generated higher revenue per patient day and per admission during the first half of 2004 because self-pay patients were charged standard gross charges until the implementation of the discounting components of the Compact began to be phased in at many of our hospitals in the second and third quarters of 2004. During the year ended December 31, 2004, there were approximately $144 million in discounts recorded on inpatient self-pay accounts under the Compact. Under the Compact, the discount offered to uninsured patients is recognized as a contractual allowance, which reduces net operating revenues at the time self-pay

accounts are recorded. As additional hospitals implement the Compact, our self-pay revenue per patient day and per admission will decrease, reflecting the additional discounts recognized.

Net inpatient revenues were also negatively impacted by a decline in our managed care revenue. We have seen a shift during 2004 in our managed care patient mix towards managed care plans with lower levels of reimbursement. This trend includes (1) a shift towards more national payers whose contract terms generate lower yields than national averages, and (2) a greater mix within our managed care volume of patients who have selected managed care Medicare and Medicaid insurance plans, which generate a lower yield than commercial managed care plans. It has been our objective to modify payment methodologies with key payers to reflect a more predictable yield, which is less dependent on stop-loss payments, with stronger increases in base rates. Specifically, stop-loss revenue has declined due to conversion of payment methodologies during contract negotiations. Managed care stop-loss payments decreased to approximately $590 million during the year ended December 31, 2004 from approximately $778 million during the year ended December 31, 2003.

Net outpatient revenues decreased approximately $149 million or 4.7% during the year ended December 31, 2004 compared to last year. Net outpatient revenues were negatively impacted by the fact that many of our hospitals began to phase in the discounting components of the Compact during the second and third quarters of 2004. During the year ended December 31, 2004, approximately $133 million in discounts were recorded on outpatient self-pay accounts under the Compact. As previously mentioned, outpatient visits also decreased 4.3% compared to the prior year due primarily to the sale or closure of certain home health agencies, hospices and clinics during the current year. These businesses typically generate lower revenue per visit amounts than other outpatient services, so this decrease had a smaller proportional percentage decline on net outpatient revenue per visit than on the percentage decline in outpatient visits.

SALARIES AND BENEFITS

Salaries and benefits expense as a percentage of net operating revenue was 43.6% and 41.8% for the years ended December 31, 2004 and 2003, respectively, 38.6% for the seven months ended December 31, 2002 and 39.4% for the year ended May 31, 2002. The increases in salaries and benefits expense during these years can be attributed to the wage and benefit pressures created by the current nursing shortage in many of our markets, state-mandated nurse-staffing ratios, standard merit increases for our employees, increased health and other benefit costs, increased labor union activity at certain of our hospitals, and our lower net operating revenues in 2004 as described above. In particular, a decline in patient volumes that reduces net operating revenues increases the percentage as a result of certain fixed staffing costs that are not reduced when volumes decrease.

We have experienced and expect to continue to experience significant wage and benefit pressures created by the nursing shortages throughout the country. In addition, approximately 14% of our employees were represented by labor unions as of December 31, 2004. As union activity increases at our hospitals, our salaries and benefits expense is likely to increase more rapidly than our net operating revenues. In May 2003, we entered into an agreement with the Service Employees International Union and the American Federation of Federal, State, County and Municipal Employees with respect to all of our California hospitals and two hospitals in Florida. In December 2003, we entered into an agreement with the California Nurses Association with respect to all of our California hospitals. The agreements are expected to streamline the organizing and contract negotiation process, with minimal impact on and disruption to patient care, if a hospital's employees choose to organize into collective bargaining units. The agreements also provide a framework for pre-negotiated salaries and benefits at these hospitals. In 2005, labor union contracts at five hospitals in Pennsylvania and California, representing 2% of our employees, will expire, but we do not expect renegotiations to have a material affect on our results of operations.

The nursing shortage is more serious in certain specialties and in certain geographic areas than others, including several areas in which we operate hospitals, and has resulted in increased costs for nursing personnel. State-mandated nurse-staffing ratios adversely affect not only our labor costs, but if we are unable to hire the necessary number of nurses to meet the required ratios, they also may cause us to limit patient admissions with a corresponding adverse effect on 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 that went into effect on January 1, 2004. We have, however, gradually improved our monthly compliance and strive to make continued improvements into 2005.

SUPPLIES

Supplies expense as a percentage of net operating revenue was 17.4% and 15.8% for the years ended December 31, 2004 and 2003, respectively, 14.3% for the seven months ended December 31, 2002 and 14.1% for the year ended May 31, 2002. The increases in supplies expense during these years were primarily attributable to higher pharmaceutical, cardiovascular, blood and orthopedic supply costs. In addition, further contributing to these percentage increases were the fluctuations in net operating revenue during the years due to changes in Medicare outlier payments, discounting of self-pay accounts under the Compact and other factors described above. In addition, the higher costs associated with new technology products are further inflating our supply costs.

We strive to control supplies expense through product standardization, contract compliance, improved utilization, and operational improvements that should minimize waste. The areas of current focus are cardiac stents, orthopedic implants and high-cost pharmaceuticals. We also utilize the group-purchasing and supplies-management services of Broadlane, Inc., a company in which we currently hold a 46% interest. Broadlane offers group-purchasing procurement strategy, outsourcing, and e-commerce services to the health care industry.

PROVISION FOR DOUBTFUL ACCOUNTS

The provision for doubtful accounts as a percentage of net operating revenue was 12.2% and 11.2% for the years ended December 31, 2004 and 2003, respectively, 7.9% for the seven months ended December 31, 2002 and 7.3% for the year ended May 31, 2002.

The increases in the provision for doubtful accounts during the years ended December 31, 2004 and December 31 2003 were primarily attributable to the additional provision for doubtful accounts of $196 million and $166 million recorded during the quarters ended June 30, 2004 and September 30, 2003, respectively. These additional charges resulted primarily from (1) an adverse change in our business as the number of uninsured and underinsured patients grew at an escalating rate and (2) the effect of re-evaluating the historical collection patterns for self-pay and managed care accounts receivable in light of the trends at that time (see Note 3 to the Consolidated Financial Statements). The majority of our provision for doubtful accounts relates to self-pay patients.

Collection of accounts receivable has been a key area of focus, particularly over the past two years, as we have experienced adverse changes in our business mix as the number of uninsured and underinsured patients have continued to grow. Potential reductions in state Medicaid budgets may result in a continued increase in uninsured patients in 2005.

One key step we have taken to address this industry-wide issue is the implementation of the Compact. By offering managed care-style discounts, we are charging the uninsured more affordable rates, whereby, they may be better able to meet their financial obligations to pay for services we provide them. The discounts recorded as contractual allowances during 2004 were approximately $277 million. However, we do not expect the Compact to have a material effect on the net economic impact of treating self-pay patients. Prior to implementing the Compact, a large portion of these discounts would have been recorded as provision for doubtful accounts. Our current estimated

collection rate on self-pay accounts is approximately 16%, including collections from point-of-service through collections by our in-house collection agency or external collection vendors.

Payment pressure from managed care payers has also affected our provision for doubtful accounts. We continue to experience ongoing managed care payment delays and disputes; however, we are working with these payers to ensure their adequate and timely reimbursement for our services. Our current estimated collection rate on managed care accounts is approximately 95%, which includes collections from point-of-service through collections by our in-house collection agency or external collection vendors.

As of December 31, 2004, we had a cumulative total of account assignments dating back at least three years or older of approximately $4.1 billion related to our continuing operations being pursued by our in-house and outside collection agencies or vendors. These accounts have already been written off and are not included in our receivables or in the allowance for doubtful accounts; however, an estimate of future recoveries from all the accounts in collection is determined based on our historical experience and recorded in accounts receivable.

Accounts receivable days outstanding ("AR Days") from continuing operations decreased to 57 days at December 31, 2004, compared to 67 days at December 31, 2003, 63 days at December 31, 2002 and 61 days at May 31, 2002. The fluctuations in AR Days are attributable to (1) reductions in Medicare outlier revenue, (2) additional provision for doubtful accounts, (3) results of our in-house and outside collection agencies and (4) lower overall net revenue due to the implementation of the Compact. AR Days at December 31, 2004 is within our target of below 60 days. This amount is calculated as our accounts receivable from continuing operations on that date divided by our revenue from continuing operations for the quarter ended on that date divided by the number of days in the quarter.

We manage the provision for doubtful accounts using hospital specific goals and benchmarks such as (1) total cash collections, (2) point-of-service cash collections and (3) accounts receivable aging. The following tables present the approximate aging by payer of our continuing operations' net accounts receivable of $1,605 million and $1,883 million, excluding cost report settlements and valuation allowances of $118 million and $101 million, at December 31, 2004 and 2003, respectively:

	December 31, 2004				
	Medicare	Medicaid	Managed Care	Indemnity, Self Pay and Other	Total
0-60 days	93%	64%	74%	47%	72%
61-120 days	6%	23%	15%	18%	15%
121-180 days	1%	13%	7%	9%	7%
Over 180 days	0%	0%	4%	26%	6%
Total	100%	100%	100%	100%	100%

	December 31, 2003				
	Medicare	Medicaid	Managed Care	Indemnity, Self Pay and Other	Total
0-60 days	92%	71%	74%	45%	67%
61-120 days	6%	22%	17%	27%	19%
121-180 days	2%	7%	6%	6%	6%
Over 180 days	0%	0%	3%	22%	8%
Total	100%	100%	100%	100%	100%

We continue to focus on initiatives to improve cash flow, which include improving the process for collecting receivables, pursuing timely payments from all payers, and standardizing and improving contract terms, billing systems and the patient registration process. We continue to review, and adjust as necessary, our methodology for evaluating the collectibility of our accounts receivable, and we may incur additional future charges resulting from the above-described trends.

We are taking numerous actions to specifically address the rapid growth in uninsured patients. These initiatives include conducting detailed reviews of intake procedures in hospitals facing these pressures, and introducing intake best practices to all of our hospitals. We have redesigned our self-pay collection workflows, enhanced technology and improved staff training to increase collections.

Our implementation of our previously announced three-year plan to consolidate billing and collection activities, which was modified in February 2004 to exclude certain hospitals that already have equally effective hospital-based business office operations, is substantially complete and includes approximately 78% of our continuing general hospitals. We are beginning to experience improved receivable performance from this initiative and anticipate continued improvement with enhanced efficiencies. We also continue to benchmark the performance of the regional business offices with the performance of the hospital-based business offices to determine the need for additional consolidation of collection activities. In addition, our previously announced initiative to standardize patient accounting systems is substantially complete and should allow us to obtain better operational data at a consolidated level, and provide us with tools to more quickly diagnose and address business mix shifts.

OTHER OPERATING EXPENSES

Other operating expenses as a percentage of net operating revenue was 22.5% and 20.8% for the years ended December 31, 2004 and 2003, respectively, 20.0% for the seven months ended December 31, 2002 and 19.6% for the year ended May 31, 2002.

The increases in other operating expenses during these years were primarily attributable to higher malpractice expense and fixed costs that do not fluctuate with the changes in net operating revenues. Malpractice expense was $272 million and $239 million for the years ended December 31, 2004 and 2003, respectively. The increase in 2004 reflects costs associated with adverse loss development and a change in the maturity composite rate from the Federal Reserve 10-year composite rate to the Federal Reserve seven-year composite rate that resulted from a change in our claims payment patterns.

Malpractice expense for the seven months ended December 31, 2002 was $190 million and included charges of (1) approximately $33 million as a result of lowering the discount rate used from 7.5% to 4.61% at December 31, 2002, (2) approximately $27 million due to an increase in reserves at one of our insurance subsidiaries, Hospital Underwriting Group, as a result of an increase in the average cost of claims being paid by this subsidiary, and (3) approximately $80 million to increase our self-retention reserves, also due to a significant increase in the average cost of claim settlements and awards. The 7.5% rate was based on our average cost of borrowings. The 4.61% rate was based on a risk-free, Federal Reserve 10-year maturity composite rate for a period that approximated our estimated claims payout period at that time. Malpractice expense for the year ended May 31, 2002 was $164 million.

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. We expect this trend to continue unless pricing for insurance becomes favorable, settlement amounts decrease, and meaningful tort reform legislation is enacted. Physicians, including those who practice at some of our hospitals, face significant and sometimes prohibitive increases in malpractice insurance premiums and limitations on availability, which could and often does cause those physicians to limit their practices. That, in turn, could and does result in lower admissions to our hospitals.

Also included in other operating expenses in the year ended December 31, 2004 is $25 million of net gains on sales of equipment and other assets, including a net gain of approximately $18 million from the sale of certain home health agencies and hospices.

IMPAIRMENT OF LONG-LIVED ASSETS AND GOODWILL AND RESTRUCTURING CHARGES

During the years ended December 31, 2004 and 2003, we recorded impairment and restructuring charges of $1.272 billion and $1.384 billion, respectively. We recorded $22 million in the seven months ended December 31, 2002 and $99 million in the year ended May 31, 2002. See Note 5 to the Consolidated Financial Statements for additional detail of these charges and related liabilities.

The significant charges in 2004 and 2003 are primarily due to the impairment of goodwill in accordance with Statement of Financial Accounting Standards ("SFAS") No. 142, "Goodwill and Other Intangible Assets" ("SFAS 142"). During 2003, we recorded a charge of $1.122 billion, primarily related to our California region and our then Central-Northeast region, and in the fourth quarter of 2004, we recorded a charge of $1.113 billion related to our Texas-Gulf Coast and Florida-Alabama regions.

The goodwill impairment charge in 2004 is the result of a lower estimated fair value due to adverse industry and company-specific challenges that continue to affect our operating results, such as reduced patient volumes, high levels of bad debt expense related to uninsured and underinsured patients, the shift of our managed care business to contracts that provide lower reimbursement, and continued pressure on labor and supply costs. The goodwill impairment charges in 2003 were the result of a comprehensive review of the near-term and long-term prospects for each of our hospitals and an impairment test performed in connection with the restructuring of our operating divisions and regions in 2003, along with a realignment of our executive team and other factors, that changed our goodwill "reporting units," as defined under SFAS 142. We estimated the fair value of the goodwill based on independent appraisals, established market values of comparable assets, or internal calculations of estimated future net cash flows.

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.

COSTS OF LITIGATION AND INVESTIGATIONS

Costs of litigation and investigations in continuing operations for the year ended December 31, 2004 were $74 million and consisted primarily of (1) a $30 million accrual of a minimum liability to address the potential resolution of a number of the civil lawsuits arising out of pricing strategies at facilities owned or formerly owned by our subsidiaries and (2) costs to defend ourselves in various lawsuits, in particular the Alvarado trial (see Note 14 to the Consolidated Financial Statements).

Costs of litigation and investigations for the year ended December 31, 2003 were $282 million and consisted primarily of:

(1) A $152 million charge recorded for an award of contract damages by a California appellate court to a former executive in connection with our alleged failure to provide certain incentive stock awards to the executive. This charge includes post-judgment interest through December 31, 2003 and attorneys' fees and costs. On February 18, 2004, the California Supreme Court declined to review the appellate court's decision. We paid $163.3 million to the former executive on March 1, 2004 in satisfaction of the final judgment.

(2) $54 million paid for the settlement of the Redding Medical Center matter as discussed in Part I, Item 3, Legal Proceedings.

(3) An aggregate of $30.2 million, which was accrued as of December 31, 2003 and paid during 2004, for the settlement of the *United States Ex Rel. Barbera v. Amisub (North Ridge Hospital), Inc*. lawsuit and the settlement of the transfer discharge investigation.

The remaining costs in 2003 were for other miscellaneous settlements and costs to defend ourselves.

LOSS FROM EARLY EXTINGUISHMENT OF DEBT

In connection with the repurchase of senior notes and the termination of our credit agreement in 2004, we recorded $13 million in losses from early extinguishment of debt in the year ended December 31, 2004. These losses primarily reflect the write off of debt issuance costs, discounts and unamortized hedging losses in accumulated other comprehensive loss. In connection with the redemption of senior notes in February 2005, we expect to record a loss of approximately $23 million.

OPERATING INCOME (LOSS)

Operating expenses were 113.2% of net operating revenues in the year ended December 31, 2004, compared to 109.7% in 2003. Lower net operating revenues, higher salaries and benefits expense, supply costs, provision for doubtful accounts and malpractice expense were only partially offset by lower costs of litigation and investigations and impairment and restructuring charges.

INTEREST EXPENSE

The increase in interest expense for the year ended December 31, 2004 compared to the year ended December 31, 2003 was largely attributable to the issuance of $1 billion of privately placed senior notes in June 2004 and the partial use of the proceeds to retire lower rate debt with maturity dates in the next several years. In January 2005, we issued an additional $800 million of senior notes through a private placement with public registration rights (see Note 6 to the Consolidated Financial Statements), which will result in additional interest expense in 2005.

NET GAINS ON SALES OF FACILITIES, LONG-TERM INVESTMENTS AND SUBSIDIARY COMMON STOCK

The $10 million of net gains in the year ended December 31, 2004 related primarily to (1) our sale of investments in various health care ventures and (2) reduction of reserves associated with hospitals sold in prior years.

The $16 million of net gains in the year ended December 31, 2003 related primarily to (1) our sale of a portion of our common stock in Broadlane, Inc. and (2) collection of certain notes receivable associated with hospitals sold in prior years that had been previously reserved for in earlier periods.

INCOME TAX BENEFIT (EXPENSE)

Income tax expense from continuing operations was $184 million on a pre-tax loss of $1.613 billion in the year ended December 31, 2004 compared to an income tax benefit from continuing operations of $228 million on a pre-tax loss of $1.272 billion in the year ended December 31, 2003.

Income tax expense in the year ended December 31, 2004 included a portion of the impact of establishing a $744 million valuation allowance for our deferred tax assets during the fourth quarter of 2004. This valuation allowance was recorded in the following manner: (1) $480 million was reflected in income tax expense in continuing operations, (2) $144 million was reflected in income tax expense in discontinued operations and (3) $120 million was recorded as an adjustment against additional paid-in capital, rather than income tax expense, due to the fact that excess tax deductions remained from prior stock option awards accounted for in accordance with the fair value based method under SFAS No. 123, "Accounting for Stock-Based Compensation" ("SFAS 123").

We established the valuation allowance as a result of assessing the realization of our deferred tax assets based on the fact that we incurred significant impairment charges, legal settlements and continued adverse results of operations in the fourth quarter of 2004, combined with having a cumulative loss for the three-year period ended December 31, 2004, which is considered "negative evidence" under SFAS No. 109, "Accounting for Income Taxes" ("SFAS 109"). We concluded that, as a

result of this negative evidence, SFAS 109 precludes us from relying upon our forecasts of future income for the purpose of supporting the realization of the deferred tax assets under the more likely than not standard. (See Note 15 to the Consolidated Financial Statements.)

PRO FORMA INFORMATION

In light of the changes CMS made to the Medicare outlier payment calculations effective January 1, 2003 (discussed in Note 2C to the Consolidated Financial Statements), the additional charges to provision for doubtful accounts recorded in the quarters ended September 30, 2003 and June 30, 2004 (discussed in Note 3 to the Consolidated Financial Statements) and the phase-in of the discounts for uninsured patients under the Compact beginning in the second quarter of 2004, we are supplementing certain historical information with information presented on a pro forma basis as if we had received no Medicare outlier revenues, recorded no additional provisions for doubtful accounts and had not implemented the discounts under the Compact during the periods indicated. This information includes numerical measures of our historical performance that have the effect of depicting such measures of financial performance differently from that presented in our consolidated financial statements prepared in accordance with U.S. generally accepted accounting principles ("GAAP") and that are defined under Securities and Exchange Commission rules as "non-GAAP financial measures." We believe that the information presented on this pro forma basis is important to our shareholders in order to show the effect that these items had on elements of our historical results of operations and provide important insight into our operations in terms of other underlying business trends, without necessarily estimating or suggesting their effect on future results of operations. This supplemental information has inherent limitations because Medicare outlier revenue in periods prior to January 1, 2003 are not indicative of future periods and such revenue in periods from January 1, 2003 forward may not be indicative of future periods. We compensate for these inherent limitations by also utilizing comparable GAAP measures. In spite of the limitations, we find the supplemental information useful to the extent it better enables us and our investors to evaluate pricing trends and we believe the consistent use of this supplemental information provides us and our investors with reliable period-to-period comparisons. Costs in our business are largely influenced by volumes and thus are generally analyzed as a percent of net operating revenues, so we provide this additional analytical information to better enable investors to measure expense categories between periods. Based on requests by certain shareholders, we believe that our investors find these non-GAAP measures useful as well. Investors are encouraged, however, to use GAAP measures when evaluating our financial performance.

The tables below illustrate actual operating expenses as a percent of net operating revenues, net inpatient revenue per admission and net outpatient revenue per visit for the years ended December 31, 2004 and 2003, and the year ended May 31, 2002 as if we had received no outlier revenue, recorded no additional provisions for doubtful accounts and had not implemented the discounts under the Compact during the periods indicated. The tables also illustrate same-hospital (excludes one cancer treatment facility acquired in December 2003, USC Kenneth Norris Jr. Cancer Hospital, located on the campus of USC University Hospital, and two general hospitals, Centennial Medical Center and St. Francis Hospital—Bartlett, which both opened in 2004) net inpatient revenue per admission and same-hospital net outpatient revenue per visit adjusted as described above for the years ended December 31, 2004

and 2003. The tables include reconciliations of GAAP measures to non-GAAP measures. Investors are encouraged, however, to use GAAP measures when evaluating our financial performance.

	Year ended December 31, 2004			
	GAAP Amounts	Compact and Bad Debt Adjustments	Medicare Outlier Revenue	Non-GAAP Amounts
	(Dollars in Millions, Except Per Admission and Per Visit Amounts)			
Net operating revenues	$ 9,919	$ 277	$ (64)	$ 10,132
Operating expenses:				
Salaries and benefits	4,325	—	—	4,325
Supplies	1,724	—	—	1,724
Provision for doubtful accounts	1,205	59(1)	—	1,264
Other operating expenses	2,231	—	—	2,231
As a percent of net operating revenues				
Net operating revenues	100.0%			100.0%
Operating expenses:				
Salaries and benefits	43.6%			42.7%
Supplies	17.4%			17.0%
Provision for doubtful accounts	12.2%			12.5%
Other operating expenses	22.5%			22.0%
Continuing general hospitals				
Net inpatient revenue	$ 6,546	$ 144	$ (64)	$ 6,626
Net outpatient revenue	$ 2,999	$ 133	$ —	$ 3,132
Admissions	687,857			687,857
Outpatient visits	5,664,357			5,664,357
Net inpatient revenue per admission	$ 9,517	$ 209	$ (93)	$ 9,633
Net outpatient revenue per visit	$ 529	$ 24	$ —	$ 553
Same-hospital				
Net inpatient revenue	$ 6,491	$ 144	$ (63)	$ 6,572
Net outpatient revenue	$ 2,931	$ 132	$ —	$ 3,063
Admissions	683,474			683,474
Outpatient visits	5,573,644			5,573,644
Net inpatient revenue per admission	$ 9,497	$ 211	$ (92)	$ 9,616
Net outpatient revenue per visit	$ 526	$ 24	$ —	$ 550

(1) Represents a $255 million impact due to the Compact, offset by $196 million of additional provisions for doubtful accounts.

	Year ended December 31, 2003			
	GAAP Amounts	Compact and Bad Debt Adjustments	Medicare Outlier Revenue	Non-GAAP Amounts
	(Dollars in Millions, Except Per Admission and Per Visit Amounts)			
Net operating revenues	$ 10,146	$ —	$ (101)	$ 10,045
Operating expenses:				
Salaries and benefits	4,239	—	—	4,239
Supplies	1,602	—	—	1,602
Provision for doubtful accounts	1,135	(166)	—	969
Other operating expenses	2,108	—	—	2,108
As a percent of net operating revenues				
Net operating revenues	100.0%			100.0%
Operating expenses:				
Salaries and benefits	41.8%			42.2%
Supplies	15.8%			15.9%
Provision for doubtful accounts	11.2%			9.6%
Other operating expenses	20.8%			21.0%
Continuing general hospitals				
Net inpatient revenue	$ 6,558	$ —	$ (101)	$ 6,457
Net outpatient revenue	$ 3,148	$ —	$ —	$ 3,148
Admissions	697,588			697,588
Outpatient visits	5,919,981			5,919,981
Net inpatient revenue per admission	$ 9,401	$ —	$ (145)	$ 9,256
Net outpatient revenue per visit	$ 532	$ —	$ —	$ 532
Same-hospital				
Net inpatient revenue	$ 6,557	$ —	$ (101)	$ 6,456
Net outpatient revenue	$ 3,146	$ —	$ —	$ 3,146
Admissions	697,488			697,488
Outpatient visits	5,917,276			5,917,276
Net inpatient revenue per admission	$ 9,401	$ —	$ (145)	$ 9,256
Net outpatient revenue per visit	$ 532	$ —	$ —	$ 532

	Year ended May 31, 2002			
	GAAP Amounts	Compact and Bad Debt Adjustments	Medicare Outlier Revenue	Non-GAAP Amounts
	(Dollars in Millions, Except Per Admission and Per Visit Amounts)			
Net operating revenues	$ 9,734	$ —	$ (454)	$ 9,280
Operating expenses:				
Salaries and benefits	3,837	—	—	3,837
Supplies	1,371	—	—	1,371
Provision for doubtful accounts	710	—	—	710
Other operating expenses	1,909	—	—	1,909
As a percent of net operating revenues				
Net operating revenues	100.0%			100.0%
Operating expenses:				
Salaries and benefits	39.4%			41.3%
Supplies	14.1%			14.8%
Provision for doubtful accounts	7.3%			7.7%
Other operating expenses	19.6%			20.6%
Continuing general hospitals				
Net inpatient revenue	$ 6,256	$ —	$ (454)	$ 5,802
Net outpatient revenue	$ 3,010	$ —	$ —	$ 3,010
Admissions	662,086			662,086
Outpatient visits	5,868,306			5,868,306
Net inpatient revenue per admission	$ 9,449	$ —	$ (686)	$ 8,763
Net outpatient revenue per visit	$ 513	$ —	$ —	$ 513

LIQUIDITY AND CAPITAL RESOURCES

CASH REQUIREMENTS

Our obligations to make future cash payments under contracts, such as debt and lease agreements, and under contingent commitments, such as debt guarantees and standby letters of credit, are summarized in the table below, all as of December 31, 2004:

		Years ending December 31					
	Total	2005	2006	2007	2008	2009	Later Years
	(In Millions)						
Long-term debt	$ 4,506	$ 38	$ 217	$ 187	$ 2	$ —	$ 4,062
Capital lease obligations	31	3	2	20	—	1	5
Long-term non-cancelable operating leases	736	162	151	135	113	60	115
Standby letters of credit and guarantees	262	226	10	7	7	5	7
Purchase orders	395	395	—	—	—	—	—
Total	**$ 5,930**	**$ 824**	**$ 380**	**$ 349**	**$ 122**	**$ 66**	**$ 4,189**

The standby letters of credit are required principally by our insurers and various states to collateralize our workers' compensation programs pursuant to statutory requirements and as security under a selected number of programs to collateralize the deductible and self-insured retentions under our professional and general liability insurance programs. The amount of collateral required is principally dependent upon the level of claims activity and our creditworthiness. The insurers require the collateral in case we are unable to meet our obligations to claimants within the deductible or self-insured retention layers. The standby letters of credit are issued under our letter of credit facility

and are fully collateralized by the $263 million of restricted cash on the consolidated balance sheet (see Note 6 to the Consolidated Financial Statements).

Our capital expenditures primarily relate to the design and construction of new buildings, expansion and renovation of existing facilities, including amounts to comply with applicable laws and regulations, equipment and systems additions and replacements, introduction of new medical technologies, construction of new hospitals and various other capital improvements.

Capital expenditures were $558 million and $833 million in the years ended December 31, 2004 and 2003, respectively, $490 million in the seven months ended December 31, 2002 and $889 million in the year ended May 31, 2002. Included in capital expenditures are costs related to the construction of two new hospitals that opened in 2004, in the amount of $84 million and $80 million in the years ended December 31, 2004 and 2003, respectively, $11 million in the seven months ended December 31, 2002, and $8 million in the year ended May 31, 2002.

We anticipate that our capital expenditures for the year ending December 31, 2005 will be approximately $500 million. These capital expenditures include approximately $7 million in 2005 of the estimated $300 million required to meet the California seismic requirements by 2012 for the remaining California facilities after all planned divestitures.

Interest payments, net of capitalized interest, were $260 million and $235 million in the years ended December 31, 2004 and 2003, respectively, $175 million in the seven months ended December 31, 2002 and $389 million in the year ended May 31, 2002. We anticipate that our interest payments for the year ending December 31, 2005 will be approximately $400 million.

Income tax payments, net of refunds received, were $46 million and $351 million in the years ended December 31, 2004 and 2003, respectively, $307 million in the seven months ended December 31, 2002 and $268 million in the year ended May 31, 2002. We anticipate receiving income tax refunds during the year ending December 31, 2005 of approximately $530 million.

We are currently involved in significant investigations and legal proceedings. (See Part I, Item 3, Legal Proceedings, for a description of these matters.) Although we cannot presently determine the timing or the amounts of any potential liabilities resulting from the ultimate resolutions of these investigations and lawsuits, we will incur significant costs in defending them and their outcomes could have a material adverse effect on our liquidity, financial position and results of operations.

SOURCES AND USES OF CASH

Our liquidity for the year ended December 31, 2004 was derived primarily from proceeds from the sale of new senior notes and sales of facilities. For the year ended December 31, 2003, our liquidity was derived primarily from net cash provided by operating activities, the sales of new senior notes and the sales of facilities. Cash flow from operations and the sale of new senior notes were the primary contributors to our liquidity in the seven months ended December 31, 2002 and the year ended May 31, 2002.

During the year ended December 31, 2004, we had a use of cash generated by our operating activities of $82 million. The primary contributors were payments made for unfavorable litigation settlements and payments made against reserves for restructuring charges, which approximated $675 million in total. Net cash provided by operating activities for the year ended December 31, 2003, seven months ended December 31, 2002 and the year ended May 31, 2002 was $838 million, $1.1 billion and $2.3 billion, respectively. The consecutive declines are due to reduced Medicare outlier revenue, reduced reimbursements by managed-care payers, higher operating costs and overall deteriorating performance from our hospitals, including those hospitals classified in discontinued operations. Our primary source of operating cash is the collection of accounts receivable. As we

experience changes in our business mix and as admissions of uninsured patients grow, our operating cash flow is negatively impacted due to lower levels of cash collections and higher levels of bad debt.

Cash proceeds from the sale of new senior notes were $954 million in the year ended December 31, 2004, $979 million in the year ended December 31, 2003, $395 million in the seven months ended December 31, 2002 and $2.5 billion in the year ended May 31, 2002. We used the proceeds to redeem other long-term debt, to retire existing bank loans under our credit agreements at the time and for general corporate purposes.

Proceeds from the sales of facilities, long-term investments and other assets during 2004 and 2003 aggregated $431 million and $730 million, respectively. Approximately $96 million of the proceeds received in 2003 were invested in an escrow account dedicated to funding costs associated with completing construction at certain of our hospitals. During 2003 and 2004, $8 million and $88 million, respectively, were released to fund construction costs. As of December 31, 2004, there was no balance remaining in the escrow account. The liquidation of working capital from hospital sales in 2004, anticipated sales proceeds and the liquidation of working capital from hospital sales anticipated to be completed during 2005 and any tax benefit associated with such sales should further bolster our liquidity, although we do not expect to realize in cash the portion of proceeds anticipated from such tax benefits, related to the hospitals sold during 2004, until April 2005.

Between July 1, 2001 and June 30, 2003, we purchased 48,734,599 shares of our common stock for $1.4 billion, of which $208 million was spent in the year ended December 31, 2003. The repurchases were authorized by our board of directors and are held as treasury stock. We have not made any repurchases since June 30, 2003 and do not intend to repurchase any shares in 2005.

DEBT INSTRUMENTS, GUARANTEES AND RELATED COVENANTS

In June 2004, we issued $1 billion of 9.875% senior notes due in 2014. The notes are unsecured. A portion of the proceeds were used to repurchase $552 million of senior notes due in 2006 and 2007.

In January 2005, we sold $800 million of 9.25% senior notes in a private placement, and, in February 2005, we redeemed our remaining outstanding senior notes of $400 million due in 2006 and 2007. As a result, we have no significant long-term debt due until December 2011. The maturities of 90% of our long-term debt now fall between December 2011 and January 2015. An additional $450 million is not due until 2031.

On December 31, 2004, we terminated our five-year revolving credit agreement and replaced it with a one-year letter of credit facility. The new facility provides for the issuance of up to $250 million in letters of credit and does not provide for any cash borrowings. The letter of credit facility contains customary affirmative and negative covenants that, among other requirements, limit (1) liens, (2) consolidations, mergers or the sale of all or substantially all assets, (3) subsidiary debt and (4) prepayment of debt. The new facility is secured by the stock of certain of our subsidiaries and cash collateral equal to 105% of the facility (approximately $263 million reflected as restricted cash on the consolidated balance sheet). 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. (See Note 6 to the Consolidated Financial Statements.)

We are currently in compliance with all covenants under our letter of credit facility and the indentures governing our senior notes. (See Note 6 to the Consolidated Financial Statements.)

At December 31, 2004, we had approximately $216 million of letters of credit outstanding under the letter of credit facility, which was fully collateralized by the $263 million of restricted cash. We had approximately $654 million in unrestricted cash and cash equivalents on hand at December 31, 2004.

LIQUIDITY

We believe that existing unrestricted cash and cash equivalents on hand, future cash provided by operating activities, including estimated income tax refunds of $530 million expected to be received during 2005, the $773 million of net proceeds from the January 2005 debt issuance described above, the sales of facilities and, depending on capital market conditions, other borrowings should be adequate to meet known debt service requirements. It should also be adequate to finance planned capital expenditures and other presently known operating needs. However, our cash needs could be materially affected by the various uncertainties discussed in this and other sections and the impact of potential judgments and settlements addressed in Part I, Item 3, Legal Proceedings, as well as changes in our results of operations.

We are aggressively identifying and implementing further actions to reduce costs and enhance our operating performance, including cash flow. Among the areas being addressed are managed care payer contracting, improved procurement efficiencies, cost standardization, bad debt expense reduction initiatives and reducing certain non-patient care hospital costs. We believe our restructuring plan and the various initiatives we have undertaken will ultimately position us to report improved operating performance, although that performance may remain somewhat below our hospital management peers because of geographic and other differences in hospital portfolios.

We believe it is important for a reader to understand that (1) if our results of operations continue to deteriorate, and/or (2) if claims, lawsuits, settlements or investigations are resolved in a materially adverse manner, there could be substantial doubt about our liquidity.

OFF-BALANCE SHEET ARRANGEMENTS

We have no off-balance-sheet arrangements that have, or are reasonably likely to have, a current or future material effect on our financial condition, changes in financial condition, revenues or expenses, results of operations, liquidity, capital expenditures or capital resources, except for $262 million of standby letters of credit and guarantees as of December 31, 2004 (shown in the cash requirements table above). The letters of credit are collateralized by $263 million of restricted cash.

RECENTLY ISSUED ACCOUNTING STANDARDS

The following summarizes noteworthy recently issued accounting standards:

- SFAS No. 153, "Exchanges of Nonmonetary Assets, an amendment of APB Opinion No. 29," was issued in December 2004. This statement amends and clarifies financial accounting for nonmonetary exchanges. The amendments eliminate certain previous exceptions to the use of fair value and are intended to improve the comparability of cross-border financial reporting by narrowing the differences with existing International Accounting Standards Board standards. This statement is effective for the third quarter of 2005 and is not expected to have a material impact on our financial position, results of operations or cash flows.

- SFAS No. 152, "Accounting for Real Estate Time-Sharing Transactions, an Amendment of FASB Statements No. 66 and 67," was issued in December 2004. This statement amends FASB Statements No. 66 and 67 to reference guidance provided in AICPA Statement of Position (SOP) 04-2, "Accounting for Real Estate Time-Sharing Transactions." This statement is effective for our 2006 calendar year and is not expected to have a material impact on our financial position, results of operations or cash flows.

- SFAS No. 123R (Revised 2004), "Share-Based Payment," was issued in December 2004, which replaces SFAS 123 and supersedes APB 25. SFAS 123R requires the measurement of all employee share-based payments to employees, including grants of employee stock options, using

a fair-value-based method. The accounting provisions of SFAS 123R are effective for interim or annual reporting periods beginning after June 15, 2005.

We will be required to adopt SFAS 123R in the third quarter of 2005. Since we previously adopted SFAS 123, we do not anticipate the cumulative effect of the adoption of SFAS 123R to have a material impact on our financial position or results of operations. Under SFAS 123R, the previously estimated fair value of non-vested stock option grants outstanding, when we adopt SFAS 123R in the third quarter of 2005, should not be adjusted for differences between the requirements of SFAS 123R and SFAS 123, except for any impact of incorporating expected forfeitures before vesting. This method of adopting SFAS 123R is referred to as the modified prospective application method.

We are still evaluating the fair value valuation techniques allowed under SFAS 123R to determine the model that we will use to estimate the fair value of stock options granted after the adoption of this standard. Under SFAS 123R, a closed-form model (e.g., Black-Scholes) and a lattice model are acceptable valuation techniques. A lattice model can be designed to accommodate estimates of option exercise patterns and post-vesting employment termination during the option's contractual term, and thereby can more fully reflect the effect of those factors than an estimate developed using a closed-form model and a single weighted-average life of the options. If we determine that utilizing a lattice model valuation technique is more appropriate when we adopt SFAS 123R, the fair value estimates of future stock option grants under a lattice model may differ from fair value estimates if the Black-Scholes model was used.

- SFAS No. 151, "Inventory Costs, an Amendment of ARB No. 43, Chapter 4," was issued in November 2004. This statement amends and clarifies financial accounting for abnormal amounts of idle facility expense, freight, handling costs, and wasted material (spoilage). These changes are intended to improve the comparability of cross-border financial reporting by narrowing the differences with existing International Accounting Standards Board standards. This statement is effective for inventory costs incurred during our 2006 calendar year and is not expected to have a material impact on our financial position, results of operations or cash flows.

- FASB Interpretation No. 46-R ("FIN 46-R"), "Consolidation of Variable Interest Entities—an interpretation of ARB 51 (revised December 2003)," was issued to amended certain provisions of FASB Interpretation No. 46, which provides guidance on the consolidation of variable interest entities, and delayed implementation for entities that were not considered special purpose entities until the first quarter of 2004. Our adoption of FIN 46-R did not have a material impact on our financial position, results of operations or cash flows.

- FASB Staff Position No. 106-2, "Accounting and Disclosure Requirements Related to the Medicare Prescription Drug, Improvement and Modernization Act of 2003" ("FSP 106-2"), was issued in response to a new law regarding prescription drug benefits under Medicare, as well as a federal subsidy to sponsors of retiree health care benefit plans. Our adoption of FSP 106-2 did not have a material impact on our financial position, results of operations or cash flows.

CRITICAL ACCOUNTING ESTIMATES

In preparing our consolidated financial statements in conformity with accounting principles generally accepted in the United States of America, we must use estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes. We regularly evaluate the accounting policies and estimates we use. In general, we base the estimates on historical experience and on assumptions that we believe to be reasonable, given the particular circumstances in which we operate. Actual results may vary from those estimates.

We consider our critical accounting estimates to be those that (1) involve significant judgments and uncertainties, (2) require estimates that are more difficult for management to determine, and (3) may produce materially different outcomes under different conditions or when using different assumptions. Our critical accounting estimates cover the following areas:

- Recognition of net operating revenues, including contractual allowances.
- Provisions for doubtful accounts.
- Accruals for general and professional liability risks.
- Impairment of long-lived assets and goodwill.
- Accounting for income taxes.
- Accounting for stock-based compensation.

REVENUE RECOGNITION

We recognize net operating revenues in the period in which services are performed. Net operating revenues consist primarily of net patient service revenues that are recorded based on established billing rates (i.e., gross charges), less estimated discounts for contractual allowances (principally for patients covered by Medicare, Medicaid and managed care and other health plans and uninsured patients under the Compact).

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

Prior to 2003, we recorded estimates for contractual allowances and cost report settlements for Medicare and Medicaid based on amounts generated from information accumulated from various accounting and information systems. Adjustments to these accruals were generally made upon the final settlement of Medicare and Medicaid cost reports. In 2003, we completed the implementation of a new system and estimation process for recording Medicare net revenue and estimated cost report settlements. This resulted in a refinement in recording the accruals to more closely reflect the expected final settlements on our cost reports. For filed cost reports, we now record the accrual based on those cost reports and subsequent activity, and record a valuation allowance against those cost reports based on historical settlement trends. The accrual for cost reports not yet filed is now recorded based on estimates of what we expected to report on the filed cost reports and a corresponding valuation allowance was recorded as previously described. Cost reports must be filed generally within the five months after the end of the annual cost report reporting period. After the cost report is filed, the accrual and corresponding valuation allowance may need to be adjusted. Estimated cost report settlements and valuation allowances are deducted from accounts receivable in the accompanying consolidated balance sheets.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted fee-for-service rates and/or other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers. The payers are billed for patient services on an individual patient basis. An individual patient's bill is

subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we attempt to estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. These estimates are continuously reviewed for accuracy by taking into consideration known contract terms as well as payment history. Although we do not separately accumulate and disclose the aggregate amount of adjustments to the estimated reimbursements for every patient bill, we believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of individual patient bills that were material to our revenues. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans.

Revenues related to self-pay patients may qualify for a discount under the Compact, whereby the gross charges based on established billing rates would be reduced by an estimated discount for contractual allowance.

We believe that adequate provision has been made for any adjustments that may result from final determination of amounts earned under all the above arrangements. We know of no material claims, disputes or unsettled matters with any payers that would affect our revenues for which we have not adequately provided for in our consolidated financial statements.

PROVISIONS FOR DOUBTFUL ACCOUNTS

Our policy is to attempt to collect amounts due from patients, including co-payments and deductibles due from patients with insurance, at the time of service while complying with all federal and state laws and regulations, including, but not limited to, the Emergency Medical Treatment and Labor Act ("EMTALA"). Generally, as required by EMTALA, patients may not be denied emergency treatment due to inability to pay. Therefore, until the legally required medical screening examination is complete and stabilization of the patient has begun, services are performed prior to the verification of the patient's insurance, if any. In non-emergency circumstances or for elective procedures and services, it is our policy, when appropriate, to verify insurance prior to a patient being treated.

We provide for an allowance against accounts receivable that could become uncollectible by establishing an allowance to reduce the carrying value of such receivables to their estimated net realizable value. We estimate this allowance based on the aging of certain of our accounts receivables by hospital, our historical collection experience by hospital and for each type of payer, and other relevant factors. Our practice is to write-down self-pay accounts receivable, including accounts related to the co-payments and deductibles due from patients with insurance, to their estimated net realizable value at the time of billing. Generally, uncollected balances are assigned to our in-house collection agency between 90 to 120 days, once patient responsibility has been identified. When accounts are assigned for collections by the hospital, the accounts are completely written off through provision for doubtful accounts, and an estimated future recovery amount is calculated and recorded as a receivable on the hospital's books at the same time. The account balance is adjusted for payments on these accounts and adjustments are made based on changes to actual recovery rates.

Managed care accounts receivable are written down to their estimated net realizable value as they age over the course of 180 days. Historically, all accounts would be written off through the provision for doubtful accounts and assigned to our in-house collection agency with an estimated future recovery amount established on the hospital's books at the same time. Based on various factors, managed care accounts are now collected through hospital-based business offices or regional business offices, whereby the account balances remain in the hospital's billing system and on the hospital's books, and are adjusted based on an analysis of the net realizable value.

During 2003 and 2004, our procedures for estimating the net realizable value of accounts identified unfavorable trends in collection experience for both self-pay and managed care accounts. We believe this trend in self-pay is due to a combination of broad economic factors, including unemployment levels, reductions in state Medicaid budgets, increasing numbers of individuals and employers who choose not to purchase insurance, and the increasing burden of co-payments and deductibles to be made by patients instead of insurers. Additionally, many of these patients, who delay or do not seek routine medical care because of the costs, are being admitted through the emergency department and often require more costly care, resulting in higher billings, which are the least collectible of all accounts. These factors cause a change in our business mix as admissions of uninsured and underinsured patients grow.

Changes in the collectibility of managed care accounts receivable are ongoing as we continue to experience payment pressure from managed care companies (which pressure is exacerbated by disputes with certain managed care companies, primarily in California) concerning substantial amounts of past billings. We aggressively pursue collection of these accounts receivable using all means at our disposal, including arbitration and litigation, but we may not be successful.

ACCRUALS FOR GENERAL AND PROFESSIONAL LIABILITY RISKS

We insure substantially all of our professional and comprehensive general liability risks in excess of self-insured retentions through insurance subsidiaries (see Note 13 to the Consolidated Financial Statements). Risks in excess of these retentions are reinsured with major independent insurance companies.

We record reserves for claims when they are probable and reasonably estimable. We maintain reserves, which are based on actuarial estimates by an independent third party, for the portion of our professional liability risks, including incurred but not reported claims, to the extent we do not have insurance coverage (i.e., self-insured retentions). We estimate reserves for losses and related expenses using expected loss-reporting patterns. Reserves are discounted to their estimated present value under a risk-free rate approach using a Federal Reserve seven-year maturity composite rate that approximates our claims payout period. There can be no assurance that the ultimate liability will not exceed our estimates. Adjustments to the estimated reserves are recorded in our results of operations in the periods when such amounts are determined.

IMPAIRMENT OF LONG-LIVED ASSETS AND GOODWILL

We evaluate our long-lived assets for possible impairment whenever events or changes in circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future cash flows. However, there is an evaluation performed at least annually. We base the measurement of the amount of the impairment, if any, on independent appraisals, established market values of comparable assets or estimates of future net cash flows expected to result from the use and ultimate disposition of the asset. The estimates of these future cash flows are based on assumptions and projections we believe to be reasonable and supportable. They require our subjective judgments and take into account assumptions about revenue and expense growth rates. These assumptions may vary by type of facility.

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

Goodwill represents the excess of costs over the fair value of assets of businesses acquired. Goodwill and other intangible assets acquired in purchase business combinations and determined to have indefinite useful lives are not amortized, but instead are subject to impairment tests performed at

least annually. For goodwill, we perform the test at the reporting unit level, as defined by appropriate accounting standards, when events occur that require an evaluation to be performed or at least annually. If we find the carrying value of goodwill to be impaired, or if the carrying value of a business that is to be sold or otherwise disposed of exceeds its fair value, then we reduce the carrying value, including any allocated goodwill, to fair value. Estimates of fair value are based on independent appraisals, established market prices for comparative assets or internal calculations of estimated future net cash flows.

ACCOUNTING FOR INCOME TAXES

We account for income taxes using the asset and liability method in accordance with SFAS 109. This approach requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of temporary differences between the carrying amounts and the tax bases of assets and liabilities.

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

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

- cumulative losses in recent years;
- income/losses expected in future years;
- unsettled circumstances that, if unfavorably resolved, would adversely affect future operations and profit levels;
- the availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits;
- the carryforward period associated with the deferred tax assets and liabilities; and
- prudent and feasible tax-planning strategies.

While we believe we have provided adequately for our income tax receivables or liabilities in our consolidated financial statements, adverse determinations by taxing authorities or changes in tax laws and regulations could have a material adverse effect on our consolidated financial position, results of operations or cash flows.

ACCOUNTING FOR STOCK-BASED COMPENSATION

We account for the cost of stock-based compensation using the fair-value method recommended by SFAS 123, under which the cost of stock option grants and other incentive awards to employees, directors, advisors and consultants generally is measured by the fair value of the awards on their grant date and is recognized over the vesting periods of the awards, whether or not the awards had any intrinsic value during the period. We estimate the fair value of stock option grants as of the date of each grant, using a Black-Scholes option-pricing model. This model incorporates our reasoned assumptions regarding (1) the expected volatility of our common stock price, (2) estimated risk-free interest rates, and (3) the expected dividend yield, if any, all over the expected lives of the respective options. We do not adjust the model for non-transferability, risk of forfeiture or the vesting restrictions

of the option—all of which would reduce the option value if factored into our calculations. The most critical of the above assumptions in our calculations of fair value is the expected life of an option, because it, in turn, is a principal part of our calculations of expected volatility and interest rates. Accordingly, we reevaluate our estimate of expected life at each major grant date. Our reevaluation is based on recent exercise patterns and is reviewed from time to time by an outside, independent consulting firm.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

The table below presents information about certain of our market-sensitive financial instruments as of December 31, 2004. The fair values were determined based on quoted market prices for the same or similar instruments. At December 31, 2004, we had no borrowings subject to or with variable interest rates.

	Maturity Date, Year ending December 31							
	2005	2006	2007	2008	2009	Thereafter	Total	Fair Value
	(Dollars in Millions)							
Fixed-rate long-term debt	$41	$219	$207	$2	$1	$4,067	$4,537	$4,464
Average interest rates	6.62%	5.28%	4.95%	4.56%	4.56%	7.36%	6.97%	

We do not hold or issue derivative instruments for trading purposes and are not a party to any instruments with leverage or prepayment features.

At December 31, 2004, we had no significant long-term, market-sensitive investments. Our market risk associated with our investments in debt securities classified as a current asset is substantially mitigated by the frequent turnover of the portfolio.

We have no affiliation with partnerships, trusts or other entities (sometimes referred to as special-purpose or variable-interest entities) whose purpose is to facilitate off-balance sheet financial transactions or similar arrangements. Thus, we have no exposure to the financing, liquidity, market or credit risks associated with such entities.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

REPORT OF MANAGEMENT

To Our Shareholders:

The management of Tenet Healthcare Corporation (together with its subsidiaries, "Tenet") is responsible for the preparation, integrity and objectivity of Tenet's consolidated financial statements and all other information in this report for the year ended December 31, 2004. The consolidated financial statements have been prepared in conformity with accounting principles generally accepted in the United States of America and, accordingly, include certain amounts that are based on management's informed judgment and best estimates.

Tenet maintains a comprehensive system of internal accounting controls to assist management in fulfilling its responsibility for financial reporting. These controls are supported by the careful selection and training of qualified personnel and an appropriate division of responsibilities. Management believes that these controls provide reasonable assurance that assets are safeguarded from loss or unauthorized use and that Tenet's financial records are a reliable basis for preparing the consolidated financial statements.

The audit committee of the board of directors (the "board"), which is comprised solely of directors who (1) are neither current nor former officers or employees, (2) otherwise meet the independence standards set forth in Tenet's corporate governance principles, and (3) the board has determined are "independent" as that term is defined by the New York Stock Exchange, meets regularly with Tenet's management, internal auditors and independent registered public accountants to review matters relating to financial reporting (including the quality of accounting principles), internal accounting controls and auditing. The independent registered public accountants and the internal auditors report to the audit committee and have direct and confidential access to the audit committee at all times to discuss the results of their audits.

Tenet's independent registered public accountants, selected and engaged by the audit committee of the board, perform annual audits of the consolidated financial statements of Tenet in accordance with the standards of the Public Company Accounting Oversight Board (United States). These standards require a consideration of the system of internal controls and tests of transactions to the extent deemed necessary by the independent registered public accountants for purposes of supporting their opinion as set forth in their independent registered public accountants' report. Their report expresses an independent opinion on the fairness of presentation of the consolidated financial statements.

Stephen D. Farber
Chief Financial Officer

Timothy L. Pullen
Executive Vice President and Chief Accounting Officer

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Shareholders
Tenet Healthcare Corporation:

We have audited management's assessment, included in the accompanying Management's Report on Internal Control Over Financial Reporting appearing under Item 9A, that Tenet Healthcare Corporation maintained effective internal control over financial reporting as of December 31, 2004, based on criteria established in *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). Management of Tenet Healthcare Corporation is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting. Our responsibility is to express an opinion on management's assessment and an opinion on the effectiveness of Tenet Healthcare Corporation's internal control over financial reporting based on our audit.

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

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

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, management's assessment that Tenet Healthcare Corporation maintained effective internal control over financial reporting as of December 31, 2004, is fairly stated, in all material respects, based on criteria established in *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). Also, in our opinion, Tenet Healthcare Corporation maintained, in all material respects, effective internal control over financial reporting as of December 31, 2004, based on criteria established in *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Tenet Healthcare Corporation and subsidiaries as of December 31, 2004 and 2003, and the related consolidated statements of operations, comprehensive income (loss), changes in stockholders' equity and cash flows for the years ended December 31, 2004 and 2003, for the seven- month transition period ended December 31, 2002 and for the year ended May 31, 2002, and our report dated March 7, 2005 expressed an unqualified opinion on those consolidated financial statements.

KPMG LLP

Dallas, Texas
March 7, 2005

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Shareholders
Tenet Healthcare Corporation:

We have audited the accompanying consolidated balance sheets of Tenet Healthcare Corporation and subsidiaries as of December 31, 2004 and 2003, and the related consolidated statements of operations, comprehensive income (loss), changes in shareholders' equity and cash flows for the years ended December 31, 2004 and 2003, for the seven-month transition period ended December 31, 2002 and for the year ended May 31, 2002. In connection with our audits of the consolidated statements, we have also audited the consolidated financial statement schedule included in Part IV of the Company's Annual Report on Form 10-K. These consolidated financial statements and consolidated financial statement schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements and consolidated financial statement schedule based on our audits.

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

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Tenet Healthcare Corporation and its subsidiaries as of December 31, 2004 and 2003, and the results of their operations and their cash flows for the years ended December 31, 2004 and 2003, for the seven-month transition period ended December 31, 2002 and for the year ended May 31, 2002, in conformity with U.S. generally accepted accounting principles. Also, in our opinion, the related consolidated financial statement schedule, when considered in relation to the basic financial statements taken as a whole, present fairly, in all material respects, the information set forth therein.

As discussed in Note 2H to the consolidated financial statements, effective June 1, 2002, the Company changed its method of accounting for goodwill and other intangible assets.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the effectiveness of Tenet Healthcare Corporation's internal control over financial reporting as of December 31, 2004, based on the criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), and our report dated March 7, 2005 expressed an unqualified opinion on management's assessment of, and the effective operation of, internal control over financial reporting.

KPMG LLP

Dallas, Texas
March 7, 2005

CONSOLIDATED BALANCE SHEETS

Dollars in Millions

	December 31	
	2004	2003
ASSETS		
Current Assets:		
Cash and cash equivalents	$ 654	$ 619
Restricted cash	263	—
Investments in debt securities	117	123
Accounts receivable, less allowance for doubtful accounts ($698 at December 31, 2004 and $500 at December 31, 2003)	1,688	2,415
Inventories of supplies, at cost	188	224
Income tax receivable	530	—
Deferred income taxes	118	401
Assets held for sale	114	129
Other current assets	320	337
Total current assets	**3,992**	**4,248**
Investments and other assets	296	386
Property and equipment, at cost, less accumulated depreciation and amortization	4,820	5,557
Goodwill	800	1,949
Other intangible assets, at cost, less accumulated amortization ($101 at December 31, 2004 and $112 at December 31, 2003)	170	158
	$ 10,078	**$ 12,298**
LIABILITIES AND SHAREHOLDERS' EQUITY		
Current liabilities:		
Current portion of long-term debt	$ 41	$ 18
Accounts payable	937	987
Accrued compensation and benefits	390	464
Income taxes payable	—	36
Professional liability reserves	137	115
Accrued interest payable	96	53
Accrued legal settlement costs	40	203
Other current liabilities	489	518
Total current liabilities	**2,130**	**2,394**
Long-term debt, net of current portion	4,395	4,039
Professional liability reserves	591	511
Other long-term liabilities and minority interests	919	989
Deferred income taxes	311	4
Total liabilities	**8,346**	**7,937**
Commitments and contingencies		
Shareholders' equity:		
Common stock, $0.05 par value; authorized 1,050,000,000 shares; 521,132,853 shares issued at December 31, 2004 and 519,012,960 shares issued at December 31, 2003	26	26
Additional paid-in capital	4,131	4,124
Accumulated other comprehensive loss	(13)	(8)
Retained earnings (deficit)	(930)	1,710
Less common stock in treasury, at cost, 53,896,498 shares at December 31, 2004 and 54,226,419 shares at December 31, 2003	(1,482)	(1,491)
Total shareholders' equity	**1,732**	**4,361**

	$	**10,078**	**$**	**12,298**

See accompanying Notes to Consolidated Financial Statements.

CONSOLIDATED STATEMENTS OF OPERATIONS

Dollars in Millions,
Except Per-Share Amounts

	Years ended December 31		Seven months ended December 31, 2002	Year ended May 31, 2002
	2004	2003		
Net operating revenues	**$ 9,919**	**$ 10,146**	**$ 6,069**	**$ 9,734**
Operating expenses:				
Salaries and benefits	4,325	4,239	2,341	3,837
Supplies	1,724	1,602	870	1,371
Provision for doubtful accounts	1,205	1,135	478	710
Other operating expenses	2,231	2,108	1,211	1,909
Depreciation	368	360	206	347
Goodwill amortization	—	—	—	85
Other amortization	20	20	13	23
Impairment of long-lived assets and goodwill	1,236	1,278	9	76
Restructuring charges	36	106	13	23
Costs of litigation and investigations	74	282	—	—
Loss from early extinguishment of debt	13	—	4	383
Operating income (loss)	**(1,313)**	**(984)**	**924**	**970**
Interest expense	(333)	(294)	(144)	(324)
Investment earnings	20	16	13	31
Minority interests	3	(21)	(10)	(24)
Net gains on sales of facilities, long-term investments and subsidiary common stock	10	16	—	—
Impairment of investment securities	—	(5)	(64)	—
Income (loss) from continuing operations before income taxes	**(1,613)**	**(1,272)**	**719**	**653**
Income tax benefit (expense)	(184)	228	(289)	(319)
Income (loss) from continuing operations	**(1,797)**	**(1,044)**	**430**	**334**
Discontinued operations:				
Income (loss) from operations of asset group	(293)	(102)	326	591
Impairment of long-lived assets and goodwill, and restructuring charges	(439)	(699)	(374)	—
Litigation settlements	(395)	—	—	—
Net gains on sales of asset group	71	274	—	—
Income tax benefit (expense)	213	94	19	(228)
Income (loss) from discontinued operations	**(843)**	**(433)**	**(29)**	**363**
Net income (loss)	**$ (2,640)**	**$ (1,477)**	**$ 401**	**$ 697**
Earnings (loss) per common share and common equivalent share				
Basic				
Continuing operations	$ (3.85)	$ (2.24)	$ 0.89	$ 0.68
Discontinued operations	(1.81)	(0.93)	(0.06)	0.74
	$ (5.66)	**$ (3.17)**	**$ 0.83**	**$ 1.42**
Diluted				
Continuing operations	$ (3.85)	$ (2.24)	$ 0.87	$ 0.66
Discontinued operations	(1.81)	(0.93)	(0.06)	0.73
	$ (5.66)	**$ (3.17)**	**$ 0.81**	**$ 1.39**

Weighted average shares and dilutive securities outstanding (in thousands):				
Basic	466,226	465,927	484,877	489,717
Diluted	466,226	465,927	493,530	502,899

See accompanying Notes to Consolidated Financial Statements.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME (LOSS)

Dollars in Millions

	Years ended December 31		Seven months ended December 31, 2002	Year ended May 31, 2002
	2004	2003		
Net income (loss)	$ (2,640)	$ (1,477)	$ 401	$ 697
Other comprehensive income (loss):				
Foreign currency translation adjustments	(5)	10	5	(4)
Losses on derivative instruments designated and qualifying as cash-flow hedges	—	(2)	—	(28)
Unrealized gains (losses) on securities held as available for sale	—	(1)	(6)	31
Reclassification adjustments for (gains) losses included in net income (loss)	(3)	4	47	1
Other comprehensive income (loss) before income taxes	**(8)**	**11**	**46**	**—**
Income tax benefit (expense) related to items of other comprehensive income (loss)	3	(4)	(17)	—
Other comprehensive income (loss)	**(5)**	**7**	**29**	**—**
Comprehensive income (loss)	**$ (2,645)**	**$ (1,470)**	**$ 430**	**$ 697**

See accompanying Notes to Consolidated Financial Statements.

CONSOLIDATED STATEMENTS OF CHANGES IN SHAREHOLDERS' EQUITY

Dollars in Millions,
Share Amounts in Thousands

	Shares Outstanding	Issued Par Amount	Additional Paid-in Capital	Other Comprehensive Income (Loss)	Retained Earnings (Deficit)	Treasury Stock	Total Shareholders' Equity
Balances at May 31, 2001	**488,201**	**$ 25**	**$ 3,153**	**$ (44)**	**$ 2,089**	**$ (70)**	**$ 5,153**
Net income	—	—	—	—	697	—	697
Issuance of common stock	692	—	21	—	—	—	21
Stock options exercised, including tax benefit	17,829	1	406	—	—	—	407
Stock-based compensation expense	—	—	134	—	—	—	134
Repurchases of common stock	(18,181)	—	—	—	—	(715)	(715)
Balances at May 31, 2002	**488,541**	**26**	**3,714**	**(44)**	**2,786**	**(785)**	**5,697**
Net income	—	—	—	—	401	—	401
Other comprehensive income	—	—	—	29	—	—	29
Issuance of common stock	378	—	36	—	—	—	36
Stock options exercised, including tax benefit	2,901	—	74	—	—	—	74
Stock-based compensation expense	—	—	87	—	—	—	87
Repurchases of common stock	(18,082)	—	—	—	—	(500)	(500)
Balances at December 31, 2002	**473,738**	**26**	**3,911**	**(15)**	**3,187**	**(1,285)**	**5,824**
Net loss	—	—	—	—	(1,477)	—	(1,477)
Other comprehensive income	—	—	—	7	—	—	7
Issuance of common stock	2,994	—	32	—	—	2	34
Stock options exercised, including tax benefit	526	—	5	—	—	—	5
Stock-based compensation expense	—	—	176	—	—	—	176
Repurchases of common stock	(12,471)	—	—	—	—	(208)	(208)
Balances at December 31, 2003	**464,787**	**26**	**4,124**	**(8)**	**1,710**	**(1,491)**	**4,361**
Net loss	—	—	—	—	(2,640)	—	(2,640)
Other comprehensive loss	—	—	—	(5)	—	—	(5)
Issuance of common stock	2,213	—	14	—	—	9	23
Stock options exercised, including tax benefit	236	—	2	—	—	—	2
Deferred tax valuation allowance offset against excess stock option tax benefits	—	—	(120)	—	—	—	(120)
Stock-based compensation expense	—	—	111	—	—	—	111
Balances at December 31, 2004	**467,236**	**$ 26**	**$ 4,131**	**$ (13)**	**$ (930)**	**$ (1,482)**	**$ 1,732**

See accompanying Notes to Consolidated Financial Statements.

CONSOLIDATED STATEMENTS OF CASH FLOWS

Dollars in Millions

	Years ended December 31		Seven months ended December 31, 2002	Year ended May 31, 2002
	2004	2003		
Net income (loss)	**$ (2,640)**	**$ (1,477)**	**$ 401**	**$ 697**
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:				
Depreciation and amortization	388	380	219	455
Provision for doubtful accounts	1,205	1,135	478	710
Deferred income tax expense (benefit)	495	(563)	(284)	44
Income tax benefit related to stock option exercises	—	—	31	134
Stock-based compensation charges	101	139	87	134
Impairment of long-lived assets, goodwill and investment securities, and restructuring charges	1,272	1,389	86	99
Loss from early extinguishment of debt	13	—	4	383
Pre-tax (income) loss from discontinued operations	1,056	527	48	(591)
Other items	(16)	52	35	35
Increases (decreases) in cash from changes in operating assets and liabilities, net of effects from purchases of new businesses and sales of facilities:				
Accounts receivable	(899)	(1,104)	(577)	(781)
Inventories and other current assets	(40)	(15)	(31)	(19)
Income taxes payable	(562)	(179)	214	90
Accounts payable, accrued expenses and other current liabilities	166	443	(195)	282
Other long-term liabilities	67	167	271	20
Payments against reserves for restructuring charges and litigation costs and settlements	**(280)**	**(145)**	**(19)**	**(77)**
Net cash provided by (used in) operating activities from discontinued operations, excluding income taxes	**(408)**	**89**	**358**	**700**
Net cash provided by (used in) operating activities	**(82)**	**838**	**1,126**	**2,315**
Cash flows from investing activities:				
Purchases of property and equipment:				
Continuing operations	(454)	(613)	(382)	(680)
Discontinued operations	(20)	(140)	(97)	(201)
Construction of new hospitals	(84)	(80)	(11)	(8)
Net cash released from (provided to) escrow accounts to fund construction costs	88	(88)	—	—
Proceeds from sales of facilities, long-term investments and other assets	431	730	6	28
Purchases of new businesses, net of cash acquired	—	(39)	(27)	(324)
Investment in hospital authority bonds	(3)	(107)	—	—
Other items, including expenditures related to prior-year purchases of new businesses	30	4	122	(42)
Net cash used in investing activities	**(12)**	**(333)**	**(389)**	**(1,227)**
Cash flows from financing activities:				
Proceeds from borrowings	—	49	1,332	4,394
Sale of new senior notes	954	979	395	2,541
Repurchases of senior, senior subordinated and exchangeable subordinated notes	(555)	—	(282)	(4,063)
Payments of borrowings	(17)	(926)	(1,551)	(3,513)
Restricted cash related to letter of credit facility	(263)	—	—	—
Purchases of treasury stock	—	(208)	(500)	(715)
Proceeds from exercise of stock options	2	5	43	273

Other items	8	5	(2)	(29)
Net cash provided by (used in) financing activities	**129**	**(96)**	**(565)**	**(1,112)**
Net increase (decrease) in cash and cash equivalents	35	409	172	(24)
Cash and cash equivalents at beginning of period	619	210	38	62
Cash and cash equivalents at end of period	**$ 654**	**$ 619**	**$ 210**	**$ 38**
Supplemental disclosures:				
Interest paid, net of capitalized interest	$ 260	$ 235	$ 175	$ 389
Income taxes paid, net of refunds received	$ 46	$ 351	$ 307	$ 268

See accompanying Notes to Consolidated Financial Statements.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1 BASIS OF PRESENTATION

Our accounting and reporting policies conform to accounting principles generally accepted in the United States of America (U.S. GAAP) and prevailing practices for investor-owned entities within the health care industry. The preparation of financial statements, in conformity with U.S. GAAP, requires us to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. We regularly evaluate the accounting policies and estimates we use. In general, we base the estimates on historical experience and on assumptions that we believe to be reasonable given the particular circumstances in which we operate. Although we believe all adjustments considered necessary for fair presentation have been included, actual results may vary from those estimates.

On March 18, 2003, our board of directors approved a change in our fiscal year. Instead of a fiscal year ending on May 31, we now have a fiscal year that coincides with the calendar year. As a result of this change, effective December 31, 2002, our audited consolidated statements of operations, comprehensive income (loss), changes in shareholders' equity and cash flows presented herein include the years ended December 31, 2004 and 2003, the seven-month transition period ended December 31, 2002, and the previous fiscal year ended May 31, 2002.

Certain prior-year balances in the accompanying consolidated financial statements have been reclassified to conform to the current period's presentation of financial information. These reclassifications, primarily for the discontinued operations as described in Note 4, have no impact on total assets, liabilities, shareholders' equity, net income (loss) or cash flows. Unless otherwise stated, all amounts disclosed in the Notes to the Consolidated Financial Statements relate to our continuing operations.

NOTE 2 SIGNIFICANT ACCOUNTING POLICIES

A. THE COMPANY

We are an investor-owned health care services company whose subsidiaries and affiliates (collectively, "subsidiaries") operate general hospitals and related health care facilities, and hold investments in other companies (including health care companies). At December 31, 2004, our subsidiaries operated 78 general hospitals, including those related to discontinued operations not yet divested, with a total of 19,668 licensed beds, serving urban and rural communities in 13 states. We also owned or operated various related health care facilities, including a small number of rehabilitation hospitals, a specialty hospital, skilled nursing facilities and medical office buildings—all of which are located on, or nearby, one of our general hospital campuses; and physician practices, captive insurance companies and various other ancillary health care businesses (including outpatient surgery centers, home health care agencies, occupational and rural health care clinics).

At December 31, 2004, our largest concentrations of hospital beds, including those related to discontinued operations not yet divested, were in California with 27.0%, Florida with 23.2% and Texas with 15.1%. On January 28, 2004, we announced a major restructuring of our operations in which we would seek to divest 27 general hospitals. That action, plus our other divestiture plans, and the opening of two new hospitals in 2004 will leave us with 69 general hospitals with a total of 17,902 licensed beds and two 25-bed critical access hospitals in 13 states. Our largest concentrations of hospital beds then will be in Florida with 25.5%, California with 19.8% and Texas with 16.6%. These high concentrations increase the risk that, should any adverse economic, regulatory or other such development occur within these states, our business, financial position, results of operations or cash flows could be materially adversely affected.

B. PRINCIPLES OF CONSOLIDATION

Our consolidated financial statements include the accounts of Tenet and its wholly owned and majority-owned subsidiaries. We account for significant investments in other affiliated companies using the equity method. We eliminate intercompany accounts and transactions in consolidation, and we include the results of operations of businesses that are newly acquired in purchase transactions from their dates of acquisition.

C. NET OPERATING REVENUES

We recognize net operating revenues in the period in which services are performed. Net operating revenues consist primarily of net patient service revenues that are recorded based on established billing rates (gross charges), less estimated discounts for contractual allowances, principally for patients covered by Medicare, Medicaid, managed care and other health plans, and self-pay patients under our *Compact with Uninsured Patients* ("Compact").

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

Percentages of consolidated net patient revenues, by payer type, for our continuing general hospitals for the years ended December 31, 2004 and 2003, the seven-month transition period ended December 31, 2002, and the fiscal year ended May 31, 2002 are shown in the table below:

	Years ended December 31		Seven months ended December 31, 2002	Year ended May 31, 2002
	2004	2003		
Medicare	26.1%	25.1%	28.5%	29.6%
Medicaid	7.4%	7.7%	6.4%	6.5%
Managed care	49.7%	51.0%	50.0%	47.4%
Indemnity, self-pay and other	16.8%	16.2%	15.1%	16.5%

We recorded the following approximate amounts of net patient revenues related to Medicare outliers in the years ended December 31, 2004 and 2003, the seven-month transition period ended December 31, 2002 and the fiscal year ended May 31, 2002:

	Medicare Outlier Payments	% of Medicare Revenues	% of Net Operating Revenues
	(Dollars in Millions)		
Years ended:			
December 31, 2004	$64	2.5%	0.6%
December 31, 2003	$101	4.0%	1.0%
Seven-month transition period ended:			
December 31, 2002	$304	17.9%	5.0%
Fiscal year ended:			
May 31, 2002	$454	16.1%	4.7%

On January 6, 2003, we voluntarily submitted a proposal to CMS that would reduce outlier payments to our hospitals retroactive to January 1, 2003. Our proposal resulted in a reduction of Medicare outlier revenue recognized by us as shown above. During 2003, CMS issued new regulations, which became effective August 8, 2003, governing the calculation of outlier payments to hospitals.

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

Prior to 2003, we recorded estimates for contractual allowances and cost report settlements for Medicare and Medicaid based on amounts generated from information accumulated from various accounting and information systems. Adjustments to these accruals were generally made upon the final settlement of Medicare and Medicaid cost reports. Adjustments related to Medicare and Medicaid cost report settlements decreased revenues by $8 million in the seven months ended December 31, 2002, and increased revenue by $33 million in the year ended May 31, 2002.

In 2003, we completed the implementation of a new system and methodology for recording Medicare net revenue and estimated cost report settlements. This resulted in a refinement in recording the accruals to more closely reflect the expected final settlements on our cost reports. For filed cost reports, we now record the accrual based on those cost reports and subsequent activity, and record a valuation allowance against those cost reports based on historical settlement trends. The accrual for cost reports not yet filed is now recorded based on estimates of what we expect to report on the filed cost reports and a corresponding valuation allowance is recorded as previously described. Cost reports must be filed generally within the five months after the end of the annual cost report reporting period. After the cost report is filed, the accrual and corresponding valuation allowance may need to be adjusted. Adjustments for valuation allowances and cost report settlements related to Medicare and Medicaid reduced revenues in each of the years ended December 31, 2004 and 2003 by $40 million and

$55 million, respectively. Estimated cost report settlements and valuation allowances are deducted from accounts receivable in the accompanying consolidated balance sheets (see Note 9).

We believe that we have made adequate provision for any adjustments that may result from final determination of amounts earned under all the above arrangements with Medicare and Medicaid.

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

We know of no material claims, disputes or unsettled matters with any payers that would affect our revenues for which we have not adequately provided for in the accompanying consolidated financial statements.

Our Compact is designed to offer managed care-style discounts to most uninsured patients, which enables us to offer lower rates to those patients who historically have been charged standard gross charges. A significant portion of those charges had previously been written down in our provision for doubtful accounts. Under the Compact, the discount offered to uninsured patients is recognized as a contractual allowance, which reduces net operating revenues at the time the self-pay accounts are recorded and should reduce our provision for doubtful accounts in the future. During the second and third quarters of 2004, we began phasing in the discounting components of the Compact at many of our hospitals, resulting in approximately $277 million in discounts recorded on self-pay accounts under the Compact during 2004. The uninsured patient accounts, net of contractual allowances recorded, are further reduced to their net realizable value through provision for doubtful accounts based on historical collection trends for self-pay accounts and other factors that affect the estimation process.

We also provide charity care to patients whose income level is below 200% of the Federal Poverty Level with only a co-pay charged to the patient. Our policy is to not pursue collection of amounts determined to qualify as charity care; and, accordingly, we do not report the amounts in net operating revenues or in the provision for doubtful accounts. Patients whose income level is between 200% and 300% of the Federal Poverty Level may also be considered under a catastrophic provision of our charity care policy. Patients without insurance who do not meet the Federal Poverty Level guidelines are offered assistance in applying for Medicaid and other programs they may be eligible for, such as state disability, Victims of Crime or county indigent programs. Patient advocates from our Medical Eligibility Program ("MEP") screen patients in the hospital and determine potential linkage to financial assistance programs. They also expedite the process of applying for these government programs.

The approximate amounts of gross charges foregone under our charity policy, including indigent care accounts, for the years ended December 31, 2004 and 2003, for the seven months ended December 31, 2002, and for the year ended May 31, 2002 are shown in the following table:

	(In Millions)
Years ended December 31	
2004	$ 573
2003	$ 740
Seven months ended December 31	
2002	$ 403
Year ended May 31	
2002	$ 477

The lower level of charity and indigent charges in the year ended December 31, 2004 is attributable to a more diligent screening process, whereby approval of accounts are based on specific criteria and require complete and sufficient documentation. In addition, certain accounts that previously were classified as indigent are now being evaluated for qualification under the Compact and provided discounts consistent with managed-care rates.

Receivables from patients who are potentially eligible for Medicaid are classified as Medicaid pending, under our MEP, with appropriate contractual allowances recorded. Based on recent trends, approximately 78% of all accounts in our MEP are ultimately approved for Medicaid or receive financial assistance under another qualifying program. If the patient does not qualify for Medicaid, the receivables are reclassified to charity care and written off, or they are reclassified to self-pay, and discounted under the Compact, if applicable, and adjusted to their net realizable value through the provision for doubtful accounts. Reclassifications of Medicaid pending accounts to self-pay do not typically have a material impact on our results of operations as the estimated Medicaid contractual allowances initially recorded are not materially different than the discount recorded on self-pay accounts under the Compact or the estimated provision for doubtful accounts recorded (if a facility had not yet implemented the Compact) when the accounts are reclassified. All accounts classified as pending Medicaid are fully reserved when they reach 180 days old.

The following table shows the approximate amount of net accounts receivable classified as Medicaid pending, still awaiting determination of eligibility at December 31, 2004 and 2003, by aging category:

	December 31	
	2004	2003
	(In Millions)	
0-60 days	$ 48	$ 39
61-120 days	26	34
121-180 days	13	17
Over 180 days(1)	—	—
Total	$ 87	$ 90

(1) Includes accounts receivable of $20 million and $28 million at December 31, 2004 and 2003, respectively, that are fully reserved.

D. CASH EQUIVALENTS

We treat highly liquid investments with original maturities of three months or less as cash equivalents. Cash equivalents were approximately $654 million and $619 million at December 31, 2004 and 2003, respectively. As of December 31, 2004 and 2003, our book overdrafts were approximately $221 million and $223 million, respectively, which were classified as accounts payable.

E. INVESTMENTS IN DEBT AND EQUITY SECURITIES

We classify investments in debt and equity securities as either available-for-sale, held-to-maturity or as part of a trading portfolio. At December 31, 2004 and 2003, we had no significant investments in securities classified as either held-to-maturity or trading. We carry securities classified as available-for-sale at fair value if unrestricted. We report their unrealized gains and losses, net of taxes, as accumulated other comprehensive income or loss unless we determine that a loss is other than temporary, at which point we would record a loss in the statement of operations. We include realized gains or losses in the statement of operations based on the specific identification method.

F. PROVISION FOR DOUBTFUL ACCOUNTS

We provide for an allowance against accounts receivable for an amount that could become uncollectible whereby such receivables are reduced to their estimated net realizable value. We estimate this allowance based on the aging of our accounts receivable, our historical collection experience by hospital and by payer, and other relevant factors. There are various factors that can impact the collection trends, such as changes in the economy, which in turn have an impact on unemployment rates and the number of uninsured and underinsured patients, volume of patients through the emergency department, the increased burden of co-payments to be made by patients with insurance and business practices related to collection efforts. These factors continuously change and can have an impact on collection trends and our estimation process.

Our policy is to attempt to collect amounts due from patients, including co-payments and deductibles due from patients with insurance, at the time of service while complying with all federal and state laws and regulations, including, but not limited to, the Emergency Medical Treatment and Labor Act ("EMTALA"). Generally, as required by EMTALA, patients may not be denied emergency treatment due to inability to pay. Therefore, until the legally required medical screening examination is complete and stabilization of the patient has begun, services are performed prior to the verification of the patient's insurance, if any. In non-emergency circumstances or for elective procedures and services, it is our policy to verify insurance prior to a patient being treated; however, there are various exceptions that can occur. Such exceptions can include, for example, instances where (1) we are unable to obtain verification because the patient's insurance company was unable to be reached or contacted, (2) a determination is made that a patient may be eligible for benefits under various government programs, such as Medicaid or Victims of Crime, and it takes several days or weeks before qualification for such benefits is confirmed or denied, and (3) under physician orders we provide services to patients that require immediate treatment.

G. PROPERTY AND EQUIPMENT

Additions and improvements to property and equipment are capitalized at cost. Expenditures for maintenance and repairs are charged to expense as incurred. We use the straight-line method of depreciation for buildings, building improvements and equipment. The estimated useful life for buildings and improvements is primarily 25 to 40 years, and for equipment, three to 15 years. We record capital leases at the beginning of the lease term as assets and liabilities. The value recorded is

the lower of either the present value of the minimum lease payments or the fair value of the asset. Such assets, including improvements, are amortized over the shorter of either the lease term or their estimated useful life. Interest costs related to construction projects are capitalized. In the years ended December 31, 2004 and 2003, capitalized interest was $11 million and $12 million, respectively, $4 million in the seven months ended December 31, 2002 and $9 million in the year ended May 31, 2002.

We evaluate our long-lived assets for possible impairment whenever circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future cash flows. However, there is an evaluation performed at least annually. Fair value estimates are derived from independent appraisals, established market values of comparable assets or internal calculations of estimated future net cash flows. Our estimates of future cash flows are based on assumptions and projections we believe to be reasonable and supportable. Our assumptions take into account revenue and expense growth rates, patient volumes, changes in payer mix, and changes in legislation and other payer payment patterns. These assumptions vary by type of facility.

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

H. GOODWILL AND OTHER INTANGIBLE ASSETS

Goodwill represents the excess of costs over the fair value of assets of businesses acquired. In accordance with Statement of Financial Accounting Standards ("SFAS") No. 142, "Goodwill and Other Intangible Assets" ("SFAS 142"), which we adopted on June 1, 2002, goodwill and other intangible assets acquired in a purchase business combination and determined to have an indefinite useful life are not amortized, but instead are subject to impairment tests performed at least annually. For goodwill, the test is performed at the reporting unit level, as defined by SFAS 142, when events occur that require an evaluation to be performed or at least annually. If we find the carrying value of goodwill to be impaired, or if the carrying value of a business that is to be sold or otherwise disposed of exceeds its fair value, then we must reduce the carrying value, including any allocated goodwill, to fair value. Estimates of fair value are based on independent appraisals, established market prices for comparative assets or internal calculations of estimated future net cash flows.

Other intangible assets primarily consist of capitalized software costs, which are amortized on a straight-line basis over the estimated useful life of the software, which ranges from three to 15 years. Also included in intangible assets are costs associated with the issuance of our long-term debt, which are being amortized under the straight-line method based on the terms of the specific notes, which is not materially different from the interest method.

I. ACCRUAL FOR GENERAL AND PROFESSIONAL LIABILITY RISKS

We record reserves for claims when they are probable and reasonably estimable. We maintain reserves, which are based on actuarial estimates by an independent third party, for the portion of our professional liability risks, including incurred but not reported claims, to the extent we do not have insurance coverage (i.e., self-insured retentions). We estimate reserves for losses and related expenses using expected loss-reporting patterns. Reserves are discounted to their estimated present value under a risk-free rate approach using a Federal Reserve seven-year maturity composite rate that approximates our claims payout period. There can be no assurance that the ultimate liability will not exceed our

estimates. Adjustments to the estimated reserves are recorded in our results of operations in the periods when such amounts are determined.

J. INCOME TAXES

We account for income taxes using the asset and liability method in accordance with SFAS No. 109, "Accounting for Income Taxes" ("SFAS 109"). This approach requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of temporary differences between the carrying amounts and the tax bases of assets and liabilities.

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

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

- cumulative losses in recent years;
- income/losses expected in future years;
- unsettled circumstances that, if unfavorably resolved, would adversely affect future operations and profit levels;
- the availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits;
- the carryforward period associated with the deferred tax assets and liabilities; and
- prudent and feasible tax-planning strategies.

While we believe we have provided adequately for our income tax receivables or liabilities in our consolidated financial statements, adverse determinations by taxing authorities or changes in tax laws and regulations could have a material adverse effect on our consolidated financial position, results of operations or cash flows.

K. STOCK OPTIONS

Through December 31, 2002, we applied the intrinsic-value-based method of accounting, prescribed by Accounting Principles Board ("APB") Opinion No. 25 ("APB 25"), and its related interpretations (including FASB Interpretation No. 44, an interpretation of APB 25 issued in March 2000), to our stock-based compensation plans. In accordance with that method, no compensation cost was recognized for stock options granted to employees or directors under the plans through that date because the exercise prices for options granted were equal to the quoted market prices on the option grant dates.

In March 2003, we adopted SFAS No. 123, "Accounting for Stock-Based Compensation" ("SFAS 123"). The new policy had a retroactive effective date of January 1, 2003 (the first day of our new fiscal year). The accounting standard establishes a fair value method of accounting for stock-based compensation plans (i.e., compensation costs are based on the fair value of stock options granted). We utilized the retroactive-restatement method to transition from the former accounting standard to the

new one. As such, presentations of periods ended prior to January 1, 2003 have been restated to reflect the fair-value method of accounting, as if the change had been effective throughout those prior periods.

L. SEGMENT REPORTING

We operate in one line of business—the provision of health care services through the operation of general hospitals and related health care facilities. Our general hospitals generated 97.6% and 97.0% of our net operating revenues in the years ended December 31, 2004 and 2003, respectively, 96.9% in the seven-month transition period ended December 31, 2002, and 96.5% in the year ended May 31, 2002.

Through March 10, 2003, we had organized these general hospitals and our related health care facilities into three operating segments or divisions. Subsequently, we consolidated into two divisions consisting of five regions. During 2004, we eliminated the two divisions and consolidated our operating regions from five to four in an effort to continue to streamline our operating structure as we build our future around 69 general hospitals. The four regions became our operating segments, as that term is defined by SFAS No. 131, "Disclosure about Segments of an Enterprise and Related Information." There was no impact on our previous segment reporting determinations as a result of this latter restructuring since the regions' economic characteristics, the nature of their operations, the regulatory environment in which they operate and the manner in which they are managed continue to be similar. In addition, these regions share certain resources and they benefit from many common clinical and management practices. Accordingly, we aggregate the four regions into a single reportable operating segment.

Our chief operating officer directly oversees operations in the four regions: California, Central Northeast-Southern States, Florida-Alabama and Texas-Gulf Coast.

M. COSTS ASSOCIATED WITH EXIT OR DISPOSAL ACTIVITIES

We account for costs associated with exit (including restructuring) or disposal activities in accordance with SFAS No. 146, "Accounting for Costs Associated with Exit or Disposal Activities," issued in June 2002 and applicable to such activities initiated after December 31, 2002. We recognize these costs when they are incurred and can be measured at fair value, rather than at the date of a commitment to an exit or disposal plan, as was the case under former accounting standards.

NOTE 3 ALLOWANCE FOR DOUBTFUL ACCOUNTS

During the quarter ended September 30, 2003, we recorded additional provisions for doubtful accounts in the amount of $212 million ($0.28 per share), of which $166 million ($0.22 per share) was for continuing operations and $46 million ($0.06 per share) was for discontinued operations, to write down our patient accounts receivable to their estimated net realizable value. The additional charge consisted of two components: (1) the effect of accelerating the write-down of self-pay accounts, and (2) the effect of re-evaluating the historical collection patterns for self-pay and managed care accounts receivable in light of the trends at that time.

This additional charge to increase the provision for doubtful accounts resulted primarily from an adverse change in our business mix as the number of uninsured and underinsured patients grew at an escalating rate. We believe this trend was due to a combination of broad economic factors, including unemployment levels, reductions in state Medicaid budgets, increasing numbers of individuals and employers who choose not to purchase insurance, and an increased burden of co-payments and deductibles to be made by patients instead of insurers. Additionally, many of these patients, who delay or do not seek routine medical care because of the costs, are being admitted through the emergency

department and often require more costly care, resulting in higher billings, which are the least collectible of all accounts.

Historically, our in-house collection agency had collected approximately 17 cents of each dollar of gross charges of self-pay accounts assigned to it. Collections on these types of accounts subsequently declined to a rate of approximately 12 cents on the dollar. Accordingly, during the third quarter of 2003, we changed our accounts receivable evaluation process to give more weight to the most recent 12 months of collection experience. Based on recent collection trends, our in-house collection agency is now collecting approximately 10 cents on the dollar of self-pay accounts assigned to them. Collection trends continue to be evaluated by us and our estimated allowance for doubtful accounts may be adjusted periodically.

Approximately 20% of the additional $212 million charge in the third quarter of 2003 related to changes in the collectibility of managed care accounts receivable. We were experiencing and continue to experience significant payment pressure from managed care companies (which pressure is exacerbated by disputes with certain managed care companies, primarily in California) concerning substantial amounts of past billings. We aggressively pursue collection of these accounts receivable using all means at our disposal, including arbitration and litigation, but we may not be successful.

During the quarter ended June 30, 2004, we further modified our process for estimating and writing down all existing self-pay accounts (and all future self-pay accounts receivable when they are recorded) to their net realizable value, resulting in an additional provision for doubtful accounts in the amount of $254 million ($0.33 per share), of which $196 million ($0.26 per share) was for continuing operations and $58 million ($0.07 per share) was for discontinued operations. This change in how we estimate the net realizable value of self-pay accounts was primarily attributable to the continued increase in numbers of uninsured and underinsured patients.

Our current total estimated collection rates on managed care accounts and self-pay accounts are approximately 95% and 16%, respectively, which includes collections from point-of-service through collections by our in-house collection agency or external collection vendors.

Our Compact is designed to offer managed care-style discounts to most uninsured patients, which enables us to offer lower rates to those patients who historically have been charged standard gross charges. A significant portion of those charges had previously been written down in our provision for doubtful accounts. Under the Compact, the discount offered to uninsured patients is recognized as a contractual allowance, which reduces net operating revenues at the time the self-pay accounts are recorded and should reduce our provision for doubtful accounts in the future. On February 19, 2004, the Secretary of Health and Human Services confirmed that hospitals can provide discounts for uninsured patients, which allows us to implement our discount plan where permitted by state law. The discounts for uninsured patients began to be phased in during the second quarter of 2004 at many of our hospitals and were in effect at 40 of our hospitals by the end of the year. Of the remaining 29 hospitals, 17 implemented the Compact during the first quarter of 2005. We are evaluating and addressing legal and other issues that may limit our ability to implement the discounting components of the Compact at our hospitals in Texas.

During the year ended December 31, 2004, there were $277 million of discounts recorded as contractual allowances on self-pay accounts under the Compact. Prior to implementation of the Compact, a large portion of these discounts would have been recognized in our provision for doubtful accounts.

NOTE 4 DISCONTINUED OPERATIONS

In March 2003, we announced a plan to divest or consolidate 14 general hospitals that no longer fit our core operating strategy of building and maintaining competitive networks of hospitals that provide quality patient care in major markets. Of the 14 hospitals included in our March 2003 divestiture plan, we sold six in November 2003, five in December 2003 and one in February 2004. Net after-tax proceeds from the sales of the 11 hospitals sold in the year ended December 31, 2003, including liquidation of working capital, are expected to be approximately $623 million. Net proceeds from the hospital sold in February 2004 are expected to be approximately $40 million, including liquidation of working capital. We recorded a gain of approximately $274 million in the year ended December 31, 2003 on the sales of the 11 hospitals sold during the year. The carrying amount of the assets sold included $106 million of goodwill. In addition to selling 12 hospitals, we ceased operations at one of the 14 hospitals when its long-term lease expired in August 2003, and we closed another hospital in September 2003. We have used and intend to use the proceeds from the divestitures for general corporate purposes.

In January 2004, we announced a major restructuring of our operations involving the proposed divestiture of 27 general hospitals (19 in California and eight others in Louisiana, Massachusetts, Missouri and Texas). By focusing our financial and management resources on our remaining 69 general hospitals, including two recently constructed in Texas and Tennessee, we expect to create a stronger company with greater potential for long-term growth. Total net proceeds from these divestitures could approximate $600 million, a significant portion of which is expected to be in the form of tax benefits from anticipated tax losses that will result from these divestitures. The proceeds from these divestitures have been used and will be used for general corporate purposes. As of December 31, 2004, we had completed the divestiture of 18 of the 27 facilities and entered into a definitive agreement to divest an additional four hospitals. We recorded a gain of approximately $71 million in the year ended December 31, 2004 on the divestiture of the 18 facilities. The carrying amount of the assets sold included $3 million of goodwill. Discussions and negotiations with potential buyers for the remaining five hospitals slated for divestiture were ongoing as of December 31, 2004.

On June 30, 2004, we sold Brownsville Medical Center in Brownsville, Texas. Net after-tax proceeds, including the liquidation of working capital, are estimated to be approximately $68 million.

On July 31, 2004, we terminated our lease to operate Doctors Medical Center—San Pablo, in San Pablo, California.

On August 31, 2004, we sold Doctors Hospital of Jefferson in Metairie, Louisiana. Net after-tax proceeds, including the liquidation of working capital, are estimated to be approximately $33 million.

On September 30, 2004, we announced that we had entered into a definitive agreement to sell four hospitals in Orange County, California. The hospitals are Chapman Medical Center, Coastal Communities Hospital, Western Medical Center—Anaheim, and Western Medical Center—Santa Ana. Net after-tax proceeds, including the liquidation of working capital, are estimated to be approximately $80 million.

On October 31, 2004, we sold four hospitals in the Los Angeles, California area. The hospitals are Garfield Medical Center, Monterey Park Hospital, Greater El Monte Community Hospital and Whittier Hospital Medical Center. Net after-tax proceeds, including the liquidation of working capital, are estimated to be approximately $95 million. Under the sales agreement, we received

$50 million of cash proceeds upon closing and entered into a $50 million senior secured loan agreement with the buyer. The $50 million loan due from the buyer matured and was repaid in December 2004.

On November 19, 2004, we completed the transfer of assets of three hospitals in the West Los Angeles, California area. The three hospitals are Centinela Hospital Medical Center, Daniel Freeman Memorial Hospital and Daniel Freeman Marina Hospital. Net after-tax proceeds, including the liquidation of working capital and tax benefits, are estimated to be approximately $47 million.

On November 30, 2004, we completed the sale of Midway Hospital Medical Center in Los Angeles, California. Net after-tax proceeds, including the liquidation of working capital, are estimated to be approximately $12 million.

On December 23, 2004, we sold two hospitals in St. Louis, Missouri. The hospitals are Forest Park Hospital and St. Alexius Hospital, consisting of St. Alexius Hospital—Broadway Campus and St. Alexius Hospital—Jefferson Campus. Net after-tax proceeds, including a $6 million note from the buyer and the liquidation of working capital, are estimated to be approximately $46 million. The $6 million note from the buyer was paid in January 2005.

On December 31, 2004, we completed the sale of five hospitals in California, Louisiana and Massachusetts to various buyers. Hollywood Presbyterian Medical Center in Los Angeles, California sold for net after-tax proceeds, including a $4 million note from the buyer and the liquidation of working capital, estimated to be approximately $71 million. St. Charles General Hospital in New Orleans, Louisiana sold for net after-tax proceeds, including the liquidation of working capital, estimated to be approximately $11 million. The three Massachusetts hospitals sold are Saint Vincent Hospital at Worcester Medical Center in Worcester, and MetroWest Medical Center, consisting of Leonard Morse Hospital in Natick and Framingham Union Hospital in Framingham. Net after-tax proceeds, including the liquidation of working capital, are estimated to be approximately $169 million.

In addition to the hospitals divested or to be divested as part of the restructuring program that we announced in January 2004, we completed three other divestitures during 2004 as follows:

In May 2004, we sold our general hospital in Barcelona, Spain. Net after-tax proceeds from the sale were approximately $50 million, including an estimated $4.4 million in contingent payments. In addition, the buyer assumed $31 million in long-term debt and other liabilities, and retained the working capital. We expect to use the net proceeds for general corporate purposes.

On July 16, 2004, we sold certain hospital assets of Redding Medical Center for net after-tax proceeds, including the liquidation of working capital, of approximately $57 million. As part of an agreement with the Office of the Inspector General of the U.S. Department of Health and Human Services, we agreed to seek a buyer for this facility (see Note 14). Redding Medical Center, Inc., our subsidiary that formerly owned the hospital, will retain substantially all of its pre-closing liabilities.

On September 1, 2004, we entered into an agreement with the Commonwealth of Pennsylvania and two Pennsylvania nonprofit corporations (WMCH, Inc. and East Falls Hospital System) to sell Medical College of Pennsylvania Hospital ("MCPH") for $1. Under the agreement, the MCPH facilities and grounds were sold to WMCH, Inc. and certain of MCPH's non-real estate assets, including most hospital equipment, were transferred by us to East Falls Hospital System, which continues to operate the facility as an acute care hospital.

In connection with these and other actions described below, we have classified the results of operations of the following hospitals as discontinued operations for all periods presented in the accompanying consolidated statements of operations in accordance with SFAS No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets" ("SFAS 144"):

- The 14 general hospitals whose intended divestiture we announced in March 2003, all of which were sold or closed prior to March 31, 2004,
- The 27 hospitals whose intended divestiture we announced in January 2004,
- Our general hospital in Barcelona, Spain,
- Redding Medical Center,
- MCPH,
- Century City Hospital in Los Angeles, California, a previously leased hospital that we no longer operated by the end of April 2004,
- NorthShore Psychiatric Hospital, in Slidell, Louisiana, which was closed in September 2004, and
- Suburban Medical Center, in Paramount, California, a previously leased hospital that we no longer operated by the end of October 2004.

We have classified $101 million of the assets of the hospitals above as "held for sale" in other current assets in the accompanying consolidated balance sheet at December 31, 2004. These assets consist primarily of property and equipment, including the associated deferred tax assets, net of valuation allowance, and are recorded at the lower of the asset's carrying amount or its fair value less costs to sell. The fair value estimates were derived from independent appraisals, established market values of comparable assets, or internal calculations of estimated future net cash flows. Because we do not intend to sell the accounts receivable of the asset group, these receivables, less the related allowance for doubtful accounts, are included in our consolidated net accounts receivable in the accompanying consolidated balance sheet. At December 31, 2004, the net accounts receivable for these hospitals was $201 million.

At December 31, 2003, only those hospitals whose intended divestitures we had announced prior to December 31, 2003 were classified as "held for sale." Assets classified as "held for sale" related to those hospitals were $113 million at December 31, 2003. The net accounts receivable of those hospitals classified as "held for sale" at that date was $128 million. Because we do not intend to sell the accounts receivable of the asset group, these receivables, less the related allowance for doubtful accounts, are included in our consolidated net accounts receivable in the accompanying consolidated balance sheet.

We recorded $439 million of impairment and restructuring charges in discontinued operations during the year ended December 31, 2004 consisting primarily of $320 million for the write-down of long-lived assets and $33 million for the write-down of goodwill to their estimated fair values, less estimated costs to sell, $32 million in employee severance and retention costs, $6 million in contract termination and other costs, and $48 million in costs related to an academic affiliation agreement with Drexel University College of Medicine in Pennsylvania. In connection with our divestiture of MCPH, we are contractually responsible for certain university costs. We also recorded impairment and restructuring charges in discontinued operations in the amount of $699 million in the year ended December 31, 2003 primarily for the write-down of long-lived assets ($584 million) and goodwill ($89 million) to their estimated fair values, less costs to sell, if applicable, at these facilities. We recorded $374 million of impairment charges in discontinued operations in the seven months ended

December 31, 2002 primarily for the write-down of long-lived assets to their estimated fair values at nine general hospitals and one psychiatric hospital.

Net operating revenues and income (loss) before taxes reported in discontinued operations for the years ended December 31, 2004 and 2003, the seven months ended December 31, 2002, and the year ended May 31, 2002 are as follows:

	Years ended December 31		Seven months ended December 31, 2002	Year ended May 31, 2002
	2004	2003		
			(In Millions)	
Net operating revenues	$ 2,577	$ 3,993	$ 2,674	$ 4,180
Income (loss) before taxes	(1,056)	(527)	(48)	591

As we move forward with our previously announced divestiture plans, we may incur additional asset impairment and restructuring charges in future periods.

During the year ended December 31, 2003, we recorded an after-tax charge in discontinued operations for taxes and interest of approximately $70 million in connection with an Internal Revenue Service audit adjustment related to the deductibility of a civil settlement we paid to the federal government in 1994 (see Notes 14 and 15).

Income tax benefit in discontinued operations for the year ended December 31, 2004 is net of $144 million of expense related to establishing a valuation allowance for deferred tax assets during the fourth quarter of 2004 (see Note 15).

NOTE 5 IMPAIRMENT AND RESTRUCTURING CHARGES

YEAR ENDED DECEMBER 31, 2004

During the year ended December 31, 2004, we recorded impairment and restructuring charges of $1.272 billion. The combined charges consisted of $1.113 billion for the impairment of goodwill related to our Texas-Gulf Coast and Florida-Alabama regions, $25 million for the write-down of an intangible asset with an indefinite useful life to its estimated fair value and $98 million for impairment of certain long-lived assets (for the write-down of long-lived assets to their estimated fair values, primarily at eight hospitals). The restructuring charges totaled $36 million and consisted of $29 million in employee severance, benefits and relocation costs, $10 million in non-cash stock option modification costs related to terminated employees, $14 million in contract termination, consulting and other costs, and a $17 million reduction in reserves for restructuring charges recorded in prior periods.

The goodwill impairment charge of $1.113 billion, recorded in the fourth quarter of 2004, is the result of lower estimated fair values for the Texas-Gulf Coast and Florida-Alabama regions due to adverse industry and company-specific challenges that continue to affect our operating results, such as reduced patient volumes, high levels of bad debt expense related to uninsured and underinsured patients, the shift of our managed care business to contracts that provide lower reimbursement, and continued pressure on labor and supply costs.

We recognized the $98 million impairment charge related to certain long-lived assets and the $25 million impairment charge in the fourth quarter of 2004 related to an intangible asset with an indefinite life due to lower estimated fair values of these assets. Our estimates of future cash flows from these assets indicated that the carrying amounts of these assets were not fully recoverable from estimated future cash flows.

The fair-value estimates were derived from independent appraisals, established market values of comparable assets, or internal calculations of estimated future net cash flows.

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.

YEAR ENDED DECEMBER 31, 2003

During the year ended December 31, 2003, we recorded impairment and restructuring charges of $1.384 billion. The combined charges consisted of $156 million for impairment of long-lived assets (for the write-down of long-lived assets to their estimated fair values primarily at eight hospitals), $1.122 billion for impairment of goodwill, primarily related to our California region and our then Central-Northeast region, $66 million in employee severance, benefits and relocation costs, $37 million in non-cash stock-option-modification costs related to terminated employees, and $3 million in contract terminations, and consulting and other costs (net of a $13 million reduction in reserves for restructuring charges recorded in prior periods).

We recognized the $156 million of impairment charges on long-lived assets because our estimates of future cash flows from these assets indicated that the carrying amount of the assets or groups of assets were not fully recoverable from estimated future cash flows. Our estimates were based on assumptions and projections that we believe to be reasonable and supportable. The fair-value estimates of our long-lived assets were derived from independent appraisals, established market values of comparable assets, or internal calculations of estimated future net cash flows.

Approximately $187 million of our goodwill impairment charge relates to the consolidation (that we announced on March 10, 2003) of our operating divisions from three to two. Because of this restructuring of our operating divisions and regions, along with a realignment of our executive management team and other factors, our goodwill "reporting units" (as defined under SFAS 142) changed. Prior to the restructuring, the reporting units consisted of our three divisions; following the restructuring, they consisted of our five new regions. Because of the change in reporting units, we performed a goodwill impairment evaluation in March 31, 2003 resulting in the above impairment charge related to our then Central-Northeast region.

The $935 million balance of our 2003 goodwill impairment charge is associated primarily with our California region and our then Central-Northeast region as a result of the completion of a comprehensive review of the near-term and long-term prospects for each of our hospitals. The estimated fair value of these regions declined based on reduced earnings forecasts as a result of the completion of updated budgets. Key factors that contributed to the reduced earnings forecasts for the hospitals included (1) significant reductions in Medicare outlier revenues, (2) significant increases in provisions for doubtful accounts, and (3) other cost increases.

The $106 million in restructuring charges were incurred primarily in connection with (1) our previously announced plans to reduce operating expenses, including the reduction of staff, and (2) the realignment of our executive management team.

SEVEN MONTHS ENDED DECEMBER 31, 2002

In the seven-month transition period ended December 31, 2002, we recorded impairment and restructuring charges of $22 million. The combined charges consisted of restructuring charges of $13 million, primarily consulting fees and severance and employee relocation costs incurred in connection with changes in our senior executive management team, and $9 million for the write-down

of long-lived assets to their estimated fair values at three general hospitals. We recognized the impairment of these long-lived assets because events or changes in circumstances indicated that the carrying amount of the assets or groups of assets were not fully recoverable from estimated future cash flows. The facts and circumstances leading to that conclusion include (1) our analyses of expected changes in growth rates for revenues and expenses and changes in payer mix, (2) changes in certain managed care contract terms and (3) the effect of projected reductions in Medicare outlier payments on net operating revenues and operating cash flows.

Our estimates of future cash flows from these assets or asset groups were based on assumptions and projections that we believe to be reasonable and supportable. Our assumptions took into account revenue and expense growth rates, patient volumes, changes in payer mix, and changes (enacted or anticipated) in legislation and other payer payment patterns. The fair value estimates of our long-lived assets were derived from either independent appraisals, established market values of comparable assets, or internal calculations of estimated future net cash flows.

YEAR ENDED MAY 31, 2002

In the second quarter of the year ended May 31, 2002, we recorded impairment and restructuring charges of $99 million primarily related to the planned closure of two general hospitals and the sales of certain other health care businesses. The total charge consists of (1) impairment write-downs of property, equipment, goodwill and other assets to estimated fair value, $76 million, and (2) expected cash disbursements related to lease-cancellation costs, severance costs and other exit costs, $23 million.

The impairment charge consists of write-downs of $39 million for property and equipment, $13 million for goodwill and $24 million for other assets. The balance of the charges consist of $7 million in lease-cancellation costs, $5 million in severance costs related to the termination of 691 employees, $2 million in legal costs and settlements and $9 million in other exit costs. We decided to close those two hospitals because they were operating at a loss, which was not significant, and were not essential to our strategic objectives. Subsequently, one of these hospitals was closed and the other was sold.

The tables below are reconciliations of beginning and ending liability balances in connection with restructuring charges recorded during the years ended December 31, 2004 and 2003, the seven months ended December 31, 2002, and the year ended May 31, 2002:

	Balances at Beginning of Period	Restructuring Charges	Cash Payments	Other Items	Balances at End of Period
			(In Millions)		
Year ended December 31, 2004					
Discontinued Operations:					
Lease cancellations and estimated costs associated with the sale or closure of hospitals and other facilities	$ 18	$ 86	$ (43)	$ (3)	$ 58
Continuing Operations:					
Severance costs in connection with hospital cost-control programs and general overhead-reduction plans	65	36	(40)	10	71
	$ 83	**$ 122**	**$ (83)**	**$ 7**	**$ 129**

Year ended December 31, 2003					
Discontinued Operations:					
Lease cancellations and estimated costs associated with the sale or closure of hospitals and other facilities	$ 20	$ 26	$ (10)	$ (18)	$ 18
Continuing Operations:					
Severance costs in connection with hospital cost-control programs and general overhead-reduction plans	43	106	(38)	(46)	65
	$ 63	**$ 132**	**$ (48)**	**$ (64)**	**$ 83**
Seven months ended December 31, 2002					
Discontinued Operations:					
Lease cancellations and estimated costs associated with the sale or closure of hospitals and other facilities	$ 20	$ —	$ —	$ —	$ 20
Continuing Operations:					
Severance costs in connection with hospital cost-control programs and general overhead-reduction plans	65	13	(15)	(20)	43
	$ 85	**$ 13**	**$ (15)**	**$ (20)**	**$ 63**
Year ended May 31, 2002					
Discontinued Operations:					
Lease cancellations and estimated costs associated with the sale or closure of hospitals and other facilities	$ 25	$ —	$ (4)	$ (1)	$ 20
Continuing Operations:					
Severance costs in connection with hospital cost-control programs and general overhead-reduction plans	110	23	(64)	(4)	65
	$ 135	**$ 23**	**$ (68)**	**$ (5)**	**$ 85**

The above liability balances are included in other current liabilities and other long-term liabilities in the accompanying consolidated balance sheets. Other items primarily include restructuring charges or reductions of reserves that are recorded in accounts other than these liabilities, such as the charges associated with stock option modifications. Cash payments to be applied against these accruals at December 31, 2004 are expected to be approximately $88 million in 2005 and $41 million thereafter.

NOTE 6 LONG-TERM DEBT AND LEASE OBLIGATIONS

The table below shows our long-term debt as of December 31, 2004 and 2003:

	December 31	
	2004	2003
	(In Millions)	
Senior notes:		
5 3/8%, due 2006	$ 215	$ 550
5%, due 2007	185	400
6 3/8%, due 2011	1,000	1,000
6 1/2%, due 2012	600	600
7 3/8%, due 2013	1,000	1,000
9 7/8%, due 2014	1,000	—
6 7/8%, due 2031	450	450
Other senior and senior subordinated notes	22	24
Notes payable and capital lease obligations, secured by property and equipment, payable in installments to 2013(1)	65	88
Other promissory notes, primarily unsecured(2)	—	34
Unamortized note discounts	(101)	(89)
Total long-term debt	**4,436**	**4,057**
Less current portion	41	18
Long-term debt, net of current portion	**$ 4,395**	**$ 4,039**

(1) Includes $5 million at December 31, 2004 and 2003 related to the general hospitals held for sale (see Note 4).
(2) Related to our general hospital in Barcelona, Spain that was sold in May 2004.

CREDIT AGREEMENTS

On December 31, 2004, we terminated our five-year revolving credit agreement and replaced it with a one-year letter of credit facility. The new facility provides for the issuance of up to $250 million in letters of credit and does not provide for any cash borrowings. The principal purpose of the new facility was to provide for the continuance of $216 million in letters of credit outstanding under the terminated revolving credit agreement. The new facility is secured by the stock of certain of our subsidiaries and cash collateral equal to 105% of the facility amount (approximately $263 million reflected as restricted cash on the consolidated balance sheet). The letter of credit facility contains customary affirmative and negative covenants that, among other requirements, limit (1) liens, (2) consolidations, mergers or the sale of all or substantially all assets unless no event of default exists, (3) subsidiary debt and (4) prepayment of debt. At December 31, 2004, outstanding letters of credit under the agreement totaled $216 million. As a result of the termination of the credit agreement, we recorded a $5 million loss from early extinguishment of debt in the fourth quarter of 2004 to write off unamortized deferred loan fees.

Loans under the previous credit agreement were unsecured and generally bore interest at a base rate equal to the prime rate or, if higher, the federal funds rate plus 0.5% or, at our option, an adjusted London Interbank Offered Rate ("LIBOR") plus an interest margin between 100 and 250 basis points. We paid the lenders an annual facility fee on the total loan commitment at rates between 50 and 57.5 basis points. The interest rate margins and the facility fee rates were based on our leverage covenant ratio (calculated as the ratio of consolidated total debt to operating income plus the sum of depreciation, amortization, impairment, other unusual charges, stock-based compensation expense, and

losses from early extinguishment of debt). In consideration for amendments to the previous credit agreement in October 2003, we paid to all participating banks a one-time fee equal to 50 basis points on the total commitment of $1.2 billion, and an additional one-time fee of 10 basis points when the leverage ratio exceeded 3.25 to 1. In consideration for further amendments to the previous credit agreement in March 2004, we paid a one-time fee equal to 12.5 basis points. Also in connection with the two amendments, we wrote off approximately $2 million in unamortized deferred loan fees in October 2003, and we wrote off approximately $5 million in March 2004.

SENIOR NOTES AND SENIOR SUBORDINATED NOTES

In January 2005, we sold $800 million of senior notes with registration rights in a private placement. The senior notes bear interest at a rate of 9 1/4% per year and mature on February 1, 2015. The senior notes are general unsecured senior obligations of Tenet and rank equally in right of payment with all of our other unsecured senior indebtedness, but are effectively subordinated to any obligations under our new letter of credit facility, which is secured by pledges of the stock of certain of our hospital operating subsidiaries. The senior notes are redeemable, in whole or in part, at any time, at our option at the greater of par or a redemption price based on a spread over comparable securities. The covenants governing the new issue are identical to the covenants for our other senior notes. The net proceeds from the sale of the senior notes were approximately $773 million after deducting discounts and related expenses. We used the proceeds in February 2005 to redeem our remaining outstanding senior notes due in 2006 and 2007, and for general corporate purposes.

In June 2004, we sold $1 billion of senior notes in a private placement. The net proceeds to us from the sale of the senior notes were approximately $954 million after deducting discounts and related expenses. We used a portion of the net proceeds from the offering to repurchase $335 million of our outstanding 5 3/8% Senior Notes due 2006, $215 million of our 5% Senior Notes due 2007 and $2 million of our other senior notes due 2008. As a result of these repurchases, we recorded an $8 million loss from early extinguishment of debt in 2004. The new senior notes bear interest at a rate of 9 7/8% per year and will mature on July 1, 2014. The senior notes are unsecured; they rank equally with all of our other unsecured senior indebtedness, but are effectively subordinated to any obligations under our new letter of credit facility; and they are redeemable at any time at our option at the greater of par or a redemption price based on a spread over comparable securities. On February 9, 2005, we filed a prospectus with the Securities and Exchange Commission pursuant to Rule 424(b)(3) in which we offer to exchange up to $1 billion of aggregate principal amount of new 9 7/8% senior notes ("New Senior Notes") due 2014, which have been registered under the Securities Act of 1933, for the $1 billion 9 7/8% senior notes issued in the June 2004 private placement ("Old Senior Notes"). We are offering the New Senior Notes, with terms substantially identical to those of the Old Senior Notes, in exchange for the Old Senior Notes in order to satisfy our registration obligations from the June 2004 private placement. If the holders of the Old Senior Notes fail to exchange their Old Senior Notes, they will continue to hold unregistered notes that they will not be able to transfer freely.

In January 2003, we sold $1 billion of 7 3/8% Senior Notes due 2013. We used the majority of the proceeds to repay all of the then-outstanding loans under our credit agreement and the remainder for general corporate purposes. The senior notes are unsecured; they rank equally with all of our other unsecured senior indebtedness; and they are redeemable at any time at our option.

In June 2002, we sold $400 million of 5% Senior Notes due 2007. We used the proceeds from the sale to repay bank loans under our credit agreements and to repurchase, at par, the $282 million balance of our 6% Exchangeable Subordinated Notes due 2005. As a result of that repurchase, we recorded a $4 million loss from early extinguishment of debt in the seven-month transition period ended December 31, 2002.

In March 2002, we sold $600 million of 6 1/2% Senior Notes due 2012 and used the majority of the proceeds to repurchase our 8 1/8% Senior Subordinated Notes due 2008 and the remainder for general corporate purposes. In connection with the repurchases of $3.7 billion of debt during the year ended May 31, 2002, we recorded losses from early extinguishments of debt in the aggregate amount of $383 million.

Prior to the sale of the senior notes in March 2002 and January 2003, we used a hedging strategy to lock in the risk-free component of the interest rate that was in effect on the offering dates of those notes. The interest-rate-lock agreement was settled on the date the notes were issued. Because the risk-free interest rate declined during the hedge period, we incurred a loss on this transaction when we unwound the hedge. However, based on our assessment using the dollar-offset method (which was performed at the inception of the hedge), we determined that the hedge was highly effective. Therefore, the loss on the hedge was charged to other comprehensive loss and is being amortized into earnings over the terms of these senior notes. The loss will be entirely offset by the effect of the lower interest rate on the notes.

All of our senior notes are unsecured obligations and are effectively subordinated in right of payment to any obligations under the letter of credit agreement.

LOAN COVENANTS

With the retirement or substantial retirement of eight issues of senior notes and senior subordinated notes over the several years prior to 2003, together with amendments to the loan covenants, we eliminated substantially all of the restrictive covenants associated with debt issued when we were considered a "high yield" issuer. During the year ended May 31, 2002, our senior notes and senior subordinated notes were upgraded to investment grade. In June 2003 and January 2004, these notes were downgraded back to "high yield" status because of concerns by certain rating agencies that unanticipated revenue and expense pressures might contribute to lower than expected cash flow in future periods, and about compliance with financial covenants as revenues were reduced due to the significant reduction in Medicare outlier payments beginning in January 2003.

Our letter of credit facility or the indentures governing our senior notes contain affirmative, negative and financial covenants that have, among other requirements, limitations on (1) liens, (2) consolidations, merger or the sale of all or substantially all assets unless no event of default exists and (3) subsidiary debt.

As discussed in Note 14, the ultimate resolution of claims and lawsuits brought against us, individually or in the aggregate, could have a material adverse effect on our business, financial position, results of operations or liquidity, including the inability to make scheduled debt payments when they become due.

Future long-term debt maturities and minimum operating lease payments as of December 31, 2004 are as follows:

		Years Ended December 31					
	Total	2005	2006	2007	2008	2009	Later Years
	(In Millions)						
Long-term debt, including capital lease obligations	$ 4,537	$ 41	$ 219	$ 207	$ 2	$ 1	$ 4,067
Long-term non-cancelable operating leases	736	162	151	135	113	60	115

Rental expense under operating leases, including short-term leases, was $181 million in the year ended December 31, 2004, $171 million in the year ended December 31, 2003, $95 million in the seven-month transition period ended December 31, 2002, and $165 million in the year ended May 31, 2002.

NOTE 7 STOCK BENEFIT PLANS

We currently grant stock-based awards to our directors and key employees pursuant to our 2001 Stock Incentive Plan, which was approved by our shareholders at their 2001 annual meeting. Under that plan, 60,000,000 shares of common stock were approved for stock-based awards. At December 31, 2004, there were 33,251,584 shares of common stock available under the plan for stock option grants and other incentive awards, including restricted stock units. Options generally have an exercise price equal to the fair market value of the shares on the date of grant and generally expire 10 years from the date of grant. A restricted stock unit is a contractual right to receive one share of our common stock in the future. Restricted stock units cannot exceed 10% of the total grants under the plan.

On February 17, 2005, we granted 173,867 restricted stock units and options for 469,333 shares of stock to Trevor Fetter, our president and chief executive officer. The options were granted at an exercise price of $10.63 per share, the closing price of our common stock on that date. The estimated fair value of the options granted was $4.87 per share, and the fair value of the restricted stock units issued was $10.63 per share.

On February 16, 2005, we granted employee stock options for approximately 4.9 million shares of common stock at an exercise price of $10.52 per share, the closing price of our common stock on that date, and we also granted approximately 1.8 million restricted stock units. The estimated fair value of the options granted was $3.81 per share, and the fair value of the restricted stock units issued was $10.52 per share. Both the options and the restricted stock units vest one-third on each of the first three anniversary dates of the grant.

On October 28, 2004, we granted 97,560 shares of restricted stock units to non-employee directors. Non-employee directors are granted restricted stock units upon joining our board of directors and annually thereafter. These restricted stock units vest over three years, but will fully vest upon the director's termination of service. Regardless of vested status, settlement of the restricted stock units will not occur until the director's termination of service to the board. Prior to August 4, 2004, non-employee directors received options for 18,000 shares per year and options for 36,000 shares upon joining the board of directors. Those awards have an exercise price equal to the fair market value of the shares on the date of the grant. At the recommendation of independent compensation consultants retained by the compensation committee of our board of directors, the options granted vested immediately upon issuance and expire 10 years after the date of the grant.

On March 4, 2004, we granted 93,867 restricted stock units and options for 469,333 shares of stock to Trevor Fetter, our president and chief executive officer. The options were granted at an exercise price of $12.02 per share, the closing price of our common stock on that date. The estimated fair value of the options granted and the fair value of the restricted stock units issued were $5.55 per share and $12.02 per share, respectively.

On March 3, 2004, we granted employee stock options for 4.3 million shares of common stock at an exercise price of $12.01 per share, the closing price of our common stock on that date, and we also granted 916,222 restricted stock units. The estimated fair value of the options granted and the fair value of the restricted stock units issued were $5.24 per share and $12.01 per share, respectively. Both the options and the restricted stock units vest one-third on each of the first three anniversary dates of the grant. Also in March 2004, the compensation committee of our board of directors eliminated the stock price performance requirements that had been attached to the option grants previously distributed in December 2002. Those options are now fully exercisable as soon as they vest without reference to our current stock price.

In November 2003, we granted 945,268 restricted stock units to 418 key hospital employees. These restricted stock units vest one-third on each of the first three anniversary dates of the grant. The closing price of our common stock on the date of the grant was $12.70, thus the aggregate value of the grant, before considering future forfeitures, was approximately $12 million, and will be amortized ratably over the 36 months following the grant date.

In January 2003, we issued 200,000 shares of restricted (non-vested) stock to Trevor Fetter, our president and chief executive officer. The stock vests on the second, third and fourth anniversary dates of the grant provided that Mr. Fetter is still employed by us and continues to hold 100,000 shares of our common stock purchased by him as a condition of the issuance of the restricted stock. The aggregate market value of the restricted stock at the date of issuance was $3.7 million based on the closing price of our common stock on that date. The restricted stock has been recorded as deferred compensation in additional paid-in capital, a component of shareholders' equity, that is adjusted periodically based on changes in our stock price, and is being amortized over the 48-month vesting period. In connection with Mr. Fetter being named our chief executive officer in September 2003, Mr. Fetter was granted options for 350,000 shares of common stock at an exercise price of $14.98 per share, the closing price of our stock on the date of grant. The estimated fair value of those options at the date of grant was $8.12 per share. Those options vest ratably on each of the first three anniversaries of the date of grant.

The following table summarizes information about our outstanding stock options at December 31, 2004:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number of Options	Weighted Average Remaining Contractual Life	Weighted Average Exercise Price	Number of Options	Weighted Average Exercise Price
$6.25 to $10.16	1,103,816	0.4 years	$ 9.09	1,103,816	$ 9.09
$10.17 to $20.34	26,297,639	6.4 years	15.77	18,535,889	16.31
$20.35 to $30.50	12,128,427	5.8 years	27.47	11,978,427	27.46
$30.51 to $40.67	8,927,034	6.9 years	40.27	8,927,034	40.27
$40.68 to $50.84	152,850	7.4 years	44.57	113,900	44.63
	48,609,766	6.2 years	$ 23.13	40,659,066	$ 24.74

As of December 31, 2004, approximately 52.5% of our outstanding options were held by current employees and approximately 47.5% were held by former employees. Approximately 2.5% of our outstanding options were in-the-money, that is, they had an exercise price less than the $10.98 market price of our common stock on December 31, 2004, and approximately 97.5% were out-of-the-money, that is, they had an exercise price of more than $10.98, as shown in the table below:

	In-the-Money Options		Out-of-the-Money Options		All Options	
	Outstanding	% of Total	Outstanding	% of Total	Outstanding	% of Total
Current employees	245,229	20.2%	25,290,030	53.4%	25,535,259	52.5%
Former employees	968,491	79.8%	22,106,016	46.6%	23,074,507	47.5%
Totals	1,213,720	100.0%	47,396,046	100.0%	48,609,766	100.0%
% of all outstanding options	2.5%		97.5%		100%	

The reconciliation below shows the changes to our stock option plans for the years ended December 31, 2004 and 2003, for the seven months ended December 31, 2002, and for the year ended May 31 2002:

	Outstanding at Beginning of Period	Granted	Exercised	Forfeited	Outstanding at End of Period	Options Exercisable
December 31, 2004						
Shares	46,506,512	4,521,151	(235,688)	(2,182,209)	48,609,766	40,659,066
Weighted average exercise price	$24.22	$11.98	$10.74	$24.66	$23.13	$24.74
December 31, 2003						
Shares	47,512,933	1,565,067	(525,920)	(2,045,568)	46,506,512	32,985,648
Weighted average exercise price	$24.53	$15.47	$9.95	$28.39	$24.22	$24.85
Seven months ended December 31, 2002						
Shares	40,396,572	11,833,821	(2,902,654)	(1,814,806)	47,512,933	23,338,625
Weighted average exercise price	$25.45	$18.32	$14.36	$20.80	$24.53	$22.39
May 31, 2002						
Shares	46,126,755	12,869,792	(17,829,297)	(770,678)	40,396,572	17,228,241
Weighted average exercise price	$17.74	$38.60	$15.29	$20.06	$25.45	$17.97

The estimated fair values of options we granted in the years ended December 31, 2004 and 2003, in the seven-month transition period ended December 31, 2002, and in the year ended May 31, 2002 were $5.07, $7.65, $9.07 and $18.45, respectively. These were calculated, as of the date of each grant, using a Black-Scholes option-pricing model with the following assumptions:

	Years ended December 31		Seven months ended December 31, 2002	Year ended May 31, 2002
	2004	2003		
Expected volatility	47.5%	48.9%	50.6%	39.9%
Risk-free interest rates	2.8%	3.2%	3.5%	4.5%
Expected lives, in years	4.5	5.9	5.5	6.8
Expected dividend yield	0.0%	0.0%	0.0%	0.0%

Expected volatility is derived using daily data drawn from five to seven years preceding the date of grant. The risk-free interest rates are based on the approximate yield on five-year, seven-year and 10-year United States Treasury Bonds as of the date of grant. The expected lives are estimates of the number of years the options will be held before they are exercised. The valuation model was not adjusted for non-transferability, risk of forfeiture, or the vesting restrictions of the options—all of which would reduce the value if factored into the calculation.

During the years ended December 31, 2004 and 2003, we recorded total stock compensation expense of $111 million and $176 million, respectively, including $10 million and $36 million for stock option modification costs related to terminated employees, which are recorded in restructuring charges. The table below shows the stock option and restricted stock unit grants and other awards, in order of monetary significance, that comprise the $111 million of stock-based compensation expense recorded in the year ended December 31, 2004. Compensation cost is measured by the fair value of the options on

their grant dates and is recognized over the vesting periods of the grants, whether or not the options had any intrinsic value during the period.

Grant Date	Awards Expected to Vest	Exercise Price per Share	Fair Value per Share at Grant Date	Stock-Based Compensation Expense for Year ended December 31, 2004
	(In Thousands)			(In Millions)
Stock Options:				
December 4, 2001	8,733	$ 40.41	$ 18.37	$ 43
December 10, 2002	10,043	17.56	8.80	33
March 3, 2004	4,357	12.01	5.08	5
June 1, 2001	2,175	30.28	17.52	5
May 29, 2001	1,500	30.17	17.57	3
Other grants, from April 10, 2001 to December 31, 2004	3,164	24.74	12.12	10
Restricted Stock Units:				
November 5, 2003	858	12.70	12.70	4
March 3, 2004	878	12.01	12.01	3
Employee stock purchase plan and other elements of stock-based compensation	1,323			5
				$ 111

Prior to our shareholders approving the 2001 Stock Incentive Plan, we granted stock-based awards to our directors and employees pursuant to other plans. Stock options remain outstanding under those other plans, but no additional stock-based awards will be granted under them. No performance-based incentive stock awards have been granted since fiscal 1994.

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

In March 2003, our board of directors approved a change in accounting for stock options granted to employees and directors from the intrinsic-value method to the fair-value method recommended by SFAS 123, effective for the calendar year ended December 31, 2003. The transition method we chose to report this change in accounting was the retroactive-restatement method. As such, presentations of periods ended prior to January 1, 2003 have been restated to reflect the fair-value method of accounting, as if the change had been effective throughout those prior periods.

NOTE 8 EMPLOYEE STOCK PURCHASE PLAN

We have an employee stock purchase plan under which we are authorized to issue up to 14,250,000 shares of common stock to our eligible employees. As of December 31, 2004, there were approximately 2,604,000 shares available for issuance under the plan. Under the terms of the plan, eligible employees may elect to have between 1% and 10% of their base earnings withheld each calendar quarter to purchase shares of our common stock. Shares are purchased on the last day of the quarter. Prior to July 1, 2004, shares were purchased at a price equal to 85% of either the closing price on the first day of the quarter or the closing price on the last day of the quarter, whichever was lower. Effective July 1, 2004, the plan was amended and shares are now purchased at a price equal to 95% of the closing price on the last day of the quarter. The amended plan also now requires a one-year

holding period for all shares issued. The holding period does not apply upon termination of employment. Under the plan, no individual may purchase, in any year, shares with a fair market value in excess of $25,000. As a result of the plan amendment effective July 1, 2004, the plan is no longer considered to be compensatory under SFAS 123.

Under the plan, we sold the following numbers of shares in the years ended December 31, 2004 and 2003, in the seven months ended December 31, 2002, and in the year ended May 31, 2002:

	Years ended December 31		Seven months ended December 31, 2002	Year Ended May 31, 2002
	2004	2003		
Number of shares	1,876,494	2,714,472	378,431	691,704
Weighted average price	$10.33	$11.71	$24.21	$30.19

NOTE 9 SELECTED BALANCE SHEET DETAILS

The principal components of other current assets are shown in the table below:

	December 31	
	2004	2003
	(In Millions)	
Other receivables	$ 192	$ 231
Prepaid expenses and other current items	128	106
Other current assets	**$ 320**	**$ 337**

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

	December 31	
	2004	2003
	(In Millions)	
Continuing Operations:		
Patient accounts receivable	$ 2,082	$ 2,165
Allowance for doubtful accounts	(577)	(394)
Estimated future recovery of accounts in collection	100	112
Net cost report settlements payable and valuation allowance	(118)	(101)
	1,487	1,782
Discontinued Operations—Accounts receivable, net of allowance for doubtful accounts ($121 at December 31, 2004 and $106 at December 31, 2003)	201	633
Accounts receivable, less allowance for doubtful accounts	**$ 1,688**	**$ 2,415**

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

	December 31	
	2004	2003
	(In Millions)	
Land	$ 397	$ 565
Buildings and improvements	4,127	4,439
Construction in progress	323	386
Equipment	2,547	2,723
	7,394	8,113
Accumulated depreciation and amortization	(2,574)	(2,556)
Net property and equipment	**$ 4,820**	**$ 5,557**

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

NOTE 10 GOODWILL AND OTHER INTANGIBLE ASSETS

Future amortization of intangibles with definite useful lives as of December 31, 2004 is as follows:

		Years Ending December 31					
	Total	2005	2006	2007	2008	2009	Later Years
	(In Millions)						
Amortization of intangible assets	$165	$22	$21	$16	$13	$12	$81

In connection with our annual impairment review, in the fourth quarter of 2004, we recorded a $25 million impairment charge related to an intangible asset with an indefinite useful life at one of our general hospitals in order to write down the carrying amount of the asset to its estimated fair value. This determination was based on the hospital's operating results and a review of the near-term and long-term prospects of the hospital.

As of June 1, 2002, we adopted SFAS 142. Among the changes implemented by this new accounting standard was the cessation of the amortization of goodwill and other intangible assets having indefinite useful lives. This change applies to the periods following the date of adoption.

The table below shows our income (loss) from continuing operations and net income (loss) for the years ended December 31, 2004 and 2003, the seven months ended December 31, 2002 and the year ended May 31, 2002, as if the cessation of goodwill amortization had occurred as of June 1, 2001:

	Years ended December 31		Seven Months ended December 31, 2002	Year ended May 31, 2002
	2004	2003		
	(In Millions, except Per-Share Amounts)			
Income (loss) from continuing operations, as reported	$ (1,797)	$ (1,044)	$ 430	$ 334
Goodwill amortization, net of applicable income tax benefits	—	—	—	74
Pro forma income (loss) from continuing operations	$ (1,797)	$ (1,044)	$ 430	$ 408
Net income (loss), as reported	$ (2,640)	$ (1,477)	$ 401	$ 697
Goodwill amortization, net of applicable income tax benefits	—	—	—	86
Pro forma net income (loss)	$ (2,640)	$ (1,477)	$ 401	$ 783
Diluted Earnings (Loss) Per Common and Common				

Equivalent Share:				
Continuing operations, as reported	$ (3.85)	$ (2.24)	$ 0.87	$ 0.66
Goodwill amortization, net of applicable income tax benefits	—	—	—	0.15
Pro forma continuing operations	$ (3.85)	$ (2.24)	$ 0.87	$ 0.81
Net income (loss), as reported	$ (5.66)	$ (3.17)	$ 0.81	$ 1.39
Goodwill amortization, net of applicable income tax benefits	—	—	—	0.17
Pro forma net income (loss)	$ (5.66)	$ (3.17)	$ 0.81	$ 1.56

During the years ended December 31, 2004 and 2003, we recorded goodwill impairment charges of $1.113 billion and $1.122 billion in continuing operations and $33 million and $89 million in discontinued operations, respectively (see Notes 4 and 5).

NOTE 11 INVESTMENTS

As of December 31, 2004, our investments consisted primarily of (1) $103 million in collateralized bonds issued by a local hospital authority from which we lease and operate two hospitals in Dallas, Texas, (2) approximately $47 million in equity investments in unconsolidated health care-related entities, and (3) a small number of minority investments, the carrying values of which aggregated approximately $4 million at December 31, 2004. These items are included in the accompanying consolidated balance sheets as investments and other assets. Of the $103 million investment in hospital authority bonds, $4 million mature in 2005, $4 million mature in 2006, $31 million mature in 2007 and $64 million mature in 2010.

Our policy has been to classify these minority investments as "available for sale." In doing so, the carrying values of the shares and debt instruments are adjusted at the end of each accounting period to their market values. This is done through a credit or charge to other comprehensive income (loss), net of taxes. There was no accumulated unrealized gain (loss) on these investments at December 31, 2004 or 2003. Through December 31, 2002 and May 31, 2002, the accumulated unrealized losses on our long-term investments were $15 million and $40 million, respectively.

In December 2002, we sold our entire portfolio (8,301,067 shares) of Ventas, Inc. for $86 million. We had decided to sell the shares in late November 2002. Prior to that time, we had accounted for the shares as an available-for-sale security whose fair value was less than its cost basis. Because we did not expect the fair value of the shares to recover prior to the expected time of sale, we recorded a $64 million charge ($40 million, net of taxes) in the seven-month transition period ended December 31, 2002 for the impairment of the carrying value of these securities. Because of a difference between the tax basis of the investment and our book basis, we reported a tax gain on the sale in our subsequent income tax return. The tax on the gain amounted to approximately $32 million.

At May 31, 2002, our long-term investments included an investment portfolio of U.S. government securities aggregating $69 million. Those securities were held in an escrow account for the benefit of the holders of our 6% Exchangeable Notes. The securities were released from escrow when we repurchased the notes in August 2002 and were sold for cash in the normal course of business over several succeeding weeks.

NOTE 12 OTHER COMPREHENSIVE INCOME (LOSS)

The table below shows the tax effect allocated to each component of other comprehensive income (loss) for the years ended December 31, 2004 and 2003, for the seven months ended December 31, 2002, and for the year ended May 31, 2002:

	Before-Tax Amount	Tax (Expense) Benefit	Net-of-Tax Amount
		(In Millions)	
Year ended December 31, 2004			
Foreign currency translation adjustment	$ (5)	$ 2	$ (3)
Less: reclassification adjustment for realized gains included in net income (loss)	(3)	1	(2)
	$ (8)	**$ 3**	**$ (5)**
Year ended December 31, 2003			
Foreign currency translation adjustment	$ 10	$ (3)	$ 7
Losses on derivatives designated and qualifying as cash flow hedges	(2)	—	(2)
Unrealized losses on securities held as available-for-sale	(1)	—	(1)
Less: reclassification adjustment for realized losses included in net income (loss)	4	(1)	3
	$ 11	$ (4)	$ 7
Seven months ended December 31, 2002			
Foreign currency translation adjustment	$ 5	$ (2)	$ 3
Unrealized losses on securities held as available-for-sale	(6)	3	(3)
Less: reclassification adjustment for realized losses included in net income (loss)	47	(18)	29
	$ 46	**$ (17)**	**$ 29**
Year ended May 31, 2002			
Foreign currency translation adjustment	$ (4)	$ 2	$ (2)
Losses on derivatives designated and qualifying as cash flow hedges	(28)	10	(18)
Unrealized gains on securities held as available-for-sale	31	(12)	19
Less: reclassification adjustment for realized losses included in net income (loss)	1	—	1
	$ —	**$ —**	**$ —**

NOTE 13 PROFESSIONAL AND GENERAL LIABILITY INSURANCE

Effective June 1, 2002, our hospitals' self-insured retention per occurrence was increased to $2 million. In addition, a new wholly owned insurance subsidiary, The Healthcare Insurance Corporation, was formed to insure substantially all of these risks. This subsidiary insures these risks under a claims-made policy with retentions per occurrence for the periods June 1, 2002 through May 31, 2003, and June 1, 2003 through May 31, 2004, of $3 million and $13 million, respectively. Risks in excess of these retentions are reinsured with major independent insurance companies. For the policy period June 1, 2004 through May 31, 2005, The Healthcare Insurance Corporation retains 17.5% of the first $10 million layer for reinsurance claims in excess of $15 million resulting in a maximum retention per occurrence of $14.75 million.

Through May 31, 2002, we insured substantially all of our professional and general liability risks in excess of self-insured retentions through Hospital Underwriting Group ("HUG"), our majority-owned insurance subsidiary, under a mature claims-made policy with a 10-year extended reporting period. (HUG became a wholly owned subsidiary effective May 31, 2003.) Our hospitals' self-insured retentions were $1 million per occurrence for fiscal years ended May 31, 1996 through May 31, 2002. HUG's retentions covered the next $2 million per occurrence. Claims in excess of $3 million per occurrence were, in turn, reinsured with major independent insurance companies. In earlier policy periods, the self-insured retentions varied by hospital and by policy period from $500,000 to $5 million per occurrence.

For the periods June 1, 2000 through May 31, 2001, and June 1, 2001 through May 31, 2002, the policies written by HUG provided a maximum of $50 million of coverage for each policy period. As of December 31, 2004, HUG's retained reserves for losses for the policy period ended May 31, 2001 were substantially close to reaching $50 million and for the policy period ended May 31, 2002, the retained reserves for losses reached the $50 million limit. However, the $50 million coverage limit each year is based on paid claims and the payments for each year have not reached the limits; therefore, the policies remain in effect. If the $50 million maximum amount is exhausted in either of these periods, we will be responsible for the first $25 million per occurrence for any subsequent claim paid that was applicable to the exhausted policy period before any excess professional and general liability insurance coverage would apply. Based on an actuarial review, we have provided for losses that exceed our self-insured retention that will not be covered by the HUG policies.

As of December 31, 2004, we had purchased claims-made excess professional and general liability insurance policies from major independent insurance companies with a total aggregate limit of $275 million, which policies provide coverage if a claim exceeds $25 million. All reinsurance applicable to HUG or The Healthcare Insurance Corporation and any excess professional and general liability insurance we purchase are subject to policy aggregate limitations. If such policy aggregate limitations should be partially or fully exhausted in the future, our financial position, results of operations or cash flows could be materially adversely affected.

In addition to the reserves recorded by the above insurance subsidiaries, we maintain self-insured retention reserves based on actuarial estimates for the portion of our professional and general liability risks, including incurred but not reported claims, for which we do not have insurance coverage (i.e., self-insured retentions). Reserves for losses and related expenses are estimated using expected loss-reporting patterns and are discounted to their present value under a risk-free rate approach using a Federal Reserve seven-year maturity composite rate of 3.8% at December 31, 2004 and a Federal Reserve 10-year maturity composite rate of 4.0% at December 31, 2003 based on our estimated claims payout period. If actual payments of claims materially exceed projected estimates of claims, our financial position, results of operations or cash flows could be materially adversely affected. Also, we provide letters of credit to our insurers as security under a selected number of programs to collateralize the deductible and self-insured retentions under our professional and general liability insurance programs, which can be drawn upon under certain circumstances. At December 31, 2004, the current and long-term professional and general liability reserves on our balance sheet were approximately $728 million.

Included in other operating expenses in the accompanying consolidated financial statements of operations is malpractice expense of $272 million for the year ended December 31, 2004 and $239 million for the year ended December 31, 2003. The increase in malpractice expense reflects costs associated with (1) adverse loss development (2) a change in the maturity composite rate that resulted from a change in our claims payment patterns, which resulted in an increase in our professional and general liability reserves and (3) a provision for losses which may exceed HUG policy aggregate limits.

Malpractice expense for the seven months ended December 31, 2002 was $190 million and included charges of approximately (1) $33 million as a result of lowering the discount rate from 7.5% to 4.6%, (2) $27 million due to an increase in HUG's reserves as a result of an increase in its average severity of claims, and (3) $80 million to increase our self-insured reserves also due to a significant increase in the average cost of claim settlements and awards.

NOTE 14 CLAIMS AND LAWSUITS

We are subject to a significant number of claims and lawsuits. We are also the subject of federal and state agencies' heightened and coordinated civil and criminal investigations and enforcement efforts, and have received subpoenas and other requests for information relating to a variety of subjects. In the present environment, we expect that these enforcement activities will take on additional importance, that government enforcement activities may intensify, and that additional matters concerning us and our subsidiaries may arise. We also expect new claims and lawsuits to be brought against us from time to time.

The results of these claims and lawsuits cannot be predicted, and it is possible that the ultimate resolution of these claims and lawsuits, individually or in the aggregate, may have a material adverse effect on our business (both in the near and long term), financial position, results of operations or cash flows. Although we defend ourselves vigorously against claims and lawsuits and cooperate with investigations, these matters (1) 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, (2) cause us to incur substantial expenses, (3) require significant time and attention from our management, and (4) could cause us to close or sell hospitals or otherwise modify the way we conduct business.

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. We presently cannot determine the ultimate resolution of all investigations and lawsuits.

Currently pending legal proceedings and investigations that are not in the ordinary course of business are principally related to the subject matters set forth below:

1. Physician Relationships—We and certain of our subsidiaries are under heightened scrutiny with respect to our hospitals' relationships with physicians. We believe that all aspects of our relationships with physicians are potentially under review. Proceedings in this area may be criminal, civil or both. After a federal grand jury indictment, Alvarado Hospital Medical Center, Inc. and Tenet HealthSystem Hospitals, Inc. (both Tenet subsidiaries) were put on trial in San Diego, California for allegedly illegal use of physician relocation, recruitment and consulting agreements. Although the trial judge declared a mistrial in the case after the members of the jury indicated that they were unable to reach a verdict, he subsequently indicated that he would set May 3, 2005 as the date a second trial will commence. Relocation agreements with physicians also are the subject of a criminal investigation by the U.S. Attorney's Office for the Central District of California, which served us and several of our subsidiaries with administrative subpoenas seeking documents related to physician relocation agreements at certain Southern California hospitals owned by our subsidiaries, as well as summary information about physician relocation agreements related to all of our hospital subsidiaries. In addition, physician relationships and other matters at several hospitals in Southern California, Northern California, El Paso, Texas, New Orleans, Louisiana and St. Louis, Missouri are the subject of ongoing federal investigations. Also, federal government agencies are conducting an investigation into agreements with the Women's Cancer

Center, a physician's group not owned by us practicing in the field of gynecologic oncology, and certain physicians affiliated with that group. An administrative subpoena for documents from us and several of our hospital subsidiaries relating to that investigation was issued in April 2003. Further, in June 2003, the Florida Medicaid Fraud Control Unit issued an investigative subpoena to us seeking the production of employee personnel records and contracts with physicians, physician assistants, therapists and management companies from the Florida hospitals owned by our subsidiaries. Since that time, we have received additional requests for information from that unit.

2. Pricing—We and certain of our subsidiaries are currently subject to government investigations and civil lawsuits arising out of pricing strategies at facilities owned or formerly owned by our subsidiaries. In that regard, federal government agencies are investigating whether outlier payments made to certain hospitals owned or formerly owned by our subsidiaries were paid in accordance with Medicare laws and regulations, and whether we omitted material facts concerning our outlier revenue from our public filings. Also, we have been named as a defendant in two civil cases in federal district court in Miami, one filed by the Florida Attorney General and 13 Florida county hospital districts, systems and non-profit corporations and a second filed as a purported class action by Boca Raton Community Hospital, principally alleging that Tenet's past pricing policies and receipt of Medicare outlier payments violated federal and state Racketeer Influenced and Corrupt Organizations (RICO) Acts, causing harm to the plaintiffs. We are vigorously defending the company in these matters. In addition, plaintiffs in California, Tennessee, Louisiana, Florida, South Carolina, Pennsylvania, Texas, Missouri and Alabama have brought class action lawsuits against us and certain of our subsidiaries in courts in those states alleging that they paid unlawful or unfair prices for prescription drugs or medical products or procedures at hospitals or other medical facilities owned or formerly owned by our subsidiaries. While the specific allegations and relief sought vary from case to case, the plaintiffs generally allege that we and our hospital subsidiaries have engaged in an unlawful scheme to inflate charges for medical services and procedures, pharmaceutical supplies and other products, and prescription drugs.

3. Securities and Shareholder Matters—A consolidated class action lawsuit is pending in federal court in Los Angeles, California against Tenet and certain of our former officers alleging violations of the federal securities laws. In addition, a number of shareholder derivative actions have been filed against certain current and former members of our board of directors and former members of senior management by shareholders. These actions purport to allege various causes of action on behalf of Tenet and for our benefit, including breach of fiduciary duty, insider trading and other causes of action. The shareholder derivative actions are pending in federal court in Los Angeles, and in state court in Santa Barbara, California. In addition, the SEC is conducting a formal investigation of Tenet and certain of our current and former directors and officers, whom the SEC did not specifically identify, with respect to whether the 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 has 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 our independent auditors, and we are cooperating with the government with respect to the investigation.

4. Redding Medical Center, Inc.—On August 4, 2003, following an investigation by federal government agencies regarding whether two physicians who had staff privileges at Redding Medical Center performed medically unnecessary invasive cardiac procedures at the hospital, we reached a settlement in the amount of $54 million with the United States and the State of California, which

we recorded in 2003. This settlement resolves all civil and monetary administrative claims that the United States and the State of California may have had arising out of the performance of, and billings for, allegedly medically unnecessary cardiac procedures at Redding Medical Center from January 1, 1997 through December 31, 2002. We were informed by the U.S. Attorney's Office for the Eastern District of California that it would not initiate any criminal charges against us for the conduct covered by the settlement. On September 3, 2003, the OIG issued a notice of its intent to exclude Redding Medical Center from participation in the Medicare and Medicaid programs and all other federal health care programs. Subsequently, on December 11, 2003, we announced that, as part of an agreement with the OIG, we would seek a buyer for Redding Medical Center. On July 16, 2004, we sold certain hospital assets of Redding Medical Center to Hospital Partners of America Inc. Redding Medical Center, Inc., our subsidiary that formerly owned the hospital, retained substantially all of its pre-closing liabilities.

A significant number of civil cases on behalf of approximately 700 to 800 patients were filed following the announcement in October 2002 that the government was investigating whether two physicians had performed medically unnecessary coronary procedures at Redding Medical Center. Although the specific claims varied from case to case, the complaints generally alleged that the physician defendants knowingly performed medically unnecessary coronary procedures on patients and that we knew or should have known that such medically unnecessary procedures were being performed. On December 21, 2004, we announced that we had reached an agreement in principle to settle substantially all of the patient litigation against us and our subsidiaries arising out of the allegations set forth in the plaintiffs' complaints. We agreed to, and did, establish a settlement fund by December 31, 2004 of $395 million to be allocated among more than 750 plaintiffs who had filed suit. Substantially all of the individual plaintiffs have ratified the settlement, and the court has held that the settlement was entered into in good faith. A small number of cases relating to this matter remain pending. We have sought recovery under our excess professional and general liability insurance policies for up to $275 million of our settlement of the Redding claims, but our insurance carriers have raised objections to coverage under our policies. We are pursuing all means available against the insurance carriers in seeking coverage, including, where permitted, filing arbitration demands. Our excess professional and general liability insurance policies covering occurrences prior to June 1, 2003 and having total limits of $275 million with three carriers, are single aggregate policies. Any limits paid, in whole or in part, could deplete or reduce the excess limits available to pay any other serious claims applicable to this policy period.

We are also subject to a qui tam action brought under California Insurance Code Section 1871.7 et seq., which allows "interested persons" to file sealed complaints for allegedly fraudulent billings to private insurers. The complaint generally alleges that false claims for payments were made to private insurers for allegedly medically unnecessary procedures performed at Redding Medical Center. Both the California Department of Insurance and the District Attorney of Shasta County, California have declined to intervene in this action. The action, which was unsealed in October 2004 and, subsequently, was served on the defendants, is moving forward.

5. Medicare Coding—The Medicare coding practices at hospitals owned or formerly owned by our subsidiaries are also under increased scrutiny. The federal government in January 2003 filed a civil lawsuit against us and certain of our subsidiaries relating to hospital billings to Medicare for inpatient stays reimbursed pursuant to four particular diagnosis-related groups. The government in this lawsuit has alleged violations of the False Claims Act and various common law claims. At December 31, 2004, we had an accrual of $34 million, recorded in prior years, for this matter. In addition, we have received and are cooperating with a voluntary document request from the U.S. Attorney's Office for the Central District of California principally relating to an investigation into

coding and billing practices at the Comprehensive Cancer Center at our Desert Regional Medical Center.

6. Other Matters

(a) On October 27, 2003, David L. Dennis, our former chief financial officer and chief corporate officer, filed a demand for arbitration alleging that he is entitled to payments under a severance benefit plan that our board of directors adopted in January 2003. Our position is that the severance benefit plan does not apply to Mr. Dennis, who resigned in November 2002. The parties are currently in the discovery phase of the arbitration process.

(b) On September 28, 2004, the court granted our petition to coordinate two pending wage and hour lawsuits in Los Angeles Superior Court in California. We will now be defending in a single court this proposed class action lawsuit alleging 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 compensation for overtime and meal breaks and rest periods not taken. Plaintiffs seek to certify this action on behalf of virtually all nonexempt employees of our California subsidiaries. We will argue that certification of a class in the action is not appropriate because there are no uniform policies that fail to comply with the applicable Labor Code and Wage Orders. In addition, it is our position that each of these claims must be addressed individually based on its particular facts and, therefore, should not be subject to class certification.

(c) We are cooperating with an investigation by the U.S. Attorney's Office in New Orleans, Louisiana of People's Health Network, an unconsolidated New Orleans health plan management services provider in which one of our subsidiaries holds a 50% membership interest, and Memorial Medical Center, a New Orleans hospital owned by one of our subsidiaries. Subpoenas issued in 2003 seek various People's Health Network-related corporate records, as well as information on patients who were admitted to a rehabilitation unit and members for whom inpatient rehabilitation services were ordered, recommended or requested, and subsequently denied. The subpoenas also seek documents related to payments to and contractual matters related to physicians and others, third-party reviews of denials of services, certain medical staff committees and other medical staff entities, and medical policies and practice guidelines. We continue to provide certain information requested by the government.

(d) We are cooperating with a voluntary document request received in April 2004 seeking records relating to the relationship between Centinela Hospital Medical Center, which we sold in November 2004, and a third-party home health care placement service.

(e) We were notified in mid-2004 that subpoenas had been issued to the buyer of two of our former hospitals, Twin Rivers Regional Medical Center in Missouri and John W. Harton Regional Medical Center in Tennessee. We retained certain liabilities in connection with the sale of these hospitals in November 2003. The Twin Rivers subpoena seeks documents for the period from 1999 through 2003 pertaining to a number of cardiac care patients. The Harton subpoena seeks a variety of documents, primarily financial, for the period from June 2000 through 2003. In addition, we are cooperating with a voluntary request from the U.S. Attorney's Office in St. Louis, Missouri, which we received in August 2004, seeking, among other things, documents regarding physician relocation agreements at four St. Louis area hospitals—two of which we no longer own—as well as Twin Rivers Regional Medical Center. The voluntary request also seeks additional information regarding certain admissions and medical procedures at Twin Rivers.

(f) We are cooperating with an investigation by the Finance Committee of the United States Senate concerning Redding Medical Center, Medicare outlier payments, patient care and other matters. In addition, we are one of 20 large health care systems in the United States that has received requests for documents and information as part of an investigation by the U.S. House of Representatives Committee on Energy and Commerce into hospital billing practices and their impact on the uninsured. We continue to cooperate with this investigation.

(g) The Internal Revenue Service has completed an examination of our federal income tax returns for the fiscal years ended May 31, 1995, 1996 and 1997, and has issued a Revenue Agent's Report in which it proposes to assess an aggregate tax deficiency for the three-year audit period of $157 million plus interest of approximately $138 million through December 31, 2004, before any federal or state tax benefit. The Revenue Agent's Report contains several disputed adjustments, including the disallowance of a deduction for a portion of the civil settlement we paid to the federal government in June 1994 related to our discontinued psychiatric hospital business and a disputed adjustment with respect to the timing of the recognition of income for tax purposes pertaining to Medicare and Medicaid net revenues. We have filed a protest with the Appeals Division of the Internal Revenue Service. We believe we have adequately provided for all tax matters in dispute related to the Revenue Agent's Report for the fiscal years ended May 31, 1995, 1996 and 1997 as of December 31, 2004.

In addition, the Internal Revenue Service has commenced an examination of our tax returns for the fiscal years ended May 31, 1998 through the seven-month transition period ended December 31, 2002. We presently cannot determine the ultimate resolution of this examination.

(h) Following a January 26, 2005 survey of our Florida Medical Center hospital in Ft. Lauderdale by the Florida Department of Children and Families (DCF) and Florida's Agency for Health Care Administration, on February 14, 2005, DCF suspended the hospital's authority to receive involuntary psychiatric patient admissions under the Baker Act, a Florida state law that governs the involuntary admission of psychiatric patients to a hospital. On March 1, 2005, we received a voluntary request for documents from the Florida Attorney General's Medicaid Fraud Control Unit Office in Ft. Lauderdale, seeking medical records and billing information for Medicaid patients admitted to Florida Medical Center's psychiatric unit from January 2004 to the present, as well as certain information concerning patients admitted to the hospital under the Baker Act. We are cooperating with all of these state agencies in connection with their reviews, and we are working with DCF to have Baker Act receiving authority reinstituted at Florida Medical Center.

(i) We recently resolved our disputes with several managed care plans regarding charges at facilities owned by our subsidiaries and the impact of those charges on stop-loss and other payments. We and our subsidiaries continue to be engaged in disputes with managed care plans, although our charges and their influence on contract provisions are less frequently the focus of these disputes.

(j) In addition to the matters described above, we are subject to claims and lawsuits in the ordinary course of business. The largest category of these relate to medical malpractice. While most medical malpractice claims arise as separate legal actions, more than 100 individual lawsuits were filed by one law firm in Palm Beach County Circuit Court against Palm Beach Gardens Medical Center in Florida, claiming damages arising as a result of alleged postoperative infections. On December 23, 2004, we announced that our subsidiary that operates Palm Beach Gardens Medical Center had agreed in principle to settle all of these lawsuits and, by the end of December, we paid $31 million into a settlement fund for the plaintiffs and their counsel, which was reflected in malpractice expense in the appropriate periods. All of the plaintiffs have since executed individual settlement agreements, and we expect dismissal of all of the suits by the end of March 2005.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

We record reserves for claims and lawsuits when they are probable and reasonably estimable. For matters where the likelihood or extent of a loss is not probable or cannot be reasonably estimated, we have not recognized in the accompanying consolidated financial statements all potential liabilities that may result. If adversely determined, the outcome of some of these matters could have a material adverse effect on our business, liquidity, financial position or results of operations.

The table below presents reconciliations of the beginning and ending liability balances in connection with legal settlements and related costs recorded during the years ended December 31, 2004 and 2003:

	Balances at Beginning of Period	Additions charged to: Costs of Litigation and Investigations	Additions charged to: Other(1)	Cash Payments	Balances at End of Period
		(In Millions)			
Year ended December 31, 2004					
Continuing operations	$ 203	$ 74	$ 25	$ (262)	$ 40
Discontinued operations	—	395	8	(403)	—
	$ 203	$ 469	$ 33	$ (665)	$ 40
Year ended December 31, 2003					
Continuing operations	$ 6	$ 282	$ 16	$ (101)	$ 203
Discontinued operations	—	—	—	—	—
	$ 6	$ 282	$ 16	$ (101)	$ 203

(1) Charges are included in other operating expenses in the consolidated statement of operations. The discontinued operations charge was recorded as an adjustment to net operating revenues within income (loss) from operations of asset group.

For the years ended December 31, 2004 and 2003, we recorded total costs of $502 million and $298 million, respectively, in connection with significant legal proceedings and investigations, including $403 million in 2004 that was reflected in discontinued operations. The December 31, 2004 costs include the fourth quarter settlement and payment of the Redding Medical Center patient litigation and a $30 million accrual of a minimum liability to address the potential resolution of a number of civil lawsuits arising out of pricing strategies at facilities owned or formerly owned by our subsidiaries. The December 31, 2003 costs included an award of $163 million for contract damages to a former executive. The award was paid in March 2004 and included in the 2004 cash payments. Also included in 2003 is the $54 million settlement with the United States and the State of California related to Redding Medical Center, which was recorded in June 2003 and paid in August 2003.

NOTE 15 INCOME TAXES

	Years ended December 31: 2004	Years ended December 31: 2003	Seven months ended December 31, 2002	Year ended May 31, 2002
			(In Millions)	
Current tax expense (benefit):				
Federal	$ (116)	$ 357	$ 340	$ 245
State	7	52	49	45
	(109)	409	389	290
Deferred tax expense (benefit):				
Federal	274	(560)	(100)	10
State	19	(77)	—	19
	293	(637)	(100)	29
	$ 184	**$ (228)**	**$ 289**	**$ 319**

A reconciliation between the amount of reported income tax expense (benefit) and the amount computed by multiplying income (loss) from continuing operations before income taxes by the statutory federal income tax rate is shown below:

	Years ended December 31		Seven months ended December 31, 2002	Year ended May 31, 2002
	2004	2003		
			(In Millions)	
Tax provision (benefit) at statutory federal rate of 35%	$ (565)	$ (445)	$ 252	$ 229
State income taxes, net of federal income tax benefit	(19)	(16)	33	47
Goodwill amortization	—	—	—	20
Nondeductible asset impairment charges	268	229	—	4
Change in valuation allowance	480	—	—	—
Change in tax contingency reserves	14	(8)	1	13
Other items	6	12	3	6
	$ 184	**$ (228)**	**$ 289**	**$ 319**

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

	December 31, 2004		December 31, 2003	
	Assets	Liabilities	Assets	Liabilities
		(In Millions)		
Depreciation and fixed-asset differences	$ —	$ 555	$ —	$ 480
Reserves related to discontinued operations and restructuring charges	39	—	80	—
Receivables (doubtful accounts and adjustments)	206	—	119	—
Accruals for insurance risks	280	—	236	—
Intangible assets	37	—	—	19
Other long-term liabilities	26	—	45	—
Benefit plans	146	—	142	—
Other accrued liabilities	37	—	92	—
Investments and other assets	37	—	39	—
Net operating loss carryforwards	108	—	—	—
Stock options	184	—	135	—
Other items	6	—	21	—
	1,106	**555**	**909**	**499**
Valuation allowance	(744)	—	—	—
Reclass to assets held for sale	—	—	(4)	9
	$ 362	**$ 555**	**$ 905**	**$ 508**

A valuation allowance of $744 million was recorded in the fourth quarter of 2004 based on an assessment of the realization of our deferred tax assets as described below.

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

- cumulative losses in recent years;
- income/losses expected in future years;
- unsettled circumstances that, if unfavorably resolved, would adversely affect future operations and profit levels;
- the availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits;
- the carryforward period associated with the deferred tax assets and liabilities; and
- prudent and feasible tax-planning strategies.

Through the third quarter of 2004, we concluded that it was more likely than not that the deferred tax assets were realizable. However, we determined that it was appropriate to record a valuation allowance after considering and weighing all evidence in the fourth quarter of 2004. In making our assessment for the fourth quarter of 2004, our adverse results of operations was a negative factor. In addition, the negative factors of having pre-tax losses for the two consecutive years ended December 31, 2004, and a cumulative pre-tax loss at the end of the three-year period ended December 31, 2004, together with the possibility of losses in early future years, imposed a high standard for compelling objective positive evidence to exist in order to overcome the negative factors indicating that the deferred tax assets may not be realized. We established the valuation allowance as a result of assessing the realization of our deferred tax assets based on the fact that we incurred significant impairment charges, legal settlements and continued adverse results of operations in the fourth quarter of 2004, combined with having a cumulative loss for the three-year period ended December 31, 2004, which is considered "negative evidence" under SFAS 109. We concluded that as a result of this negative evidence, SFAS 109 precludes us from relying upon our forecasts of future income for the purpose of supporting the realization of the deferred tax assets under the more likely than not standard.

Income tax expense in the year ended December 31, 2004 included a portion of the impact of establishing the $744 million valuation allowance for our deferred tax assets during the fourth quarter of 2004. This valuation allowance was recorded in the following manner: (1) $480 million was reflected in income tax expense in continuing operations, (2) $144 million was reflected in income tax expense in discontinued operations and (3) $120 million was recorded as an adjustment against additional paid-in capital, rather than income tax expense, due to the fact that excess tax deductions remained from prior stock option awards accounted for in accordance with the fair value based method under SFAS 123.

Given the magnitude of our valuation allowance, our future income/losses could result in a significant adjustment to this valuation allowance.

At December 31, 2004, our carryforwards available to offset future taxable income consisted of (1) federal net operating pre-tax loss carryforwards of approximately $199 million expiring in 2024, and (2) approximately $6 million in alternative minimum tax credits with no expiration.

The Internal Revenue Service has completed an examination of our federal income tax returns for fiscal years ended May 31, 1995, 1996 and 1997 and it has issued a Revenue Agent's Report in which it proposes to assess an aggregate tax deficiency for the three-year audit period of $157 million plus interest of approximately $138 million through December 31, 2004, before any federal or state tax benefit (see Note 14). The Internal Revenue Service has commenced an examination of our tax returns for the fiscal years ended May 31, 1998 through the seven-month transition period ended December 31, 2002. We presently cannot determine the ultimate resolution of this examination. We believe we have adequately provided for tax matters related to the fiscal years ended May 31, 1998 through the seven-month transition period ended December 31, 2002.

NOTE 16 EMPLOYEE RETIREMENT PLAN

Substantially all of our domestic employees, upon qualification, are eligible to participate in a defined contribution 401(k) plan. Under the plan, employees may contribute 1% to 25% of their eligible compensation, and we match such contributions annually up to a maximum percentage for participants actively employed as of December 31. Prior to July 1, 2004, we matched such contributions each pay period. Our contributions to the plan were approximately $86 million for the year ended December 31, 2004, $77 million for the year ended December 31, 2003, $28 million for the seven-month transition period ended December 31, 2002 and $41 million for the year ended May 31, 2002. Such amounts are reflected in salaries and benefits in the consolidated statements of operations. The increases in 2004 and 2003 are due to more employees participating in the plan and an increase in the maximum company matching percentage from 3% to 5%.

NOTE 17 REPURCHASES OF COMMON STOCK

With authorization from our board of directors to repurchase up to 66,263,100 shares of our common stock, we repurchased, from July 2001 through June 30, 2003, a total of 48,734,599 shares as shown in the following table:

Quarter ended	Number of Shares	Cost	Average Cost per Share
September 30, 2001	5,055,750	$ 187,834,570	$ 37.15
December 31, 2001	1,500,000	58,314,006	38.87
March 31, 2002	7,500,000	295,924,291	38.99
June 30, 2002	4,125,000	173,345,977	41.70
September 30, 2002	2,791,500	118,988,346	42.35
December 31, 2002	15,290,850	381,385,362	24.76
March 31, 2003	6,000,000	109,700,554	18.28
June 30, 2003	6,471,499	97,999,961	15.14
Total	**48,734,599**	**$ 1,423,493,067**	**$ 29.21**

The repurchased shares are held as treasury stock. We have not purchased, nor do we intend to purchase, any shares from our directors, officers or employees. We have not made any repurchases of common stock since June 30, 2003.

NOTE 18 ACQUISITIONS OF FACILITIES

During the year ended December 31, 2003, the seven-month transition period ended December 31, 2002, and the fiscal year ended May 31, 2002, our subsidiaries acquired six general hospitals, one cancer treatment facility and certain other health care entities, as shown in the table below:

	Year ended December 31, 2003	Seven months ended December 31, 2002	Year ended May 31, 2002
	(Dollars in Millions)		
Number of hospitals	1(a)	1	5
Number of licensed beds	60	125	1,528
Purchase price information:			
Fair value of assets acquired	$ 19	$ 28	$ 370
Liabilities assumed	—	(1)	(53)
Net assets acquired	**19**	**27**	**317**
Other health care entities	20	—	7
Net cash paid	**$ 39**	**$ 27**	**$ 324**
Goodwill	**$ 5**	**$ 9**	**$ 128**

(a) USC Kenneth Norris Jr. Cancer Hospital, which is a 60-bed cancer hospital located on the campus of USC University Hospital.

On June 1, 2002, we adopted SFAS 142. Under this new accounting standard, goodwill is no longer amortized, but is subject to impairment tests performed at least annually. All of the goodwill related to those acquisitions is expected to be fully deductible for income tax purposes.

NOTE 19 EARNINGS PER COMMON SHARE

The table below is a reconciliation of the numerators and denominators of our basic and diluted earnings per common share calculations for income (loss) from continuing operations for each of the two years ended December 31, 2004 and 2003, for the seven-month transition period ended December 31, 2002, and for the year ended May 31, 2002. Income (loss) is expressed in millions and weighted average shares are expressed in thousands.

	Income (Loss) (Numerator)	Weighted Average Shares (Denominator)	Per-Share Amount
	(Dollars in Millions, except Per-Share Amounts, Shares in Thousands)		
Year ended December 31, 2004			
Loss to common shareholders for basic earnings per share	$ (1,797)	466,226	$ (3.85)
Effect of dilutive stock options	—	—	—
Loss to common shareholders for diluted earnings per share	$ (1,797)	466,226	$ (3.85)
Year ended December 31, 2003			
Loss to common shareholders for basic earnings per share	$ (1,044)	465,927	$ (2.24)
Effect of dilutive stock options	—	—	—
Loss to common shareholders for diluted earnings per share	$ (1,044)	465,927	$ (2.24)

	Income (Loss) (Numerator)	Weighted Average Shares (Denominator)	Per-Share Amount
		(Dollars in Millions, except Per-Share Amounts, Shares in Thousands)	
Seven months ended December 31, 2002			
Income available to common shareholders for basic earnings per share	$ 430	484,877	$ 0.89
Effect of dilutive stock options and other contracts to issue common stock	—	8,653	(0.02)
Income available to common shareholders for diluted earnings per share	$ 430	493,530	$ 0.87
Year ended May 31, 2002			
Income available to common shareholders for basic earnings per share	$ 334	489,717	$ 0.68
Effect of dilutive stock options, warrants and other contracts to issue common stock	—	13,182	(0.02)
Income available to common shareholders for diluted earnings per share	$ 334	502,899	$ 0.66

All potentially dilutive securities were excluded from the calculation of diluted loss per share for the years ended December 31, 2004 and 2003 because we reported a loss from continuing operations in each of the periods. In circumstances where we have a loss from continuing operations, the effect of employee stock options (or any other dilutive securities) is anti-dilutive, that is, losses have the effect of making the diluted loss per share from continuing operations less than the basic loss per share from continuing operations. Had we generated net income from continuing operations in these periods, the effect (in thousands) of employee stock options and restricted stock units on the diluted shares calculation would have been an increase in shares of 491 and 258 for the year ended December 31, 2004 and 2003, respectively.

Stock options with prices that exceeded the average market price are excluded from the earnings-per-share computations for the above periods with income from continuing operations. For the seven months ended December 31, 2002, the number of shares excluded (in thousands) was 9,946, and for the year ended May 31, 2002, the number of shares excluded was 171.

NOTE 20 DISCLOSURES ABOUT FAIR VALUE OF FINANCIAL INSTRUMENTS

The carrying amounts of cash and cash equivalents, accounts receivable, current portion of long-term debt, accounts payable, and accrued interest payable approximate fair value because of the short maturity of these instruments. The carrying values of investments, both short-term and long-term (excluding investments accounted for by the equity method), are reported at fair value. Long-term receivables are carried at cost and are not materially different from their estimated fair values. The fair value of our long-term debt is based on quoted market prices. At December 31, 2004 and 2003, the estimated fair value of our long-term debt was approximately 100.6% and 99.4%, respectively, of the carrying value of the debt.

NOTE 21 RELATED PARTY TRANSACTIONS

One of our previous board members was also the president of Saint Louis University ("SLU"). As a result of our 1998 acquisition of the SLU Hospital, we entered into a 30-year Academic Affiliation

Agreement with SLU and in connection therewith paid SLU $31.6 million in the year ended December 31, 2003, $20.7 million in the seven-month transition period ended December 31, 2002 and $28.2 million in the year ended May 31, 2002. As of May 2004, SLU is no longer considered a related party.

Effective June 28, 2003, Broadlane, Inc. was deconsolidated due to the Share Repurchase described below. We currently hold a 46% interest in Broadlane, which is accounted for under the equity method. We have entered into the following agreements with Broadlane:

- Management Outsourcing Agreement—We retained Broadlane to manage all functions of corporate materials management for us and each of our hospitals. We have also appointed Broadlane as our exclusive contracting and group-purchasing agent. This agreement, as amended, was entered into on December 9, 1999 for a 10-year term. Under the agreement, Broadlane earned administrative fees of approximately $20 million for the year ended December 31, 2004 and $10 million for the period June 28, 2003 through December 31, 2003 on contracted purchases made by our hospitals.

- Office Lease Guarantees—During 2000, we entered into agreements to guarantee Broadlane's office building leases in Dallas and San Francisco for the original terms through April 2011 and November 2010, respectively. The remaining minimum lease payments for these leases total approximately $22 million as of December 31, 2004.

- Other Service Agreements—During 2002, we entered into multiple consulting agreements with Broadlane pursuant to which Broadlane provides diagnostic, sourcing, and implementation services in the area of temporary nurse staffing. Broadlane also entered into agreements with several of our facilities to provide capital expenditure planning services. We incurred approximately $3.8 million and $2.6 million of expenses for the year ended December 31, 2004, and the period June 28, 2003 through December 31, 2003, respectively, for such services.

- In April 2003, Broadlane entered into a consulting agreement with us under which Broadlane is providing additional diagnostic and contracting support in an effort to lower our operating expenses in both supplies and non-traditional areas, such as recruiting and transcription services. We incurred $11.5 million and $1.8 million of expenses for the year ended December 31, 2004 and the period June 28, 2003 through December 31, 2003, respectively, for such services.

- Share Repurchase—In connection with Broadlane's issuance of debt and equity securities, in June 2003, Broadlane repurchased 5,842,000 shares of Broadlane common stock from us for approximately $17.5 million. We recognized a gain of approximately $9 million in 2003 from the sale of Broadlane common stock. The shares were repurchased at $3.00 per share, which was the price at which Broadlane sold equivalent common shares to third-party private investors.

NOTE 22 RECENTLY ISSUED ACCOUNTING STANDARDS

The following summarizes noteworthy recently issued accounting standards:

- SFAS No. 153, "Exchanges of Nonmonetary Assets, an amendment of APB Opinion No. 29," was issued in December 2004. This statement amends and clarifies financial accounting for nonmonetary exchanges. The amendments eliminate certain previous exceptions to the use of fair value and are intended to improve the comparability of cross-border financial reporting by narrowing the differences with existing International Accounting Standards Board standards. This statement is effective for the third quarter of 2005 and is not expected to have a material impact on our financial position, results of operations or cash flows.

- SFAS No. 152, "Accounting for Real Estate Time-Sharing Transactions, an Amendment of FASB Statements No. 66 and 67," was issued in December 2004. This statement amends FASB Statements No. 66 and 67 to reference guidance provided in AICPA Statement of Position

(SOP) 04-2, "Accounting for Real Estate Time-Sharing Transactions." This statement is effective for our 2006 calendar year and is not expected to have a material impact on our financial position, results of operations or cash flows.

- SFAS No. 123R (Revised 2004), "Share-Based Payment," was issued in December 2004, which replaces SFAS 123 and supersedes APB 25. SFAS 123R requires the measurement of all employee share-based payments to employees, including grants of employee stock options, using a fair-value-based method. The accounting provisions of SFAS 123R are effective for interim or annual reporting periods beginning after June 15, 2005.

  We will be required to adopt SFAS 123R in the third quarter of 2005. Since we previously adopted SFAS 123, we do not anticipate the cumulative effect of the adoption of SFAS 123R to have a material impact on our financial position or results of operations. Under SFAS 123R, the previously estimated fair value of non-vested stock option grants outstanding, when we adopt SFAS 123R in the third quarter of 2005, should not be adjusted for differences between the requirements of SFAS 123R and SFAS 123, except for any impact of incorporating expected forfeitures before vesting. This method of adopting SFAS 123R is referred to as the modified prospective application method.

  We are still evaluating the fair value valuation techniques allowed under SFAS 123R to determine the model that we will use to estimate the fair value of stock options granted after the adoption of this standard. Under SFAS 123R, a closed-form model (e.g., Black-Scholes) and a lattice model are acceptable valuation techniques. A lattice model can be designed to accommodate estimates of option exercise patterns and post-vesting employment termination during the option's contractual term, and thereby can more fully reflect the effect of those factors than an estimate developed using a closed-form model and a single weighted-average life of the options. If we determine that utilizing a lattice model valuation technique is more appropriate when we adopt SFAS 123R, the fair value estimates of future stock option grants under a lattice model may differ from fair value estimates if the Black-Scholes model was used.

- SFAS No. 151, "Inventory Costs, an Amendment of ARB No. 43, Chapter 4," was issued in November 2004. This statement amends and clarifies financial accounting for abnormal amounts of idle facility expense, freight, handling costs, and wasted material (spoilage). These changes are intended to improve the comparability of cross-border financial reporting by narrowing the differences with existing International Accounting Standards Board standards. This statement is effective for inventory costs incurred during our 2006 calendar year and is not expected to have a material impact on our financial position, results of operations or cash flows.

- FASB Interpretation No. 46-R ("FIN 46-R"), "Consolidation of Variable Interest Entities—an interpretation of ARB 51 (revised December 2003)," was issued to amended certain provisions of FASB Interpretation No. 46, which provides guidance on the consolidation of variable interest entities, and delayed implementation for entities that were not considered special purpose entities until the first quarter of 2004. Our adoption of FIN 46-R did not have a material impact on our financial position, results of operations or cash flows.

- FASB Staff Position No. 106-2, "Accounting and Disclosure Requirements Related to the Medicare Prescription Drug, Improvement and Modernization Act of 2003" ("FSP 106-2"), was issued in response to a new law regarding prescription drug benefits under Medicare, as well as a federal subsidy to sponsors of retiree health care benefit plans. Our adoption of FSP 106-2 did not have a material impact on our financial position, results of operations or cash flows.

SUPPLEMENTAL FINANCIAL INFORMATION

SELECTED QUARTERLY FINANCIAL DATA (UNAUDITED)

	Year ended December 31, 2004			
	First	Second	Third	Fourth
	(In Millions, except Per-Share Amounts)			
Net operating revenues	$ 2,574	$ 2,505	$ 2,428	$ 2,412
Net loss	$ (122)	$ (426)	$ (70)	$ (2,022)
Loss per share:				
Basic	$ (0.26)	$ (0.91)	$ (0.15)	$ (4.33)
Diluted	$ (0.26)	$ (0.91)	$ (0.15)	$ (4.33)

	Year ended December 31, 2003			
	First	Second	Third	Fourth
	(In Millions, except Per-Share Amounts)			
Net operating revenues	$ 2,623	$ 2,556	$ 2,505	$ 2,462
Net loss	$ (20)	$ (195)	$ (308)	$ (954)
Loss per share:				
Basic	$ (0.04)	$ (0.42)	$ (0.66)	$ (2.05)
Diluted	$ (0.04)	$ (0.42)	$ (0.66)	$ (2.05)

Operating results for an interim period are not necessarily representative of operations for a full year for various reasons, including changes in Medicare regulations, levels of occupancy, interest rates, acquisitions, divestitures, revenue allowance and discount fluctuations, the timing of price changes, gains and losses on sales of assets, impairment and restructuring charges, and fluctuations in quarterly tax rates. For example, the year ended December 31, 2004 includes impairment and restructuring charges of $146 million, $289 million, $10 million and $1,266 million recorded in the first, second, third and fourth quarters, respectively. The year ended December 31, 2003 includes impairment and restructuring charges of $244 million, $284 million, $121 million and $1,439 million recorded in each of the four quarters, respectively.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

We carried out an evaluation of the effectiveness of the design and operation of our disclosure controls and procedures as defined by Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended. The evaluation was performed under the supervision and with the participation of management, including our chief executive officer and chief financial officer. Based upon that evaluation, the chief executive officer and chief financial officer concluded that, as of the end of the period covered by this report, our disclosure controls and procedures are effective in alerting them in a timely manner to material information related to the Company (including its consolidated subsidiaries) required to be included in our periodic Securities and Exchange Commission filings.

Management's Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Securities Exchange Act of 1934, as amended. Our management assessed the effectiveness of our internal control over financial reporting as of December 31, 2004. This assessment was performed under the supervision of and with the participation of our management, including our chief executive officer and chief financial officer.

In making this assessment, our management used criteria based on the framework in *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO"). Based on our assessment using the COSO framework, management concluded that our internal control over financial reporting was effective as of December 31, 2004.

Our management's assessment of the effectiveness of our internal control over financial reporting as of December 31, 2004 has been audited by KPMG LLP, an independent registered public accounting firm, as stated in their report, which is included herein. KPMG LLP has also audited our consolidated financial statements as of and for the year ended December 31, 2004, whose audit report on such consolidated financial statements is also included herein.

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

ITEM 9B. OTHER INFORMATION

None.

PART III.

ITEM 10. DIRECTORS AND EXECUTIVE OFFICERS OF THE REGISTRANT

Certain information regarding our directors will be included in our definitive proxy statement to be filed with the Securities and Exchange Commission not later than 120 days after the end of the fiscal year covered by this Form 10-K, and such information is incorporated by reference to the definitive proxy statement. Information concerning our executive officers appears under Part I, Item 1, Business—Executive Officers, of this Form 10-K.

ITEM 11. EXECUTIVE COMPENSATION

Certain information regarding compensation of our executive officers will be included in our definitive proxy statement to be filed with the Securities and Exchange Commission not later than 120 days after the end of the fiscal year covered by this Form 10-K, and such information is incorporated by reference to the definitive proxy statement.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT

Certain information regarding security ownership of certain beneficial owners and management and securities authorized for issuance under equity compensation plans will be included in our definitive proxy statement to be filed with the Securities and Exchange Commission not later than 120 days after the end of the fiscal year covered by this Form 10-K, and such information is incorporated by reference to the definitive proxy statement.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS

Certain information regarding transactions with management and other related parties can be found in Note 21 to the accompanying Consolidated Financial Statements. Additional information will be included in our definitive proxy statement to be filed with the Securities and Exchange Commission not later than 120 days after the end of the fiscal year covered by this Form 10-K, and such information is incorporated by reference to the definitive proxy statement.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

Certain information regarding accounting fees and services will be included in our definitive proxy statement to be filed with the Securities and Exchange Commission not later than 120 days after the end of the fiscal year covered by this Form 10-K, and such information is incorporated by reference to the definitive proxy statement.

PART IV.

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES

FINANCIAL STATEMENTS

The consolidated financial statements to be included in Part II, Item 8, can be found on pages 79 through 125.

FINANCIAL STATEMENT SCHEDULES

Schedule II—Valuation and Qualifying Accounts (included on page 134).

All other schedules and financial statements of the Registrant are omitted because they are not applicable or not required or because the required information is included in the consolidated financial statements or notes thereto.

EXHIBITS

(3) Articles of Incorporation and Bylaws

(a) Amended and Restated Articles of Incorporation of the Registrant, as amended and restated July 23, 2003 (Incorporated by reference to Exhibit 3(a) to Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2003, filed August 8, 2003)

(b) Amended and Restated Bylaws of the Registrant, as amended and restated November 6, 2003 (Incorporated by reference to Exhibit 3(b) to Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended September 30, 2003, filed November 10, 2003)

(4) Instruments Defining the Rights of Security Holders, Including Indentures

(a) Indenture, dated as of November 6, 2001, between the Registrant and The Bank of New York, as Trustee (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated November 6, 2001 and filed November 9, 2001)

(b) Second Supplemental Indenture, dated as of November 6, 2001, between the Registrant and The Bank of New York, as Trustee, relating to $6^{3}/_{8}$% Senior Notes due 2011 (Incorporated by reference to Exhibit 4.3 to Registrant's Current Report on Form 8-K, dated November 6, 2001 and filed November 9, 2001)

(c) Third Supplemental Indenture, dated as of November 6, 2001, between the Registrant and The Bank of New York, as Trustee, relating to $6^{7}/_{8}$% Senior Notes due 2031 (Incorporated by reference to Exhibit 4.4 to Registrant's Current Report on Form 8-K, dated November 6, 2001 and filed November 9, 2001)

(d) Fourth Supplemental Indenture, dated as of March 7, 2002, between the Registrant and The Bank of New York, as Trustee, relating to $6^{1}/_{2}$% Senior Notes due 2012 (Incorporated by reference to Exhibit 4.3 to Registrant's Current Report on Form 8-K, dated and filed March 7, 2002)

(e) Sixth Supplemental Indenture, dated as of January 28, 2003, between the Registrant and The Bank of New York, as Trustee, relating to $7^{3}/_{8}$% Senior Notes due 2013 (Incorporated by reference to Exhibit 4.3 to Registrant's Current Report on Form 8-K, dated January 28, 2003 and filed January 31, 2003)

(f) Seventh Supplemental Indenture, dated as of June 18, 2004, between the Registrant and The Bank of New York, as Trustee, relating to $9^{7}/_{8}$% Senior Notes due 2014 (Incorporated

by reference to Exhibit 4(a) to Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2004, filed August 3, 2004)

(g) Eighth Supplemental Indenture, dated as of January 28, 2005, between the Registrant and The Bank of New York, as Trustee, relating to 9 1/4% Senior Notes due 2015

(10) Material Contracts

(a) Five-Year Credit Agreement, dated as of March 1, 2001, as amended by Amendment No. 1, dated as of October 10, 2001, as amended by Amendment No. 2, dated February 28, 2003, as amended by Amendment No. 3, dated September 30, 2003, among the Registrant as Borrower, the Lenders, Managing Agents and Co-Agents party thereto, the Swingline Bank party thereto, The Bank of New York, The Bank of Nova Scotia and Salomon Smith Barney, Inc. as Documentation Agents, Bank of America, N.A. as Syndication Agent, and Morgan Guaranty Trust Company of New York as Administrative Agent (Incorporated by reference to Exhibit 10(a) to Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended September 30, 2003, filed November 10, 2003)

(b) Fourth Amendment to Five-Year Credit Agreement, dated as of March 9, 2004, among the Registrant, the Lenders and Agents party thereto, and JPMorgan Chase Bank, N.A. as Administrative Agent (Incorporated by reference to Exhibit 10(b) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2003, filed March 15, 2004)

(c) Credit Agreement (One-Year Letter of Credit Facility), dated as of December 31, 2004, among the Registrant, the Lenders thereto, Citicorp USA, Inc. as Syndication Agent, and Bank of America, N.A. as Administrative Agent and LC Issuing Bank

(d) Letter from the Registrant to Trevor Fetter, dated November 7, 2002 (Incorporated by reference to Exhibit 10(k) to Registrant's Transition Report on Form 10-K for the seven-month transition period ended December 31, 2002, filed May 15, 2003)

(e) Restricted Stock Agreement, dated as of January 21, 2003, between Trevor Fetter and the Registrant (Incorporated by reference to Exhibit 10(b) to Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended February 28, 2003, filed April 14, 2003)

(f) Letter from the Registrant to Trevor Fetter dated September 15, 2003 (Incorporated by reference to Exhibit 10(l) to Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended September 30, 2003, filed November 10, 2003)

(g) Letter from the Registrant to Reynold Jennings, dated January 30, 2004 (Incorporated by reference to Exhibit 10(i) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2003, filed March 15, 2004)

(h) Letters from the Registrant to W. Randolph Smith, dated March 10, 2004 and January 11, 2005

(i) Letter from the Registrant to Robert Shapard, dated February 16, 2005, and Tenet Executive Severance Protection Plan (Robert Shapard)

(j) Letter from the Registrant to E. Peter Urbanowicz, dated December 22, 2003 (Incorporated by reference to Exhibit 10(k) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2003, filed March 15, 2004)

(k) Tenet Executive Severance Protection Plan (Incorporated by reference to Exhibit 10(p) to Registrant's Transition Report on Form 10-K for the seven-month transition period ended December 31, 2002, filed May 15, 2003)

(l) Board of Directors Retirement Plan, effective January 1, 1985, as amended August 18, 1993, April 25, 1994 and July 30, 1997 (Incorporated by reference to Exhibit 10(q) to Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended September 30, 2003, filed on November 10, 2003)

(m) Tenet Healthcare Corporation Fourth Amended and Restated Supplemental Executive Retirement Plan

(n) Sixth Amended and Restated Tenet 2001 Deferred Compensation Plan

(o) Tenet Healthcare Corporation Second Amended and Restated 1994 Directors Stock Option Plan (Incorporated by reference to Exhibit 10(s) to Registrant's Annual Report on Form 10-K for the fiscal year ended May 31, 2001, filed August 21, 2001)

(p) 1991 Stock Incentive Plan (Incorporated by reference to Exhibit 10(t) to Registrant's Annual Report on Form 10-K for the fiscal year ended May 31, 2001, filed August 21, 2001)

(q) Amended and Restated 1995 Stock Incentive Plan (Incorporated by reference to Exhibit 10(s) to Registrant's Annual Report on Form 10-K for the fiscal year ended May 31, 2002, filed August 14, 2002)

(r) First Amended and Restated Tenet Healthcare Corporation 1999 Broad-Based Stock Incentive Plan (Incorporated by reference to Exhibit 10(t) to Registrant's Annual Report on Form 10-K for the fiscal year ended May 31, 2002, filed August 14, 2002)

(s) Tenet Healthcare Corporation Second Amended and Restated 2001 Stock Incentive Plan

(t) Tenet Healthcare Corporation 2001 Annual Incentive Plan (Incorporated by reference to Appendix B to Registrant's Definitive Proxy Statement for the Annual Meeting of Shareholders held on October 10, 2001, filed August 20, 2001)

(21) Subsidiaries of the Registrant

(23) Consent of KPMG LLP

(31) Rule 13a-14(a)/15d-14(a) Certifications

(a) Certification of Trevor Fetter, President and Chief Executive Officer

(b) Certification of Stephen D. Farber, Chief Financial Officer

(32) Section 1350 Certifications of Trevor Fetter, President and Chief Executive Officer, and Stephen D. Farber, Chief Financial Officer

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

TENET HEALTHCARE CORPORATION

Date: March 7, 2005 By: /s/ STEPHEN D. FARBER

Stephen D. Farber
Chief Financial Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

Date: March 7, 2005 By: /s/ TREVOR FETTER

Trevor Fetter
President, Chief Executive Officer and Director
(*Principal Executive Officer*)

Date: March 7, 2005 By: /s/ STEPHEN D. FARBER

Stephen D. Farber
Chief Financial Officer
(*Principal Financial Officer*)

Date: March 7, 2005 By: /s/ TIMOTHY L. PULLEN

Timothy L. Pullen
Executive Vice President and Chief Accounting Officer
(*Principal Accounting Officer*)

Date: March 7, 2005 By: /s/ VAN B. HONEYCUTT

Van B. Honeycutt
Director

Date: March 7, 2005 By: /s/ JOHN C. KANE

John C. Kane
Director

Date: March 7, 2005 By: /s/ EDWARD A. KANGAS

Edward A. Kangas
Director

Date: March 7, 2005 By: /s/ J. ROBERT KERREY

J. Robert Kerrey
Director

Date: March 7, 2005	By:	/s/ FLOYD D. LOOP
		Floyd D. Loop, M.D. Director
Date: March 7, 2005	By:	/s/ MÓNICA C. LOZANO
		Mónica C. Lozano Director
Date: March 7, 2005	By:	/s/ RICHARD R. PETTINGILL
		Richard R. Pettingill Director
Date: March 7, 2005	By:	/s/ JAMES A. UNRUH
		James A. Unruh Director

SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
ALLOWANCE FOR DOUBTFUL ACCOUNTS
(In Millions)

	Balance at Beginning of Period	Additions charged to: Costs and Expenses(1)	Additions charged to: Other Accounts	Deductions(2)	Other Items(3)	Balance at End of Period
Year ended December 31, 2004	$500	$1,557	$—	$(1,347)	$(12)	$698
Year ended December 31, 2003	$350	1,575	—	(1,425)	—	$500
Seven months ended December 31, 2002	$315	676	—	(641)	—	$350
Year ended May 31, 2002	$333	986	—	(1,004)	—	$315

(1) Before considering recoveries on accounts or notes previously written off.
(2) Accounts written off.
(3) Primarily beginning balances for purchased business, net of balances of businesses sold.

COMPANY INFORMATION

COMMON STOCK LISTING

Tenet Healthcare Corporation's common stock is listed under the symbol "THC" on the New York Stock Exchange and the Pacific Stock Exchange. On May 27, 2004, we submitted to the NYSE the annual CEO Certification regarding our compliance with NYSE corporate governance listing standards. This year, we intend to submit the certification with our NYSE Annual Written Affirmation following our 2005 annual meeting of shareholders.

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.

INVESTOR RELATIONS

To request any financial literature be mailed to you and for all other shareholder inquiries, please contact Tenet Investor Relations.

Thomas R. Rice
Senior Vice President, Investor Relations
Tenet Healthcare Corporation
13737 Noel Road
Dallas, TX 75240
E-mail: *thomas.rice@tenethealth.com*

PRINCIPAL OFFICE

Effective January 3, 2005, our corporate headquarters are located at:

13737 Noel Road
Dallas, TX 75240
(469) 893-2200

ANNUAL MEETING

The annual meeting of shareholders of Tenet Healthcare Corporation will be held on Thursday, May 26, 2005 at The Westin Galleria, 13340 Dallas Parkway, Dallas, Texas 75240.

Exhibit 4(g)

EXECUTION COPY

TENET HEALTHCARE CORPORATION

_____

Eighth Supplemental Indenture

Dated as of January 28, 2005

_____

(Supplemental to Indenture Dated as of November 6, 2001)

_____

THE BANK OF NEW YORK,
as Trustee

EIGHTH SUPPLEMENTAL INDENTURE, dated as of January 28, 2005, between Tenet Healthcare Corporation, a corporation duly organized and existing under the laws of the State of Nevada (herein called the "Company"), and The Bank of New York, a New York banking corporation, as trustee (herein called "Trustee").

R E C I T A L S:

WHEREAS, the Company has heretofore executed and delivered to the Trustee, an Indenture, dated as of November 6, 2001 (the "Existing Indenture", and the Existing Indenture, as the same may be amended or supplemented from time to time, including by this Eighth Supplemental Indenture, the "Indenture"), providing for the issuance from time to time of the Company's unsecured debentures, notes or other evidences of indebtedness (herein and therein called the "Securities"), to be issued in one or more series as provided in the Indenture;

WHEREAS, Section 901 of the Existing Indenture permits the Company and the Trustee to enter into an indenture supplemental to the Existing Indenture to provide for the issuance of and establish the form and terms and conditions of any additional series of Securities;

WHEREAS, Sections 201, 301 and 901 of the Existing Indenture permit the form of notes of each additional series of notes to be established pursuant to an indenture supplemental to the Existing Indenture;

WHEREAS, Section 301 of the Existing Indenture permits certain terms of any additional series of notes to be established pursuant to an indenture supplemental to the Existing Indenture; and

WHEREAS, pursuant to resolutions of the Board of Directors of the Company adopted at a meeting duly called on January 21, 2005, the Company is authorized to issue up to $800,000,000 aggregate principal amount of Securities in one or more series of Securities;

WHEREAS, in accordance with such resolutions, the Company has authorized the issuance of $800,000,000 aggregate principal amount of 9.250% Senior Notes due 2015 (the "Notes");

WHEREAS, the Company has duly authorized the execution and delivery of this Eighth Supplemental Indenture to establish the form and terms of the Notes;

WHEREAS, all things necessary to make this Eighth Supplemental Indenture a valid agreement according to its terms have been done; and

WHEREAS, the foregoing recitals are made as statements of fact by the Company and not by the Trustee;

NOW, THEREFORE, THIS EIGHTH SUPPLEMENTAL INDENTURE WITNESSETH:

For and in consideration of the premises and the issuance of the Notes provided for herein, it is mutually agreed, for the equal and proportionate benefit of all Holders of the Notes, as follows:

ARTICLE I
DEFINITIONS AND OTHER PROVISIONS OF GENERAL APPLICATION

Section 1.1 ***Relation to Existing Indenture***

This Eighth Supplemental Indenture constitutes an integral part of the Existing Indenture (the provisions of which, as modified by this Eighth Supplemental Indenture, shall apply to the Notes) in respect of the Notes but shall not modify, amend or otherwise affect the Existing Indenture insofar as it relates to any other series of Securities or affect in any manner the terms and conditions of the Securities of any other series.

Section 1.2 *Definitions*

For all purposes of this Eighth Supplemental Indenture, the capitalized terms used herein (i) which are defined in this Section 1.2 have the respective meanings assigned thereto in this Section 1.2, and (ii) which are defined in the Existing Indenture (and which are not defined in this Section 1.2) have the respective meanings assigned thereto in the Existing Indenture. For all purposes of this Eighth Supplemental Indenture:

1.2.1 All references herein to Articles and Sections, unless otherwise specified, refer to the corresponding Articles and Sections of this Eighth Supplemental Indenture;

1.2.2 The terms "hereof", "herein", "hereby", "hereto", "hereunder" and "herewith" refer to this Eighth Supplemental Indenture; and

1.2.3 The following terms, as used herein, have the following meanings:

"Adjusted Treasury Rate" has the meaning specified in the form of Note contained in Section 2.3.

"Affiliated Entity" has the meaning specified under the definition of "Subsidiary" in this Section 1.2.3.

"Attributable Debt" when used in connection with a Sale and Lease-Back Transaction, means, as of the date of determination, (i) as to any capitalized lease obligations, the liability related thereto set forth on the consolidated balance sheet of the Company and (ii) as to any operating lease, the present value (discounted at the rate per annum equal to the rate of interest set forth or implicit in the term of the lease, as determined in good faith by the Board of Directors of the Company) of the total obligation of the lessee for net rental payments during the remaining term of the lease (including any period for which an option to extend such lease has been exercised).

"Code" means the Internal Revenue Code of 1986, as amended and as in effect on the date hereof.

"Comparable Treasury Issue" has the meaning specified in the form of Note contained in Section 2.3.

"Comparable Treasury Price" has the meaning specified in the form of Note contained in Section 2.3.

"Depositary" means The Depository Trust Company, its nominees and their respective successors.

"Exchange Notes" means the notes issued pursuant to the Exchange Offer and their Successor Securities.

"Exchange Offer" has the meaning specified in the form of Note contained in Section 2.2.

"Exchange Offer Registration Statement" has the meaning specified in the form of Note contained in Section 2.2.

"Global Note" means any Note bearing the legend specified in Section 2.2 evidencing all or part of the Notes, issued to the Depositary or its nominee and registered in the name of the Depositary. The Restricted Global Note shall be a Global Note.

"Independent Investment Banker" has the meaning specified in the form of Note contained in Section 2.3.

"Initial Purchasers" means Citigroup Global Markets Inc., Banc of America Securities LLC, Scotia Capital (USA) Inc. and SunTrust Capital Markets, Inc.

"Interest Payment Date" has the meaning specified in the form of Note contained in Section 2.2.

"Liens" means liens, mortgages, pledges, charges, security interests or other encumbrances.

"Make-Whole Price" has the meaning specified in the form of Note contained in Section 2.3.

"Original Notes" means all Notes other than Exchange Notes.

"Primary Treasury Dealer" has the meaning specified in the form of Note contained in Section 2.3.

"Principal Property" means each hospital owned solely by the Company and/or one or more of its Subsidiaries which has an asset value shown on the books of the Company in excess of 5% of the Consolidated Net Tangible Assets of the Company.

"Purchase Agreement" means the Purchase Agreement, dated as of January 25, 2005 among the Company and the Initial Purchasers.

"Reference Treasury Dealer" has the meaning specified in the form of Note contained in Section 2.3.

"Reference Treasury Dealer Quotations" has the meaning specified in the form of Note contained in Section 2.3.

"Registered Notes" means the Exchange Notes and all other Notes sold or otherwise disposed of pursuant to an effective registration statement under the Securities Act, together with their respective Successor Securities.

"Registration Default" has the meaning specified in the form of Note contained in Section 2.2.

"Registration Default Period" has the meaning specified in the form of Note contained in Section 2.2.

"Registration Rights Agreement" has the meaning specified in Section 2.2.

"Regulation S" means Regulation S under the Securities Act (including any successor rule or regulation thereto), as the same may be amended from time to time.

"Remaining Life" has the meaning specified in the form of Note contained in Section 2.3.

"Restricted Global Note" has the meaning specified in Section 2.1.

"Restricted Note" means all Notes required pursuant to Section 2.6 to bear any Restricted Securities Legend. Such term includes the Restricted Global Note.

"Restricted Securities Legend" has the meaning specified in Section 2.6.

"Rule 144A" means Rule 144A under the Securities Act (including any successor rule thereto), as the same may be amended from time to time.

"Sale and Lease-Back Transactions" has the meaning specified in Section 3.2.

"Securities" has the meaning ascribed to it in the first paragraph under the caption "Recitals."

"Securities Act" means the Securities Act of 1933, as amended.

"Shelf Registration Statement" has the meaning specified in the form of Note contained in Section 2.2.

"Special Interest" has the meaning specified in the form of Note contained in Section 2.2.

"Special Interest Notice" has the meaning specified in Section 2.5.

"Step Down Date" has the meaning specified in the form of Note contained in Section 2.2.

"Step Up" has the meaning specified in the form of Note contained in Section 2.2.

"Subsequent Step Up" has the meaning specified in the form of Note contained in Section 2.2.

"Successor Security" of any particular Security means every Security issued after, and evidencing all or a portion of the same debt as that evidenced by, such particular Security; and, for the purposes of this definition, any Security authenticated and delivered under Section 306 in exchange for or in lieu of a mutilated, destroyed, lost or stolen Security shall be deemed to evidence the same debt as the mutilated, destroyed, lost or stolen Security.

ARTICLE II
GENERAL TERMS AND CONDITIONS OF THE NOTES

Section 2.1 ***Forms of Notes Generally***

The Notes shall be in substantially the forms set forth in this Article with such appropriate insertions, omissions, substitutions and other variations as are required or permitted by the Indenture, and may have such letters, numbers or other marks of identification and such legends or endorsements placed thereon as may be required to comply with the rules of any securities exchange or Depositary thereof, the Code and regulations thereunder, or as may, consistently herewith, be determined by the officers executing such Notes, as evidenced by their execution thereof. The Trustee's certificates of authentication shall be in substantially the form set forth in Section 2.4.

The definitive Notes shall be printed, lithographed or engraved or produced by any combination of these methods on steel engraved borders or may be produced in any other manner permitted by the rules of any securities exchange on which the Notes may be listed, all as determined by the officers executing such Notes, as evidenced by their execution thereof.

In certain cases described elsewhere herein, the legends set forth in the first five paragraphs of Section 2.2 may be omitted from Notes issued hereunder.

Notes offered and sold in their initial distribution in reliance on Rule 144A or Regulation S shall be Restricted Notes and shall be issued in the form of one or more Global Notes (each, a "Restricted Global Note"), in fully-registered form without interest coupons, substantially in the form of Note set forth in Sections 2.2 and 2.3, with such applicable legends as are provided for in Section 2.2, except as otherwise permitted herein. Such Restricted Global Notes shall be registered in the name of the Depositary or its nominee and deposited with the Trustee, at its New York office, as custodian for the Depositary, duly executed by the Company and authenticated by the Trustee as hereinafter provided. The Restricted Global Notes and all other Notes evidencing the debt, or any portion of the debt, initially evidenced by such Restricted Global Notes, other than the Notes which are not required to bear the Restricted Securities Legend, shall collectively be referred to herein as the "Restricted Notes." Global Notes are Global Securities as defined under the Existing Indenture and are subject to the restrictions and provisions of the Indenture governing Global Securities in the Existing Indenture, except as specifically provided in this Eighth Supplemental Indenture.

The Notes will be issued only in registered form. The Notes will be issued in minimum denominations of $1,000.

Section 2.2 ***Form of Face of the Notes***

[**INCLUDE IF NOTE IS A RESTRICTED NOTE—**THIS SECURITY (OR ITS PREDECESSOR) WAS ORIGINALLY ISSUED IN A TRANSACTION EXEMPT FROM REGISTRATION UNDER THE UNITED STATES SECURITIES ACT OF 1933, AS AMENDED (THE "SECURITIES ACT"), AND THIS SECURITY MAY NOT BE OFFERED, SOLD OR OTHERWISE TRANSFERRED IN THE ABSENCE OF SUCH REGISTRATION OR AN APPLICABLE EXEMPTION THEREFROM. EACH PURCHASER OF THIS SECURITY IS HEREBY NOTIFIED THAT THE SELLER OF THIS SECURITY MAY BE RELYING ON THE EXEMPTION FROM THE PROVISIONS OF SECTION 5 OF THE SECURITIES ACT PROVIDED BY RULE 144A THEREUNDER OR RULE 903 OR RULE 904 OF REGULATION S THEREUNDER.

THE HOLDER OF THIS SECURITY AGREES FOR THE BENEFIT OF THE COMPANY THAT (A) THIS SECURITY MAY BE OFFERED, RESOLD, PLEDGED OR OTHERWISE TRANSFERRED ONLY (I) TO THE COMPANY, (II) INSIDE THE U.S. TO A PERSON WHOM THE SELLER REASONABLY BELIEVES IS A "QUALIFIED INSTITUTIONAL BUYER" (AS DEFINED IN RULE 144A UNDER THE SECURITIES ACT) IN A TRANSACTION MEETING THE REQUIREMENTS OF RULE 144A, (III) OUTSIDE THE U.S. IN A TRANSACTION COMPLYING WITH THE PROVISIONS OF RULE 904 UNDER THE SECURITIES ACT AND SUBJECT TO THE COMPANY'S RIGHT PRIOR TO ANY SUCH REOFFER, RESALE OR TRANSFER TO REQUIRE THE DELIVERY OF AN OPINION OF COUNSEL, CERTIFICATION OR OTHER INFORMATION REASONABLY SATISFACTORY TO IT THAT SUCH REOFFER, RESALE OR TRANSFER IS IN COMPLIANCE WITH THE SECURITIES ACT AND OTHER APPLICABLE LAWS, (IV) PURSUANT TO AN EXEMPTION FROM REGISTRATION UNDER THE SECURITIES ACT PROVIDED BY RULE 144 (IF AVAILABLE), (V) PURSUANT TO AN EFFECTIVE REGISTRATION STATEMENT UNDER THE SECURITIES ACT OR (VI) IN ACCORDANCE WITH ANOTHER EXEMPTION FROM THE REGISTRATION REQUIREMENTS OF THE SECURITIES ACT (AND BASED UPON AN OPINION OF COUNSEL ACCEPTABLE TO IT), AND IN EACH OF CASES (II) THROUGH (VI) IN ACCORDANCE WITH ANY APPLICABLE SECURITIES LAWS OF ANY STATE OF THE UNITED STATES, AND (B) THE HOLDER WILL AND EACH SUBSEQUENT HOLDER IS REQUIRED TO, NOTIFY ANY PURCHASER OF THIS SECURITY FROM IT OF THE RESALE RESTRICTIONS REFERRED TO IN (A) ABOVE.]

[**INCLUDE IF NOTE IS A GLOBAL NOTE—**THIS NOTE IS A GLOBAL NOTE WITHIN THE MEANING OF THE INDENTURE HEREINAFTER REFERRED TO AND IS REGISTERED IN THE NAME OF A DEPOSITARY OR A NOMINEE THEREOF. THIS NOTE MAY NOT BE EXCHANGED IN WHOLE OR IN PART FOR A NOTE REGISTERED, AND NO TRANSFER OF THIS NOTE IN WHOLE OR IN PART MAY BE REGISTERED, IN THE NAME OF ANY PERSON OTHER THAN SUCH DEPOSITARY OR A NOMINEE THEREOF, EXCEPT IN THE LIMITED CIRCUMSTANCES DESCRIBED IN THE INDENTURE.]

[**INCLUDE IF NOTE IS A GLOBAL NOTE AND THE DEPOSITORY TRUST COMPANY IS THE DEPOSITARY—**UNLESS THIS CERTIFICATE IS PRESENTED BY AN AUTHORIZED REPRESENTATIVE OF THE DEPOSITORY TRUST COMPANY ("DTC"), A NEW YORK CORPORATION, TO THE COMPANY OR ITS AGENT FOR REGISTRATION OF TRANSFER, EXCHANGE OR PAYMENT, AND ANY CERTIFICATE ISSUED IS REGISTERED IN THE NAME OF CEDE & CO. OR IN SUCH OTHER NAME AS IS REQUESTED BY AN AUTHORIZED REPRESENTATIVE OF DTC (AND ANY PAYMENT IS MADE TO CEDE & CO. OR TO SUCH OTHER ENTITY AS IS REQUESTED BY AN AUTHORIZED REPRESENTATIVE OF DTC), ANY TRANSFER, PLEDGE OR OTHER USE HEREOF FOR VALUE OR OTHERWISE BY OR TO ANY PERSON IS WRONGFUL INASMUCH AS THE REGISTERED OWNER HEREOF, CEDE & CO., HAS AN INTEREST HEREIN.

THIS SECURITY MAY NOT BE EXCHANGEABLE IN WHOLE OR IN PART FOR A SECURITY REGISTERED, AND NO TRANSFER OF THIS SECURITY IN WHOLE OR IN PART MAY BE REGISTERED, IN THE NAME OF ANY PERSON OTHER THAN SUCH DEPOSITARY OR A NOMINEE THEREOF, EXCEPT IN THE LIMITED CIRCUMSTANCES DESCRIBED IN THE INDENTURE.]

TENET HEALTHCARE CORPORATION

9.250% SENIOR NOTES DUE 2015

No. ____
CUSIP No.: $ _____

TENET HEALTHCARE CORPORATION, a corporation duly organized and existing under the laws of Nevada (herein called the "Company," which term includes any successor Person under the Indenture referred to on the reverse hereof), for value received, hereby promises to pay to Cede & Co., or registered assigns, the principal sum of Dollars (U.S. $), [include if Global Note—or such other amount (not to exceed Eight Hundred Million (U.S. $800,000,000) when taken together with all of the Company's 9.250% Senior Notes due 2015 issued and outstanding in definitive certificated form or in the form of another Global Note) as may from time to time represent the principal amount of the Company's 9.250% Senior Notes due 2015 in respect of which beneficial interests are held through the Depositary in the form of a Global Note,] on February 1, 2015, and to pay interest thereon from January 28, 2005, or from the most recent Interest Payment Date (as defined below) to which interest has been paid or duly provided for, semi-annually in arrears on February 1 and August 1 in each year (each such date, an "Interest Payment Date"), commencing on August 1, 2005, until the principal hereof is paid or made available for payment. The interest so payable, and punctually paid or duly provided for, on any Interest Payment Date will, as provided in such Indenture, be paid to the Person in whose name this Note (or one or more Predecessor Notes) is registered at the close of business on the Regular Record Date for such interest, which shall be the January 15 or July 15 (whether or not a Business Day), as the case may be, next preceding such Interest Payment Date. Any such interest not so punctually paid or duly provided for will forthwith cease to be payable to the Holder on such Regular Record Date and may either be paid to the Person in whose name this Note (or one or more Predecessor Notes) is registered at the close of business on a Special Record Date for the payment of such Defaulted Interest to be fixed by the Trustee, notice whereof shall be given to Holders of Notes not less than 10 days prior to such Special Record Date, or be paid at any time in any other lawful manner not inconsistent with the requirements of any securities exchange on which the Notes may be listed, and upon such notice as may be required by such exchange, all as more fully provided in said Indenture.

Interest shall be computed on the basis of a 360-day year comprised of twelve 30-day months.

In the event that an Interest Payment Date is not a Business Day, the Company shall pay interest on the next day that is a Business Day, with the same force and effect as if made on the Interest Payment Date, and without any interest or other payment with respect to the delay. If the Stated Maturity or earlier Redemption Date falls on a day that is not a Business Day, the payment of principal and interest, if any, need not be made on such date, but may be made on the next succeeding Business Day, with the same force and effect as if made on the Stated Maturity or earlier Redemption Date, provided that no interest shall accrue for the period from and after such Stated Maturity or earlier Redemption Date.

[Pursuant to the Exchange and Registration Rights Agreement, dated as of January 28, 2005 (the "Registration Rights Agreement"), by and among the Company and the Initial Purchasers, the Company has agreed for the benefit of the Holders from time to time of the Notes that they will (i) file under the Securities Act, within 30 days after the earlier of (a) the date of filing of the Company's Annual Report on Form 10-K for the year ended December 31, 2004 and (b) the date on which such report should have been timely filed under the Securities Act, a registration statement (the "Exchange Offer Registration Statement") registering securities substantially identical to the Notes (except that such securities will not contain terms with respect to the Special Interest payments described below or transfer restrictions) pursuant to an exchange offer (the "Exchange Offer"), (ii) use its commercially reasonable efforts to cause the Exchange Registration Statement to become effective under the Securities Act no later than 360 days following the date of the Offering Memorandum (as defined in the Registration Rights Agreement), and (iii) use its commercially reasonable efforts to cause the Exchange Offer to remain open at least 20 business days and to commence and complete the Exchange Offer no later than 30 business days after the Exchange Offer Registration Statement has become effective; provided, however, that if (a) on or prior to the time the Exchange Offer is completed, existing Commission (as defined in the Indenture) interpretations are changed such that this Note is not or would not be, upon receipt under the Exchange Offer, transferable by the Holder of this Note without restriction under the Securities Act, (b) for any reason the Exchange Offer is not commenced and completed by the applicable date or (c) the Exchange Offer is not available to the Holder of this Note, the Company agreed, in lieu of (or, in the case of clause (c), in addition to) conducting the Exchange Offer, to file under the Securities Act no later than the later of 30 days after the time such obligation to file arises, a "shelf" registration statement providing for the registration of and the sale on a continuous or delayed basis by the Holder of this Note (such registration statement, the "Shelf Registration Statement") and to use its commercially reasonable efforts to cause the Shelf Registration Statement to become effective no later than 90 days after it is filed.

In the event that (i) the Company has not filed the Exchange Offer Registration Statement or, if applicable, the Shelf Registration Statement on or before the date on which such registration statement is required to be filed in the respective time frames provided above, or (ii) such Exchange Offer Registration Statement or, if applicable, such Shelf Registration Statement has not become effective on or before the date on which such registration statement is required to become effective in the respective time frames provided above, or (iii) the Exchange Offer has not been completed within 30 business days after the Exchange Offer Registration Statement has become effective (if the Exchange Offer is then required to be made) or (iv) the Exchange Offer Registration Statement or, if applicable, the Shelf Registration Statement is filed and declared effective but shall thereafter either be withdrawn by the Company or shall become subject to an effective stop order issued pursuant to Section 8(d) of the Securities Act suspending the effectiveness of such registration statement (except as specifically permitted in the Indenture) without being succeeded immediately by an additional registration statement filed and declared effective, in each case (i) through (iv) upon the terms and conditions set forth in the Registration Rights Agreement (each such event referred to in clauses (i) through (iv), a "Registration Default" and each period during which a Registration Default has occurred and is continuing, a "Registration Default Period"), then interest will accrue (in addition to any stated interest on this Note) at a per annum rate of 0.25% for the first 90 days of the Registration Default Period (the "Step-Up"), at a per annum rate of 0.50% for the second 90 days of the Registration Default Period, at a per annum rate of 0.75% for the third 90 days of the Registration Default Period and at a per annum rate of 1.0% thereafter for the remaining portion of the Registration Default Period (each such increase, a "Subsequent Step-Up"). The Company shall not be required to pay Special Interest for more than one Registration Default at any given time. Interest accruing as a result of the Step-Up or any Subsequent Step-Up (which shall be computed on the basis of a 360-day year comprised of twelve

30-day months) is referred to herein as "Special Interest," and will be payable at such increased rate until such time as the Registration Default Period is no longer continuing, after which such interest rate will be restored to its initial rate (such event, a "Step-Down Date"). Accrued Special Interest, if any, shall be paid in cash in arrears on each Interest Payment Date for the Notes; and the amount of accrued Special Interest shall be determined on the basis of the number of days actually elapsed. Any accrued and unpaid interest (including Special Interest) on this Note upon the issuance of an Exchange Note (as defined in the Indenture) in exchange for this Note shall cease to be payable to the Holder hereof but such accrued and unpaid interest (including Special Interest) shall be payable on the next Interest Payment Date for such Exchange Note to the Holder thereof on the related Regular Record Date.]

Payment of the principal of this Note, any premium and any interest due at Stated Maturity will be made in immediately available funds upon surrender at the office or agency of the Paying Agent, as defined on the reverse hereof, maintained for that purpose within the City and State of New York, or at such other paying agency as the Company may determine. Payments of interest, other than interest due at Stated Maturity, may at the Company's option be made by check mailed to the address of the Person entitled thereto as such address shall appear in the Securities Register. Holders who have given wire instructions to the Paying Agent will be entitled to receive payments of interest, other than interest due at Stated Maturity, by wire transfer of immediately available funds if appropriate wire transfer instructions have been received by the Paying Agent in writing earlier than the relevant Record Date.

Reference is hereby made to the further provisions of this Note set forth on the reverse hereof, which further provisions shall for all purposes have the same effect as if set forth at this place.

Unless the certificate of authentication hereon has been executed by the Trustee referred to on the reverse hereof by the manual signature of one of its authorized signatories, this Note shall not be entitled to any benefit under the Indenture or be valid or obligatory for any purpose.

IN WITNESS WHEREOF, the Company has caused this instrument to be duly executed.

Dated: TENET HEALTHCARE CORPORATION

By _____

Section 2.3 ***Form of Reverse of the Notes***

This Note is one of a duly authorized issue of securities of the Company (herein called the "Notes"), issued and to be issued in one or more series under an Indenture, dated as of November 6, 2001, as supplemented by the Eighth Supplemental Indenture (the "Eighth Supplemental Indenture"), dated as of January 28, 2005 (as so supplemented, the "Indenture", which term shall have the meaning assigned to it in such instrument), between the Company and The Bank of New York, as Trustee (herein called the "Trustee", which term includes any successor trustee under the Indenture), and reference is hereby made to the Indenture for a statement of the respective rights, limitations of rights, duties and immunities thereunder of the Company, the Trustee and the Holders of the Notes and of the terms upon which the Notes are, and are to be, authenticated and delivered. This Note is one of the series designated on the face hereof. The Company has appointed The Bank of New York at its corporate trust office in New York, New York as the paying agent (herein called the "Paying Agent", which term includes any additional or successor Paying Agent appointed by the Company) with respect to the Notes.

The Notes are subject to redemption, in whole or in part, at any time, at the election of the Company upon not less than 30 nor more than 60 days' notice at a Redemption Price equal to the Make-Whole Price.

"Make-Whole Price" means an amount equal to the greater of (i) 100% of the principal amount of the Notes being redeemed and (ii) the sum of the present values of the remaining scheduled payments of principal and interest thereon (excluding accrued and unpaid interest to the Redemption Date) discounted to the Redemption Date on a semiannual basis (assuming a 360-day year consisting of twelve 30-day months) at the Adjusted Treasury Rate (as defined herein) plus 0.50%, plus, in each of cases (i) and (ii), accrued and unpaid interest thereon to the Redemption Date.

"Adjusted Treasury Rate" means, with respect to any Redemption Date: (i) the yield, under the heading that represents the average for the immediately preceding week, appearing in the most recently published statistical release designated "H.15(519)" or any successor publication that is published weekly by the Board of Governors of the Federal Reserve System and that establishes yields on actively traded United States Treasury securities adjusted to constant maturity under the caption "Treasury Constant Maturities," for the maturity corresponding to the Comparable Treasury Issue (if no maturity is within three months before or after the Remaining Life, yields for the two published maturities most closely corresponding to the Comparable Treasury Issue shall be determined and the adjusted Treasury Rate shall be interpolated or extrapolated from such yields on a straight line basis, rounded to the nearest month); or (ii) if such release (or any successor release) is not published during the week preceding the calculation date or does not contain such yields, the rate per annum equal to the semi-annual equivalent yield to maturity of the Comparable Treasury Issue, calculated using a price for the Comparable Treasury Issue (expressed as a percentage of its principal amount) equal to the Comparable Treasury Price for such Redemption Date. The Adjusted Treasury Rate shall be calculated on the third business day preceding the Redemption Date.

"Comparable Treasury Issue" means the United States Treasury security selected by an Independent Investment Banker as having a maturity comparable to the remaining term of the Notes to be redeemed that would be utilized, at the time of selection and in accordance with customary financial practice, in pricing new issues of corporate debt securities of comparable maturity to the remaining term of the Notes (the "Remaining Life").

"Comparable Treasury Price" means, with respect to any Redemption Date, (i) the average of the Reference Treasury Dealer Quotations for such Redemption Date, after excluding the highest and lowest Reference Treasury Dealer Quotations, or (ii) if the Independent Investment Banker obtains fewer than five such Reference Treasury Dealer Quotations, the average of all such quotations.

"Independent Investment Banker" means one of the Reference Treasury Dealer appointed by the Company.

"Reference Treasury Dealer" means (i) each of Citigroup Global Markets Inc., Banc of America Securities LLC, Scotia Capital (USA) Inc. and SunTrust Capital Markets, Inc. and their respective successors; provided that if any of the foregoing ceases to be a primary U.S. Government securities dealer in New York City (a "Primary Treasury Dealer"), the Company will substitute therefor another Primary Treasury Dealer, and (ii) any other Primary Treasury Dealer selected by the Company.

"Reference Treasury Dealer Quotations" means, with respect to each Reference Treasury Dealer and any redemption date, the average, as determined by the Independent Investment Banker, of the bid and asked prices for the Comparable Treasury Issue (expressed in each case as a percentage of its principal amount) quoted in writing to the Independent Investment Banker by such Reference Treasury Dealer at 5:00 p.m., New York City time, on the third Business Day preceding such Redemption Date.

In the event of redemption of this Note in part only, a new Note or Notes of this series and of like tenor for the unredeemed portion hereof will be issued in the name of the Holder hereof upon the cancellation hereof.

This Note does not have the benefit of any sinking fund obligations.

The Indenture contains provisions for defeasance at any time of the entire indebtedness of this Note or certain restrictive covenants and Events of Default with respect to this Note, in each case upon compliance with certain conditions set forth in the Indenture.

If an Event of Default with respect to Notes of this series shall occur and be continuing, the principal of the Notes of this series may be declared due and payable in the manner and with the effect provided in the Indenture.

The Notes are entitled to the benefits of the covenants of the Company set forth in Article Ten of the Indenture and Article Three of the Eighth Supplemental Indenture.

This Note is a Global Note and shall be exchangeable for Notes registered in the names of Persons other than the Depositary or its nominee only if (i) the Depositary notifies the Company that it is unwilling or unable to continue as Depositary for this Global Note or if at any time such Depositary ceases to be a clearing agency registered as such under the Securities Exchange Act of 1934, as amended, at a time when such Depositary is required to be so registered in order to act as Depositary, and the Company fails to appoint a successor Depositary under the Indenture, (ii) the Company executes and delivers to the Trustee a Company Order that the Global Note shall be so exchangeable, or (iii) there shall have occurred and be continuing an Event of Default with respect to the Notes. To the extent that the Global Note is exchangeable pursuant to the preceding sentence, it shall be exchangeable for Notes registered in such names as the Depositary may direct. In the event of a deposit or withdrawal of an interest in this Note (including upon an exchange, transfer, redemption or repurchase of this Note in part only) effected in accordance with the Applicable Procedures, the Security Registrar, upon receipt of notice of such event from the Depositary's custodian for this Note, shall make an adjustment on its records to reflect an increase or decrease of the Outstanding principal amount of Notes of this series resulting from such deposit or withdrawal, as the case may be.

Unless the context otherwise requires, the Original Notes (as defined in the Indenture) and the Exchange Notes (as defined in the Indenture) shall constitute one series for all purposes under the Indenture, including without limitation, amendments, waivers and redemptions.

The Indenture permits, with certain exceptions as therein provided, the amendment thereof and the modification of the rights and obligations of the Company and the rights of the Holders of the Securities of each series to be affected under the Indenture at any time by the Company and the Trustee with the consent of the Holders of a majority in principal amount of the Securities at the time Outstanding of each series to be affected. The Indenture also contains provisions permitting the Holders of specified percentages in principal amount of the Securities at the time Outstanding, on behalf of the Holders of all Securities of such series, to waive compliance by the Company with certain provisions of the Indenture and certain past defaults under the Indenture and their consequences. Any such consent or waiver by the Holder of this Note shall be conclusive and binding upon such Holder and upon all future Holders of this Note and of any Note issued upon the registration of transfer hereof or in exchange hereof or in lieu hereof, whether or not notation of such consent or waiver is made upon this Note.

As provided in and subject to the provisions of the Indenture, the Holder of this Note shall not have the right to institute any proceeding with respect to the Indenture or for the appointment of a receiver or trustee or for any other remedy thereunder, unless such Holder shall have previously given the Trustee written notice of a continuing Event of Default with respect to the Notes of this series, the Holders of not less than 25% in principal amount of the Notes of this series at the time Outstanding shall have made written request to the Trustee to institute proceedings in respect of such Event of Default as Trustee and offered the Trustee reasonable indemnity, and the Trustee shall not have received from the Holders of a majority in principal amount of Notes of this series at the time Outstanding a direction inconsistent with such request, and shall have failed to institute any such proceeding, for 60 days after receipt of such notice, request and offer of indemnity. The foregoing shall not apply to any suit instituted by the Holder of this Note for the enforcement of any payment of principal hereof or any premium or interest hereon on or after the respective due dates expressed herein.

No reference herein to the Indenture and no provision of this Note or of the Indenture shall alter or impair the obligation of the Company, which is absolute and unconditional, to pay the principal of (and premium, if any) and interest on this Note at the times, place and rate, and in the coin or currency, herein prescribed.

As provided in the Indenture and subject to certain limitations therein set forth, the transfer of this Note is registrable in the Security Register, upon surrender of this Note for registration of transfer at the office or agency of the Company in any place where the principal of and any premium and interest on this Note are payable, duly endorsed by, or accompanied by a written instrument of transfer in form satisfactory to the Company and the Security Registrar duly executed by, the Holder hereof or his attorney duly authorized in writing, and thereupon one or more new Notes of this series and of like tenor, of authorized denominations and for the same aggregate principal amount, will be issued to the designated transferee or transferees.

The Notes of this series are issuable only in fully registered form without coupons in denominations of $1,000 and any integral multiple thereof. As provided in the Indenture and subject to certain limitations therein set forth, the Notes of this series are exchangeable for a like aggregate principal amount of Notes of this series and of like tenor of a different authorized denomination, as requested by the Holder surrendering the same.

No service charge shall be made for any such registration of transfer or exchange, but the Company may require payment of a sum sufficient to cover any tax or other governmental charge payable in connection therewith.

Prior to due presentment of this Note for registration of transfer, the Company, the Trustee and any agent of the Company or the Trustee may treat the Person in whose name this Note is registered as the owner hereof for all purposes, whether or not this Note be overdue, and neither the Company, the Trustee nor any such agent shall be affected by notice to the contrary.

All terms used in this Note which are defined in the Indenture shall have the meanings assigned to them in the Indenture.

The Indenture and this Note shall be governed by and construed in accordance with the laws of the State of New York, without regard to conflicts of laws principles thereof.

Section 2.4 ***Form of Trustee's Certificate of Authentication of the Notes***

The Trustee's certificates of authentication shall be in substantially the following form:

This is one of the Notes of the series designated therein referred to in the within-mentioned Indenture.

Dated: THE BANK OF NEW YORK, as Trustee

By: _____
Authorized Signatory

Section 2.5 ***Title and Terms***

The Notes shall be issued in one series and shall be known and designated as the "9.250% Senior Notes due 2015" of the Company. The aggregate principal amount of the Notes that may initially be authenticated and delivered under this Eighth Supplemental Indenture is limited to $800,000,000, except for Notes authenticated and delivered upon registration of transfer of, or in exchange for, or in lieu of, other Notes pursuant to Section 304, 305, 306 or 906 of the Existing Indenture or Article Two of this Eighth Supplemental Indenture. The Company may, without the consent of the Holders of the Notes, issue additional notes having the same ranking, interest rate, Stated Maturity, CUSIP number and terms as to status, redemption or otherwise as the Notes, in which event such notes, the Original Notes and the Exchange Notes shall constitute one series for all purposes under the Indenture, including without limitation, amendments, waivers and redemptions.

The Stated Maturity of the Notes shall be February 1, 2015, and they shall bear interest and have such other terms as are described in Sections 2.2 and 2.3 of this Eighth Supplemental Indenture.

The Company shall have no obligation to redeem or purchase the Notes pursuant to any sinking fund or analogous provision, or at the option of a Holder thereof. The Notes shall be redeemable at the election of the Company, as a whole or from time to time in part at the times and at the prices specified in the form of Note set forth in Section 2.3 of this Eighth Supplemental Indenture.

The Notes shall be subject to the defeasance and discharge provisions of Section 1302 of the Existing Indenture and the defeasance of certain obligations and certain events of default provisions of Section 1303 of the Existing Indenture.

Upon their original issuance, the Notes shall be issued in the form of one or more Global Notes, as provided in this Eighth Supplemental Indenture, registered in the name of The Depository Trust Company, as Depositary, or its nominee and deposited with the Trustee, as custodian for The Depository Trust Company, for credit by The Depository Trust Company to the respective accounts of beneficial owners of the Notes represented thereby (or such other accounts as they may direct). The Global Notes shall bear the legends provided for in the form of Note contained in Section 2.2 of this Eighth Supplemental Indenture and may be exchanged in whole or in part for Notes registered, and transfers of Global Notes in whole or in part may be registered, in the name or names of Persons other than the Depositary only as set forth herein and in the Indenture.

Subject to the limitations set forth in this Indenture, the Company may, without the consent of the Holders, issue additional Notes under this Indenture having the same terms in all respects as such Notes or similar in all respects to such Notes except for payment of interest (1) scheduled and paid prior to the date of issuance of those additional Notes or (2) payable on the first interest payment date following the date of their issuance. All Notes issued under this Indenture shall be treated as a single class for all purposes hereunder.

The Notes shall have the benefit of the covenants set forth in Article Three of this Eighth Supplemental Indenture, in addition to the covenants set forth in Article Ten of the Existing Indenture. Unless the context otherwise requires, the Original Notes and the Exchange Notes shall constitute one series for all purposes under the Indenture, including without limitation, amendments, waivers and redemptions.

The Notes shall be issuable only in registered form without coupons and only in denominations of $1,000 and integral multiples thereof.

The Notes shall be executed, authenticated, delivered and dated in accordance with Section 303 of the Existing Indenture.

Section 2.6 ***Restricted Securities Legend***

(a) Subject to the following clauses of this Section 2.6, Restricted Notes and their respective Successor Securities shall bear the legends required by Section 2.2 hereof (the "Restricted Securities Legend"). Registered Notes shall not bear the legend required for Restricted Securities. The Security Registrar shall distinguish between Restricted Notes and Registered Notes in the Security Register.

(b) At any time after a Restricted Note may be freely transferred without registration under the Securities Act or without being subject to transfer restrictions pursuant to the Securities Act, a new Note which does not bear a Restricted Securities Legend may be issued in exchange for or in lieu of such Note or any portion thereof if there is delivered to the Company such satisfactory evidence, which may include an opinion of independent counsel licensed to practice law in the State of New York, as the Company may require in its sole discretion, or the Company otherwise determines in its sole discretion that neither the Restricted Securities Legend nor the restrictions on transfer set forth therein are required to ensure that transfers of such Note will not violate the registration requirements of the Securities Act. The Trustee, at the written direction of the Company, shall authenticate and deliver in exchange for such Note another Note or Notes having an equal aggregate principal amount that does not bear the Restricted Securities Legend as provided in the Indenture.

(c) Notwithstanding the foregoing provisions of this Section 2.6, a Successor Security of a Note that does not bear a Restricted Securities Legend shall not bear such legend unless the Company has reasonable cause to believe that such Successor Security is a "restricted security" within the meaning of Rule 144 under the Securities Act, in which case the Trustee, at the written direction of the Company, shall authenticate and deliver the Successor Security bearing a Restricted Securities Legend as provide in this Indenture.

ARTICLE III
COVENANTS

Section 3.1 ***Limitations on Liens***

Nothing in this Indenture or in the Notes shall in any way restrict or prevent the Company or any Subsidiary from incurring any debt; provided that the Company covenants and agrees that neither it nor any Subsidiary will issue, incur, create, assume or guarantee any debt secured by Liens upon any Principal Property, without effectively providing that the Notes then Outstanding and thereafter created (together with, if the Company so determines, any other debt then existing and any other debt thereafter created ranking equally with the Notes) shall be secured equally and ratably with, or prior to, such debt as long as such debt shall be so secured, except that the foregoing provisions shall not apply to:

(a) (i) Liens securing all or any part of the purchase price or the cost of construction of property acquired or constructed by the Company or a Subsidiary, provided such debt and related Lien are incurred within 12 months after acquisition, or completion of construction and full operation, whichever is later;

(ii) Liens on property owned by the Company or a Subsidiary securing all or any part of the purchase price or the cost of construction of additions, substantial repairs or alterations or substantial improvements to such property, provided such debt and related Lien are incurred within 12 months after the completion of such construction, additions, repairs, alterations or improvements;

(b) Liens existing on property at the time of acquisition of such property by the Company or a Subsidiary or on the property of an entity at the time of the acquisition of such entity by the Company or a Subsidiary (including acquisitions through merger or consolidation), *provided* that such Liens were in existence prior to the closing of, and not incurred in contemplation of, such acquisition and, in the case of the acquisition of an entity, the Liens do not extend to any assets other than those of the entity acquired;

(c) In the case of a Consolidated Subsidiary, Liens in favor of the Company or another Consolidated Subsidiary;

(d) Liens existing on the date of this Eighth Supplemental Indenture;

(e) Liens in favor of a government or governmental entity that:

(i) secure debt that is guaranteed by the government or governmental entity, or

(ii) secure debt incurred to finance all or some of the purchase price or cost of construction of goods, products or facilities produced under contract or subcontract for the government or governmental entity;

(f) Liens arising in connection with the transfer of tax benefits in accordance with Section 168(f)(8) of the Code (or any similar provision of law from time to time in effect); provided, that such Liens (i) are incurred within 90 days (or any longer period, not in excess of one year, as any such provision of law may from time to time permit) after the acquisition of the property or equipment subject to said Lien, (ii) do not extend to any other property or equipment, and (iii) are solely for the purpose of said transfer of tax benefits or otherwise permitted by this Section 3.1;

(g) Liens created in substitution of or as replacements for any Liens permitted by clauses (a) to (f) set forth herein, provided that, based on a good faith determination of the Board of Directors of the Company, the property encumbered by any substitute or replacement Lien is substantially similar in nature to and no greater in value than the property encumbered by the otherwise permitted Lien that is being replaced; and

(h) Any extension, renewal or replacement (or successive extensions, renewals or replacements), in whole or in part, of any Lien referred to in the foregoing clauses (a) to (g) inclusive or of any debt secured thereby; provided that the principal amount of debt secured thereby shall not exceed the principal amount of debt so secured at the time of such extension, renewal or replacement, and that such extension, renewal or replacement Lien shall be limited to all or part of the same property that secured the Lien extended, renewed or replaced (plus improvements on such property).

Section 3.2 ***Limitations on Sale and Lease-Back Transactions***

The Company covenants and agrees that neither it nor any Subsidiary will enter into any arrangement with any Person (other than the Company or a Subsidiary), or to which any such Person is a party, providing for the leasing to the Company or a Subsidiary for a period of more than three years of any Principal Property that has been or is to be sold or transferred by the Company or such Subsidiary to such Person or to any other Person (other than the Company or a Subsidiary), to which the funds have been or are to be advanced by such Person on the security of the leased property (herein referred to as "Sale and Lease-Back Transactions") unless either:

(i) the Company or such Subsidiary would be entitled, pursuant to Section 3.1, to incur debt secured by a Lien on the property to be leased, without equally and ratably securing the Notes, or

(ii) the Company (and in any such case the Company covenants and agrees that it will do so) during or immediately after the expiration of 120 days after the effective date of such Sale and Lease-Back Transaction (whether made by the Company or a Subsidiary) applies an amount equal to the value of such Sale and Leaseback Transaction to the acquisition, construction, addition, reparation, alteration or improvement of a Principal Property and/or to the voluntary retirement of any debt of the Company which would be defined as long-term debt on a balance sheet prepared in accordance with generally accepted accounting principles.

For purposes of this Section 3.2, the term "value" shall mean, with respect to a Sale and Lease-Back Transaction, as of any particular time, the amount equal to the net proceeds of the sale or transfer of the property leased pursuant to such Sale and Lease-Back Transaction divided first by the number of full years of the term of the lease and then multiplied by the number of full years of such term remaining at the time of determination, without regard to any renewal or extension options contained in the lease.

Section 3.3 ***Exception to Limitations***

Notwithstanding the provisions of Sections 3.1 and 3.2, the Company and any Subsidiary may issue, incur, create, assume or guarantee debt secured by Liens and enter into Sale and Lease-Back Transactions that would otherwise be subject to the restrictions in Sections 3.1 and 3.2, respectively, provided (a) the aggregate outstanding principal amount of all other debt of the Company and its Subsidiaries that is subject to the restrictions in Section 3.1 (not including debt permitted to be secured under clauses (a) to (f) inclusive of Section 3.1), plus (b) the aggregate Attributable Debt in respect of the Sale and Lease-Back Transactions in existence at such time (not including Sale and Lease-Back Transactions permitted by Section 3.2(i) or (ii)), does not exceed 15% of the Consolidated Net Tangible Assets.

Section 3.4 ***Waiver of Certain Covenants***

The Company may, with respect to the Notes, omit in any particular instance to comply with any term, provision or condition set forth in any particular instance to comply with any term, provision or condition set forth in any covenant in any of Sections 3.1 or 3.2, if before the time for such compliance the Holders of at least a majority in principal amount of the Outstanding Notes shall, by Act of such Holders, either waiver such compliance in such instance or generally waive compliance with such term, provision or condition, but no such waiver shall extend to or effect such term, provision or condition except to the extent so expressly waived, and, until such waiver shall become effective, the obligations of the Company and the duties of the Trustee in respect of any such term, provision or condition shall remain in full force and effect. No supplemental indenture shall, without the consent of the Holder of each Outstanding Note affected thereby, modify any of the provisions of this Section 3.4, except to increase the percentage required to waive compliance by the Company of the covenants referenced here, provided, however, that this clause shall not be deemed to require the consent of any Holder with respect to changes in the references to "the Trustee" and concomitant changes in this Section 3.4.

ARTICLE IV
MISCELLANEOUS

Section 4.1 ***Conditions Precedent***

The effectiveness of this Eighth Supplemental Indenture is conditioned upon the receipt by the Trustee of the items specified in Section 903 of the Existing Indenture.

Section 4.2 ***Relationship to Existing Indenture***

The Eighth Supplemental Indenture is a supplemental indenture within the meaning of the Existing Indenture. The Existing Indenture, as supplemented and amended by this Eighth Supplemental Indenture, is in all respects ratified, confirmed and approved and, with respect to the Notes, the Existing Indenture, as supplemented and amended by this Eighth Supplemental Indenture, shall be read, taken and construed as one and the same instrument.

Section 4.3 ***Modification of the Existing Indenture***

Except as expressly modified by this Eighth Supplemental Indenture, the provisions of the Existing Indenture shall govern the terms and conditions of the Notes.

Section 4.4 ***Governing Law***

This instrument shall be governed by and construed in accordance with the laws of the State of New York, without regard to conflicts of laws principles thereof.

Section 4.5 ***Counterparts***

This instrument may be executed in any number of counterparts, each of which so executed shall be deemed to be an original, but all such counterparts shall together constitute but one and the same instrument.

In Witness Whereof, the parties hereto have caused this Eighth Supplemental Indenture to be duly executed all as of the day and year first above written.

TENET HEALTHCARE CORPORATION

By /s/ STEPHEN D. FARBER

Name: Stephen D. Farber
Title: Chief Financial Officer

THE BANK OF NEW YORK, as Trustee

By: /s/ MICHAEL PITFICK

Name: Michael Pitfick
Title: Vice President

QuickLinks

Eighth Supplemental Indenture
ARTICLE I DEFINITIONS AND OTHER PROVISIONS OF GENERAL APPLICATION
ARTICLE II GENERAL TERMS AND CONDITIONS OF THE NOTES
ARTICLE III COVENANTS
ARTICLE IV MISCELLANEOUS

Exhibit 10(c)

CREDIT AGREEMENT

dated as of

December 31, 2004

among

Tenet Healthcare Corporation,

The Lenders,

Citicorp USA, Inc.,
as Syndication Agent

and

Bank of America, N.A.
as Administrative Agent and LC Issuing Bank

Arranged by:

Banc of America Securities LLC
and
Citigroup Global Markets Inc.
as Joint Lead Arrangers and Joint Book Managers

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[All schedules and exhibits are omitted from this filing.]

CREDIT AGREEMENT

CREDIT AGREEMENT dated as of December 31, 2004 among TENET HEALTHCARE CORPORATION, a Nevada corporation, the Lenders, Citicorp USA, Inc., as Syndication Agent and Bank of America, N.A., as Administrative Agent and LC Issuing Bank.

The parties hereto agree as follows:

ARTICLE 1
DEFINITIONS

Section 1.01 *Definitions*.

The following terms, as used herein, have the following meanings:

"*Administrative Agent*" means Bank of America, N.A., in its capacity as Administrative Agent for the Lenders hereunder, and its successors in such capacity.

"*Administrative Agent Fee Letter*" means the letter agreement dated December 31, 2004 among the Borrower and the Administrative Agent.

"*Administrative Questionnaire*" means, with respect to each Lender, an administrative questionnaire in the form prepared by the Administrative Agent and submitted to the Administrative Agent (with a copy to the Borrower) duly completed by such Lender.

"*Affiliate*" means, with respect to any Person, (i) any Person that directly, or indirectly through one or more intermediaries, controls such Person (a "*Controlling Person*") or (ii) any Person which is controlled by or is under common control with a Controlling Person. As used herein, the term "*control*" means possession, directly or indirectly, of the power to direct or cause the direction of the management of a Person by voting securities, by contract or otherwise.

"*Aggregate LC Exposure*" means at any time the sum, without duplication, of (i) the aggregate amount that is (or may thereafter become) available for drawing under all Letters of Credit outstanding at such time and (ii) the aggregate unpaid amount of all LC Reimbursement Obligations outstanding at such time.

"*Approved Fund*" means any Fund that is managed (whether as manager or administrator) by (i) a Lender, (ii) an affiliate of a Lender or (iii) an entity or an affiliate of an entity that administers or manages a Lender.

"*Assignment of Collateral Account*" means that certain Assignment of Collateral Account and Security Agreement dated as of the Closing Date executed by the Borrower in favor of the Administrative Agent, as amended or modified from time to time.

"*Availability Period*" means the period from and including the Closing Date to but excluding the Termination Date.

"*Bank of America*" means Bank of America, N.A. and its successors.

"*BAS*" means Banc of America Securities LLC or its successor.

"*Base Rate*" means, for any day, a rate per annum equal to the higher of (i) the Prime Rate for such day and (ii) the sum of $^{1}/_{2}$ of 1% plus the Federal Funds Rate for such day.

"*Borrower*" means Tenet Healthcare Corporation, a Nevada corporation, and its successors.

"*Borrower's Existing Credit Agreement*" means the Five Year Credit Agreement dated as of March 1, 2001, as amended, among the Borrower, the lenders party thereto, JPMorgan Chase Bank, N.A. (as successor to Morgan Guaranty Trust Company of New York), as administrative agent and the other agents party thereto as in effect immediately before the Closing Date.

"*Closing Date*" means December 31, 2004.

"*Collateral*" means the collective reference to all property with respect to which liens in favor of the Administrative Agent are granted pursuant to and in accordance with the Security Documents.

"*Commitment*" means (i) with respect to any Lender listed on the Commitment Schedule, the amount set forth opposite its name on the Schedule 1.01 as its Commitment or (ii) with respect to any Eligible Assignee, the amount of the transferor Lender's Commitment assigned to such Eligible Assignee pursuant to Section 9.06(c), as such amount may be changed as result of an assignment pursuant to Section 9.06(c).

"*Commitment Percentage*" means, with respect to any Lender at any time, the percentage which the amount of such Lender's Commitment at such time represents of the aggregate amount of all of the Lenders' Commitments at such time. At any time after the Commitments shall have terminated, the term "*Commitment Percentage*" shall refer to a Lender's Commitment Percentage immediately before such termination, adjusted to reflect any subsequent assignments pursuant to Section 9.06(c).

"*Commitment Schedule*" means the Commitment Schedule in Schedule 1.01 attached hereto.

"*Continuing Director*" means (i) any individual who is a director of the Borrower on the date of this Agreement and (ii) any individual who becomes a director of the Borrower after the date of this Agreement and is elected or nominated for election as a director of the Borrower by a majority of the individuals who were Continuing Directors immediately before such election or nomination.

"*Credit Exposure*" means, with respect to any Lender at any time, (i) the amount of its Commitment at such time or (ii) if its Commitment shall have terminated, an amount equal to its LC Exposure at such time.

"*Credit Parties*" means the Borrower and the Subsidiary Guarantors, and "Credit Party" means any one of them.

"*CUSA*" means Citicorp USA, Inc. or its successors.

"*Debt*" of any Person means at any date, without duplication, (i) all obligations of such Person for borrowed money, (ii) all obligations of such Person evidenced by bonds, debentures, notes or other similar instruments, (iii) all obligations of such Person to pay the deferred purchase price of property or services, except trade accounts payable arising in the ordinary course of business and deferred compensation payable to members of management of such Person, (iv) all obligations of such Person as lessee which are capitalized in accordance with GAAP, (v) all obligations pursuant to any Synthetic Lease, (vi) all Debt secured by a Lien on any asset of such Person, whether or not such Debt is otherwise an obligation of such Person (such Debt of such Person to be in a principal amount equal to the lesser of (x) the outstanding principal amount of the Debt so secured and (y) the book value of such asset or assets) and (vii) all Guarantees by such Person of obligations of other Persons of the types described in the foregoing clauses (i) through (vi), inclusive (any such Guarantee to be included in any calculation of the amount of such Person's Debt at an amount equal to the principal amount guaranteed thereby). If such Person Guarantees Debt of another Person by causing a letter of credit to be issued in support thereof, the "Debt" of such Person includes (without duplication) such Person's obligation to reimburse the issuing bank for drawings (including any future drawings) in respect of principal under such letter of credit.

"*Default*" means any condition or event which constitutes an Event of Default or which with the giving of notice or lapse of time or both would, unless cured or waived, become an Event of Default.

"*Domestic Business Day*" means any day except a Saturday, Sunday or other day on which commercial banks are authorized by law to close in the state where the Administrative Agent's Office is located, as set forth on Schedule 9.01.

"*Domestic Hospital Subsidiary*" means each Domestic Subsidiary that (i) owns or operates a hospital facility (other than any such facility with respect to which the Borrower publicly announced on or before January 28, 2004 the discontinuation of operations) or (ii) owns an Investment in a Domestic Hospital Subsidiary.

"*Domestic Subsidiary*" means each Subsidiary which is not a "controlled foreign corporation" within the meaning of the Internal Revenue Code.

"*Domestic Lending Office*" means, as to each Lender, its office located at its address set forth in its Administrative Questionnaire (or identified in its Administrative Questionnaire as its Domestic Lending Office) or such other office as such Lender may hereafter designate as its Domestic Lending Office by notice to the Borrower and the Administrative Agent.

"*Eligible Assignee*" means (a) a Lender; (b) an affiliate of a Lender; (c) an Approved Fund; and (d) any other Person (other than a natural Person) approved by the Administrative Agent and the LC Issuing Bank, and unless an Event of Default has occurred and is continuing, the Borrower (each such approval not to be unreasonably withheld or delayed). If the consent of the Borrower to an assignment or to an Eligible Assignee is required hereunder (including a consent to an assignment which does not meet the minimum assignment amount threshold), the Borrower shall be deemed to have given its consent five Domestic Business Days after the date notice thereof has been delivered to the Borrower by the assigning Lender (through the Administrative Agent) unless such consent is expressly refused by the Borrower prior to such fifth Domestic Business Day.

"*Environmental Laws*" means any and all federal, state and local statutes, laws, judicial decisions, regulations, ordinances, rules, judgments, orders, decrees, plans, injunctions, permits, concessions, grants, franchises, licenses, agreements and other governmental restrictions relating to the environment, the effect of the environment on human health or to emissions, discharges or releases of pollutants, contaminants, Hazardous Substances or wastes into the environment including, without limitation, ambient air, surface water, ground water or land, or otherwise relating to the manufacture, processing, distribution, use, treatment, storage, disposal, transport or handling of pollutants, contaminants, Hazardous Substances or wastes or the clean-up or other remediation thereof.

"*Equity Interest*" means (i) in the case of a corporation, any shares of its capital stock, (ii) in the case of a partnership, any partnership interest (whether general or limited), (iii) in the case of any other business entity, any participation or other interest in the equity or profits thereof or (iv) any warrant, option or other right to acquire any Equity Interest described in the foregoing clauses (i), (ii) and (iii), other than a right to convert a debt security into, or exchange a debt security for, any such Equity Interest.

"*ERISA*" means the Employee Retirement Income Security Act of 1974, as amended, or any successor statute.

"*ERISA Group*" means the Borrower, its Subsidiaries and all members of a controlled group of corporations and all trades or businesses (whether or not incorporated) under common control which, together with the Borrower or any Subsidiary, are treated as a single employer under Section 414 of the Internal Revenue Code.

"*Events of Default*" has the meaning set forth in Section 6.01.

"*Exchange Act*" means the Securities Exchange Act of 1934, as amended.

"*Existing Letters of Credit*" means those standby letters of credit identified on Schedule 3.03.

"*Federal Funds Rate*" means, for any day, the rate per annum (rounded upward, if necessary, to a whole multiple of 1/100 of 1%) equal to the weighted average of the rates on overnight Federal funds transactions with members of the Federal Reserve System arranged by Federal funds brokers on such day, as published by the Federal Reserve Bank of New York on the Domestic Business Day next succeeding such day; *provided* that (a) if such day is not a Domestic Business Day, the Federal Funds Rate for such day shall be such rate on such transactions on the next preceding Domestic Business Day as so published on the next succeeding Domestic Business Day, and (b) if no such rate is so published on such next succeeding Domestic Business Day, the Federal Funds Rate for such day shall be the average rate charged to Bank of America on such day on such transactions as determined by the Administrative Agent.

"*Fee Letter*" means the letter agreement dated December 31, 2004 among the Borrower, the Administrative Agent, BAS, CUSA and Citigroup Global Markets Inc.

"*Financial Obligations*" of any Person means at any date, without duplication:

(i) Debt of such Person,

(ii) all obligations of such Person to reimburse any bank or other Person in respect of amounts paid under a letter of credit or similar instrument or to make any payment pursuant to a Hedging Obligation, and

(iii) all Guarantees by such Person of Financial Obligations of other Persons of the types described in clauses (i) and (ii) of this definition.

"*Financing Documents*" means this Agreement (including the Schedules and Exhibits hereto), the Letters of Credit, the Security Documents, the Fee Letter, and the Administrative Agent Fee Letter, and "Financing Document**"**means any one of them.

"*Fiscal Quarter*" means a fiscal quarter of the Borrower.

"*Fiscal Year*" means a fiscal year of the Borrower.

"*Fund*" means any Person (other than a natural Person) that is (or will be) engaged in purchasing, holding or otherwise investing in revolving commercial loans in the ordinary course of its business.

"*GAAP*" means at any time generally accepted accounting principles as then in effect in the United States, applied on a basis consistent (except for changes with which the Borrower's independent public accountants have concurred) with the most recent audited consolidated financial statements of the Borrower and its Subsidiaries theretofore delivered to the Lenders.

"*Governmental Authority*" means any nation or government, any state or other political subdivision thereof, any agency, authority, instrumentality, regulatory body, court, administrative tribunal, central bank or other entity exercising executive, legislative, judicial, taxing, regulatory or administrative powers or functions of or pertaining to government.

"*Guarantee*" by any Person means any obligation, contingent or otherwise, of such Person directly or indirectly guaranteeing any Debt or other payment obligation of any other Person, including without limiting the generality of the foregoing, any obligation, direct or indirect, contingent or otherwise, of such Person (i) to purchase or pay (or advance or supply funds for the purchase or payment of) such Debt or other payment obligation (whether arising by virtue of partnership arrangements, by agreement to keep-well, to purchase assets, goods, securities or services, to take-or-pay, or to maintain financial statement conditions or otherwise) or (ii) entered into for the purpose of assuring in any other manner the obligee of such Debt or other payment obligation of the payment thereof or to protect such obligee against loss in respect thereof (in whole or in part), *provided* that the term Guarantee shall not include endorsements for collection or deposit in the ordinary course of business. The term "*Guarantee*" used as a verb has a corresponding meaning.

"*Guarantee and Pledge Agreement*" means that certain Guarantee and Pledge Agreement dated as of the Closing Date executed in favor of the Administrative Agent by each of the Credit Parties, as amended or modified from time to time.

"*Hazardous Substances*" means any toxic, radioactive, caustic or otherwise hazardous substance, including petroleum, its derivatives, by-products and other hydrocarbons, or any substance having any constituent elements displaying any of the foregoing characteristics.

"*Healthcare Business*" means any going concern healthcare business or any other going concern business that is related or ancillary to one or more Healthcare Facilities or healthcare businesses.

"*Healthcare Facility*" means a hospital, outpatient clinic, long-term care facility, medical office building or other comparable facility that is used or useful in providing healthcare services.

"*Hedging Obligation*" means, with respect to any Person, any obligation of such Person under (i) any interest rate swap agreement, interest rate cap agreement or interest rate collar agreement, (ii) any foreign exchange contract or currency swap agreement or (iii) any other agreement or arrangement of a type designed to protect a Person against fluctuations in interest rates or currency exchange rates.

"*Indemnitee*" has the meaning set forth in Section 9.03(b).

"*Internal Revenue Code*" means the Internal Revenue Code of 1986, as amended, or any successor statute.

"*Investment*" means, with respect to any Person, any investment by such Person in any other Person (including an Affiliate) in the form of loans, capital contributions (excluding commission, travel and similar advances to officers and employees made in the ordinary course of business), purchases or other acquisitions for consideration of Debt, Equity Interests or other securities and all other items that are or would be classified as investments on a balance sheet prepared in accordance with GAAP.

"*LC Exposure*" means, with respect to any Lender at any time, an amount equal to its Commitment Percentage of the Aggregate LC Exposure at such time.

"*LC Fee Rate*" means, at any date, a rate per annum equal to 1.5%.

"*LC Indemnitees*" has the meaning set forth in Section 2.01(l).

"*LC Issuing Bank*" means Bank of America in its capacity as issuer of the Letters of Credit hereunder, or any successor or assign.

"*LC Office*" means, with respect to the LC Issuing Bank, the office at which it books the Letters of Credit.

"*LC Payment Date*" has the meaning set forth in Section 2.01(h).

"*LC Reimbursement Due Date*" has the meaning set forth in Section 2.01(i).

"*LC Reimbursement Obligations*" means, at any time, all obligations of the Borrower to reimburse the LC Issuing Bank for amounts paid by the LC Issuing Bank in respect of drawings under Letters of Credit, including any portion of any such obligation to which a Lender has become subrogated pursuant to Section 2.01(j).

"*Lender*" means each lender listed on the Commitment Schedule, each Eligible Assignee which becomes a Lender pursuant to Section 9.06(c), and their respective successors.

"*Lending Parties*" means the Lenders, the LC Issuing Bank and the Administrative Agent.

"*Letter of Credit*" means a standby letter of credit issued hereunder by the LC Issuing Bank and shall include the Existing Letters of Credit.

"*Lien*" means, with respect to any asset, any mortgage, lien, pledge, charge, security interest or encumbrance of any kind, or any other type of preferential arrangement that has substantially the same practical effect as a security interest, in respect of such asset. For purposes of this Agreement, the Borrower or any Subsidiary shall be deemed to own subject to a Lien any asset which it has acquired or holds subject to the interest of a vendor or lessor under any conditional sale agreement, capital lease or other title retention agreement relating to such asset.

"*Material Adverse Effect*" means a material adverse effect on the business, operations, properties, financial condition or prospects of the Borrower and its Subsidiaries, considered as a whole.

"*Material Financial Obligations*" means non-contingent Financial Obligations (other than the LC Reimbursement Obligations) of the Borrower and/or one or more Subsidiaries, arising in one or more related transactions, in an aggregate principal or face amount exceeding $70,000,000; *provided* that, for purposes of this definition and clause (g) of Section 6.01, (i) contingent obligations of the Borrower or any Subsidiary to reimburse a bank or other Person for amounts not yet drawn under a letter of credit or similar instrument shall be deemed to be non-contingent (and to have been accelerated) if they are required to be prepaid or cash collateralized as a result of a default under the relevant reimbursement agreement, (ii) contingent obligations of the Borrower or any Subsidiary under any Hedging Obligation shall be deemed to be non-contingent (and to have been accelerated) if such Hedging Obligation is terminated by reason of a default by the Borrower or any Subsidiary and (iii) in no event shall the Metrocrest Lease, or any obligation of the Borrower or any of its Subsidiaries thereunder or with respect thereto or under or with respect to any financing of the Healthcare Facility subject to the Metrocrest Lease by the Metrocrest Hospital Authority or any successor owner of such facility, constitute a Material Financial Obligation.

"*Material Plan*" means at any time a Plan or Plans having aggregate Unfunded Liabilities in excess of $70,000,000.

"*Material Subsidiary*" means any Subsidiary of the Borrower, except a Subsidiary that has assets of less than $70,000,000 and liabilities of less than $70,000,000.

"*Metrocrest Lease*" means the Fifth Amendment and Restatement of Lease Agreement dated as of November 1, 1994 between Metrocrest Hospital Authority, as lessor, and Tenet HealthSystems Hospitals Dallas, Inc. (formerly NME Hospitals Dallas, Inc.), as lessee, as the same has been or may be amended, restated, modified, renewed or replaced from time to time, which Metrocrest Lease shall be limited to the lease of the RHD Memorial Medical Center, the Trinity Medical Center and related facilities, including, without limitation, medical office buildings and parking structures.

"*Metrocrest Reimbursement Agreement*" means the Letter of Credit and Reimbursement Agreement dated as of November 1, 1994 among the Borrower, the banks party thereto, and The Bank of New York, as Issuing Bank and Agent thereunder, as amended from time to time.

"*Multiemployer Plan*" means at any time an employee pension benefit plan within the meaning of Section 4001(a)(3) of ERISA to which any member of the ERISA Group is then making or accruing an obligation to make contributions or has within the preceding five plan years made contributions, including for these purposes any Person which ceased to be a member of the ERISA Group during such five year period.

"*Non-Recourse Purchase Money Debt*" of any Person means Debt incurred to finance additions to its property, plant and equipment (or to refinance Debt incurred for such purpose); *provided* that the lender or other obligee of such Debt has no recourse (except for breach of representations, warranties and/or covenants customary in asset-based financing) to assets of such Person, the Borrower or any Subsidiary other than the assets financed or refinanced by such Debt and cash flows attributable to such assets.

"*Organization Documents*" means, (a) with respect to any corporation, the certificate or articles of incorporation and the bylaws (or equivalent or comparable constitutive documents with respect to any non-U.S. jurisdiction); (b) with respect to any limited liability company, the certificate or articles of formation or organization and operating agreement; and (c) with respect to any partnership, joint venture, trust or other form of business entity, the partnership, joint venture or other applicable agreement of formation or organization and any agreement, instrument, filing or notice with respect thereto filed in connection with its formation or organization with the applicable Governmental Authority in the jurisdiction of its formation or organization and, if applicable, any certificate or articles of formation or organization of such entity.

"*Outstanding Committed Amount*" means, with respect to any Lender at any time, the sum of its LC Exposure, determined at such time after giving effect to any prior assignments by or to such Lender pursuant to Section 9.06(c).

"*Parent*" means, with respect to any Lender, any Person controlling such Lender.

"*Participant*" has the meaning set forth in Section 9.06(b).

"*Person*" means an individual, a corporation, a partnership, an association, a trust or any other entity or organization, including a government or political subdivision or an agency or instrumentality thereof.

"*Plan*" means at any time an employee pension benefit plan (other than a Multiemployer Plan) which is covered by Title IV of ERISA or subject to the minimum funding standards under Section 412 of the Internal Revenue Code and either (i) is maintained, or contributed to, by any member of the ERISA Group for employees of any member of the ERISA Group or (ii) has at any time within the preceding five years been maintained, or contributed to, by any Person which was at such time a member of the ERISA Group for employees of any Person which was at such time a member of the ERISA Group.

"*Prime Rate*" the rate of interest in effect for such day as publicly announced from time to time by Bank of America as its "prime rate." The "prime rate" is a rate set by Bank of America based upon various factors including Bank of America's costs and desired return, general economic conditions and other factors, and is used as a reference point for pricing some loans, which may be priced at, above, or below such announced rate. Any change in such rate announced by Bank of America shall take effect at the opening of business on the day specified in the public announcement of such change.

"*Regulation U*" means Regulation U of the Board of Governors of the Federal Reserve System, as in effect from time to time.

"*Related Parties*" means, with respect to any Person, such Person's Affiliates and the partners, directors, officers, employees, agents and advisors of such Person and of such Person's Affiliates.

"*Required Lenders*" means at any time Lenders having more than 50% of the aggregate amount of the Credit Exposures at such time.

"*Restricted Payment*" has the meaning set forth in Section 5.12.

"*SEC*" means the United States Securities and Exchange Commission.

"*Secured Obligations*" has the meaning specified in the Guarantee and Pledge Agreement.

"*Security Documents*" means the Guarantee and Pledge Agreement, the Assignment of Collateral Account and each other security agreement, instrument or document executed and delivered to secure any of the Secured Obligations.

"*Senior Officer of the Borrower*" means an Executive Vice President, a Senior Vice President or the Treasurer of the Borrower.

"*Subsidiary*" means, as to any Person at any date, any corporation or other entity the accounts of which would be consolidated with those of such Person in its consolidated financial statements if such statements were prepared as of such date in accordance with GAAP. Unless otherwise specified, "*Subsidiary*" means a Subsidiary of the Borrower.

"*Subsidiary Guarantors*" means each Domestic Hospital Subsidiary of the Borrower now existing or hereafter organized or acquired, other than Creighton Saint Joseph Regional Healthcare System, L.L.C. and TCC Partners.

"*Syndication Agent*" means Citicorp USA, Inc., and its successors in such capacity.

"*Synthetic Lease*" means a lease as to which (i) the obligations of the lessee are not capitalized in accordance with GAAP but (ii) the lessee is treated as owner of the leased property for purposes of the Internal Revenue Code.

"*Termination Date*" means December 31, 2005.

"*Unfunded Liabilities*" means, with respect to any Plan at any time, the amount (if any) by which (i) the value of all benefit liabilities under such Plan, determined on a plan termination basis using the assumptions prescribed by the PBGC for purposes of Section 4044 of ERISA, exceeds (ii) the fair market value of all Plan assets allocable to such liabilities under Title IV of ERISA (excluding any accrued but unpaid contributions), all determined as of the then most recent valuation date for such Plan, but only to the extent that such excess represents a potential liability of a member of the ERISA Group to the PBGC or any other Person under Title IV of ERISA.

"*United States*" means the United States of America, including the States and the District of Columbia, but excluding its territories and possessions.

Section 1.02 *Accounting Terms and Determinations*.

Unless otherwise specified herein, all accounting terms used herein shall be interpreted, all accounting determinations hereunder shall be made, and all financial statements required to be delivered hereunder shall be prepared in accordance with GAAP as in effect from time to time; *provided* that, if the Borrower notifies the Administrative Agent that the Borrower wishes to amend any provision hereof to eliminate the effect of any change in GAAP on the operation of such provision (or if the Administrative Agent notifies the Borrower that the Required Lenders wish to amend any provision hereof for such purpose), then such provision shall be applied on the basis of GAAP as in effect immediately before the relevant change in GAAP became effective, until either such notice is withdrawn or such provision is amended in a manner satisfactory to the Borrower and the Required Lenders.

ARTICLE 2
THE LETTERS OF CREDIT

Section 2.01 *Letters of Credit*.

(a) *Issuance*. The LC Issuing Bank agrees, on the terms and conditions set forth in this Agreement, to issue at the request of the Borrower the Letters of Credit that the LC Issuing Bank has agreed with the Borrower to issue; *provided* that (i) no Letter of Credit shall be issued after the date that is thirty days before the Termination Date and (ii) immediately after each such Letter of Credit is issued and participations therein are sold to the Lenders as provided in this subsection, no Lender's Outstanding Committed Amount shall exceed its Commitment. Whenever the LC Issuing Bank issues a Letter of Credit hereunder, the LC Issuing Bank shall be deemed, without further action by any party hereto, to have sold to each Lender (including the LC Issuing Bank in its capacity as a Lender), and each Lender shall be deemed, without further action by any party hereto, to have purchased from the LC Issuing Bank, a participation in such Letter of Credit, on the terms specified in this Section, equal to such Lender's Commitment Percentage thereof.

(b) *Notice of Proposed Issuance*. With respect to each Letter of Credit, the Borrower shall give the LC Issuing Bank and the Administrative Agent at least three Domestic Business Days' prior notice (i) specifying the date such Letter of Credit is to be issued and (ii) describing the proposed terms of such Letter of Credit and the nature of the transactions to be supported thereby. Promptly after it receives such notice, the Administrative Agent shall notify each Lender of the contents thereof.

(c) *Conditions to Issuance*. The LC Issuing Bank shall not issue any Letter of Credit unless:

(i) such Letter of Credit shall be satisfactory in form and substance to the LC Issuing Bank,

(ii) the Borrower shall have executed and delivered such other instruments and agreements relating to such Letter of Credit as the LC Issuing Bank shall have reasonably requested,

(iii) the LC Issuing Bank shall have confirmed with the Administrative Agent on the date of such issuance that the limitation specified in subsection (a)(ii) of this Section will not be exceeded immediately after such Letter of Credit is issued and

(iv) the LC Issuing Bank shall not have been notified in writing by the Borrower, the Administrative Agent or the Required Lenders that any condition specified in clause (b), (c) or (d) of Section 3.02 is not satisfied at the time such Letter of Credit is to be issued.

Furthermore, the LC Issuing Bank shall not be under any obligation to issue any Letter of Credit if:

(i) any order, judgment or decree of any Governmental Authority or arbitrator shall by its terms purport to enjoin or restrain the LC Issuing Bank from issuing such Letter of Credit, or any law applicable to the LC Issuing Bank or any request or directive (whether or not having the force of law) from any Governmental Authority with jurisdiction over the LC Issuing Bank shall prohibit, or request that the LC Issuing Bank refrain from, the issuance of letters of credit generally or such Letter of Credit in particular or shall impose upon the LC Issuing Bank with respect to such Letter of Credit any restriction, reserve or capital requirement (for which the LC Issuing Bank is not otherwise compensated hereunder) not in effect on the Closing Date, or shall impose upon the LC Issuing Bank any unreimbursed loss, cost or expense which was not applicable on the Closing Date and which the LC Issuing Bank in good faith deems material to it; or

(ii) the issuance of such Letter of Credit would violate one or more policies of the LC Issuing Bank.

(d) *Notice of Actual Issuance*. Promptly after it issues any Letter of Credit, the LC Issuing Bank shall notify the Administrative Agent of the date, face amount, beneficiary or beneficiaries and expiry date of such Letter of Credit. Promptly after it receives such notice, the Administrative Agent shall notify each Lender of the contents thereof and the amount of such Lender's participation in such Letter of Credit.

(e) *Expiry Dates*. No Letter of Credit (other than the Existing Letter identified on Schedule 2.01, the expiry date of which shall be automatically extended to January 31, 2006) shall have an expiry date later than the fifth Domestic Business Day before the Termination Date; provided, that the expiry date of any Letter of Credit may be extended at the Borrower's request delivered pursuant to Section 2.01(f) so long as such extension has been approved by all of the Lenders.

(f) *Notice of Proposed Extensions of Expiry Dates*. Such request by the Borrower for extension shall be delivered to the LC Issuing Bank and the Administrative Agent at least ten Domestic Business Days prior to the requested extension date (but such request shall not be permitted to be made sooner than 45 days prior to the existing expiry date of the applicable Letter of Credit and the Lenders shall not be requested to grant such request sooner than 30 days prior to the existing expiry date of the applicable Letter of Credit) and shall identify such Letter of Credit, the date on which the Borrower requests its extension and the date on which the Borrower desires the extension. Promptly after it receives such notice, the Administrative Agent shall notify each Lender of the contents thereof. The LC Issuing Bank shall only extend (or allow the extension of) the expiry date of any Letter of Credit if (i) such extension has been approved by all of the Lenders and (ii) the LC Issuing Bank shall not have been notified by the Administrative Agent or the Required Lenders that any condition specified in clause (b), (c) or (d) of Section 3.02 is not satisfied at the time of such proposed extension. If any Letter of Credit is not extended after request for extension thereof has been made by the Borrower, the Administrative Agent shall notify each Lender thereof. For the avoidance of doubt, it is agreed by the parties hereto that the Existing Letters of Credit that have automatic extension provisions will not be permitted to be extended by the LC Issuing Bank unless such extension is approved by the Lenders in their sole discretion.

(g) *Fees*.

(i) The Borrower shall pay to the Administrative Agent, for the account of the Lenders ratably in proportion to their Commitment Percentages, a letter of credit fee for each day at the LC Fee Rate for such day on the aggregate amount available for drawing (whether or not conditions for drawing have been satisfied) under all Letters of Credit outstanding at the close of business on such day (the "*Letter of Credit Fees*"). Such Letter of Credit Fee shall be payable with respect to each Letter of Credit in arrears on the last Domestic Business Day of each calendar quarter and on the Termination Date.

(ii) The Borrower shall pay directly to the LC Issuing Bank for its own account a fronting fee at the rate per annum specified in the Administrative Agent Fee Letter, computed on the actual daily maximum amount available to be drawn under such Letter of Credit (whether or not such maximum amount is then in effect under such Letter of Credit) and on a quarterly basis in arrears, and due and payable on the first Business Day after the end of each March, June, September and December, commencing with the first such date to occur after the issuance of such Letter of Credit, on the Termination Date and thereafter on demand. In addition, the Borrower shall pay directly to the LC Issuing Bank for its own account the customary issuance, presentation, amendment and other credit processing fees, and other standard costs and charges, of the LC Issuing Bank relating to letters of credit as from time to time in effect. Such customary fees and standard costs and charges are due and payable on demand and are nonrefundable.

(h) *Drawings*. If the LC Issuing Bank receives a demand for payment under any Letter of Credit and determines that such demand should be honored, the LC Issuing Bank shall (i) promptly notify the Borrower and the Administrative Agent as to the amount to be paid by the LC Issuing Bank as a result of such demand and the date of such payment (an "*LC Payment Date*") and (ii) make such payment in accordance with the terms of such Letter of Credit.

(i) *Reimbursement by the Borrower*.

(i) If any amount is drawn under any Letter of Credit, the Borrower irrevocably and unconditionally agrees to reimburse the LC Issuing Bank for such amount, together with any and all reasonable charges and expenses which the LC Issuing Bank may pay or incur relative to such drawing. Such reimbursement shall be due and payable on the relevant LC Payment Date or the date on which the LC Issuing Bank notifies the Borrower of such drawing, whichever is later; *provided* that, if such notice is given after 10:00 A.M. (New York City time) on the later of such dates, such reimbursement shall be due and payable on the next following Domestic Business Day (the date on which it is due and payable being an "*LC Reimbursement Due Date*").

(ii) In addition, the Borrower agrees to pay, on the applicable LC Reimbursement Due Date, interest on each amount drawn under a Letter of Credit, for each day from and including the date such amount is drawn to but excluding such LC Reimbursement Due Date, at the Base Rate for such day. The Borrower also agrees to pay, on demand, interest on any overdue amount (including any overdue interest) payable under this subsection (ii), for each day from and including the date when such amount becomes due to but excluding the date such amount is paid in full, at a rate per annum equal to the sum of 2% plus the Base Rate for such day.

(iii) Each payment by the Borrower pursuant to this subsection (i) shall be made to the LC Issuing Bank in Federal or other funds immediately available to it at its address referred to in Section 9.01.

(j) *Payments by Lenders*.

(i) If the Borrower fails to pay any LC Reimbursement Obligation in full when due, the Administrative Agent shall notify the Lenders of the unreimbursed amount and request that the Lenders reimburse the Administrative Agent, for the account of the LC Issuing Bank, for their respective Commitment Percentages thereof. Upon receiving such notice from the Administrative Agent, each Lender shall make available to the Administrative Agent, for the account of the LC Issuing Bank, at its address referred to in Section 9.01, an amount equal to such Lender's Commitment Percentage of such unreimbursed amount, in Federal or other funds immediately available to the Administrative Agent, for the account of the LC Issuing Bank, by 3:00 P.M. (New York City time) (A) on the date such Lender receives such notice if it is received at or before 12:00 Noon (New York City time) on such day or (B) on the next Domestic Business Day if such notice is received after 12:00 Noon (New York City time) on the date of receipt, in each case together with interest on such amount for each day from and including the relevant LC Payment Date to but excluding the day such payment is due from such Lender at the Federal Funds Rate for such day. Upon payment in full thereof, such Lender shall be subrogated to the rights of the LC Issuing Bank against the Borrower to the extent of such Lender's Commitment Percentage of the related LC Reimbursement Obligation (including interest accrued thereon).

(ii) If any Lender fails to pay when due any amount to be paid by it pursuant to clause (i) of this subsection, interest shall accrue on such Lender's obligation to make such payment, for each day from and including the date such payment became due to but excluding the date such Lender makes such payment, at a rate per annum equal to (x) for each day from the day such payment is due to the third succeeding Domestic Business Day, inclusive, the Federal Funds Rate for such day and (y) for each day thereafter the sum of 2% plus the Base Rate for such day.

(iii) If the Borrower shall reimburse the Administrative Agent, for the account of the LC Issuing Bank, for any drawing with respect to which any Lender shall have made funds available to the Administrative Agent, for the account of the LC Issuing Bank, in accordance with clause (i) of this subsection, the Administrative Agent, for the account of the LC Issuing Bank, shall promptly upon receipt of such reimbursement distribute to such Lender its Commitment Percentage thereof, including interest, to the extent received by the Administrative Agent, for the account of the LC Issuing Bank.

(k) *Exculpatory Provisions*. The Borrower's obligations under this Section shall be absolute and unconditional under any and all circumstances and irrespective of any setoff, counterclaim or defense to payment which the Borrower may have or have had against the LC Issuing Bank, any Lender, any beneficiary of any Letter of Credit or any other Person. The Borrower assumes all risks of the acts or omissions of any beneficiary of any Letter of Credit with respect to the use of such Letter of Credit by such beneficiary. None of the Lenders, the LC Issuing Bank, (in the absence of its own gross negligence or willful misconduct) and their respective officers, directors, employees and agents shall be responsible for, and the obligations of each Lender to make payments to the LC Issuing Bank and of the Borrower to reimburse the LC Issuing Bank for drawings pursuant to this Section (other than obligations resulting solely from the gross negligence or willful misconduct of the LC Issuing Bank) shall not be excused or affected by, among other things, (i) the use which may be made of any Letter of Credit or any acts or omissions of any beneficiary or transferee in connection therewith; (ii) the validity, sufficiency or genuineness of

documents presented under any Letter of Credit or of any endorsements thereon, even if such documents should in fact prove to be in any or all respects invalid, insufficient, fraudulent or forged; (iii) payment by the LC Issuing Bank against presentation of documents to it which do not comply with the terms of the relevant Letter of Credit or (iv) any dispute between or among the Borrower, any beneficiary of any Letter of Credit or any other Person or any claims or defenses whatsoever of the Borrower or any other Person against any beneficiary of any Letter of Credit. The LC Issuing Bank shall not be liable for any error, omission, interruption or delay in transmission, dispatch or delivery of any message or advice, however transmitted, in connection with any Letter of Credit. Any action taken or omitted by the LC Issuing Bank or any Lender in connection with any Letter of Credit and the related drafts and documents, if done without willful misconduct or gross negligence, shall be binding upon the Borrower and shall not place the LC Issuing Bank or any Lender under any liability to the Borrower.

(l) *Indemnification by Borrower*. The Borrower agrees to indemnify and hold harmless each Lender, the LC Issuing Bank and the Administrative Agent (collectively, the "*LC Indemnitees*") from and against any and all claims, damages, losses, liabilities, reasonable costs and reasonable expenses (including, without limitation, the reasonable fees and disbursements of counsel) which such LC Indemnitee may incur (or which may be claimed against such LC Indemnitee by any Person whatsoever) by reason of or in connection with any execution and delivery or transfer of or payment or failure to pay under any Letter of Credit or any actual or proposed use of any Letter of Credit; *provided* that the Borrower shall not be required to indemnify the LC Issuing Bank for any such claims, damages, losses, liabilities, costs or expenses to the extent, but only to the extent, caused by (i) its own willful misconduct or gross negligence or (ii) its failure to pay under any Letter of Credit issued by it after the presentation to it of a request strictly complying with the terms and conditions of such Letter of Credit. Nothing in this subsection is intended to limit the obligations of the Borrower under any other provision of this Section.

(m) *Indemnification by Lenders*. The Lenders shall, ratably in proportion to their Commitment Percentages, indemnify the LC Issuing Bank (to the extent not reimbursed by the Borrower) against any claims, damages, losses, liabilities, reasonable costs and reasonable expenses (including, without limitation, reasonable fees and disbursements of counsel) that any such indemnitee may suffer or incur in connection with this Section or any action taken or omitted by such indemnitee under this Section; *provided* that the Lenders shall not be required to indemnify the LC Issuing Bank for any such claims, damages, losses, liabilities, costs or expenses to the extent, but only to the extent, caused by (i) its own gross negligence or willful misconduct, (ii) its failure to pay under any Letter of Credit issued by it after the presentation to it of a request strictly complying with the terms and condition of such Letter of Credit, (iii) its liabilities under any Letter of Credit issued by it in contravention of clause (iii) (to the extent that the limitations referred to therein were in fact exceeded) or clause (iv) of subsection (c) of this Section or (iv) its liabilities under any Letter of Credit extended (or allowed to be automatically extended) by it in contravention of clause (i) or (ii) of subsection (f) of this Section.

(n) *Liability for Damages*. Nothing in this Section shall preclude the Borrower or any Lender from asserting against the LC Issuing Bank any claim for direct (but not consequential) damages suffered by the Borrower or such Lender to the extent, but only to the extent, caused by (A) the willful misconduct or gross negligence of the LC Issuing Bank in determining whether a request presented under any Letter of Credit issued by it complied with the terms thereof or (B) the LC Issuing Bank's failure to pay under any such Letter of Credit after the presentation to it of a request strictly complying with the terms and conditions thereof.

(o) *Dual Capacities*. In its capacity as a Lender, the LC Issuing Bank shall have the same rights and obligations under this Section as any other Lender.

(p) *Letter of Credit Amounts*. Unless otherwise specified, all references herein to the amount of a Letter of Credit at any time shall be deemed to mean the maximum face amount of such Letter of Credit after giving effect to all increases thereof contemplated by such Letter of Credit or any documents related thereto, whether or not such maximum face amount is in effect at such time.

(q) *Applicability of ISP*. Unless otherwise expressly agreed by the LC Issuing Bank and the Borrower when a Letter of Credit is issued (including any such agreement applicable to an Existing Letter of Credit), the rules of the ISP shall apply to each Letter of Credit.

Section 2.02 ***Termination or Reduction of Commitments*****.**

The Borrower may, upon at least three Domestic Business Days' notice to the Administrative Agent, (i) terminate the Commitments at any time, if there are no LC Exposures outstanding at such time, or (ii) ratably reduce from time to time by an aggregate amount of $10,000,000 or any multiple of $1,000,000 in excess thereof, the aggregate amount of the Commitments in excess of the Aggregate LC Exposure at such time. Unless previously terminated, the Commitments shall terminate at the close of business on the Termination Date.

Section 2.03 ***General Provisions as to Payments*****.**

(a) The Borrower shall make each payment of LC Reimbursement Obligations, and of fees hereunder (other than fees payable directly to the LC Issuing Bank), not later than 12:00 Noon (New York City time) on the date when due, in Federal or other funds immediately available in New York City, to the Administrative Agent at its address referred to in Section 9.01 and without reduction by reason of set-off or counterclaim. The Administrative Agent will promptly distribute to each Lender its ratable share (if any) of each such payment received by the Administrative Agent for the account of the Lenders. Whenever any payment of LC Reimbursement Obligations or any payment of fees shall be due on a day which is not a Domestic Business Day, the date for payment thereof shall be extended to the next succeeding Domestic Business Day.

(b) Unless the Administrative Agent shall have received notice from the Borrower prior to the date on which any payment is due to any Lenders hereunder that the Borrower will not make such payment in full, the Administrative Agent may assume that the Borrower has made such payment in full to the Administrative Agent on such date and the Administrative Agent may, in reliance upon such assumption, cause to be distributed to each Lender on such date an amount equal to the amount then due such Lender. If and to the extent that the Borrower shall not have so made such payment, each Lender shall repay to the Administrative Agent forthwith on demand the amount so distributed to such Lender together with interest thereon, for each day from the date such amount is distributed to such Lender until the date such Lender repays such amount to the Administrative Agent, at the Federal Funds Rate.

Section 2.04 ***Computation of Interest and Fees*****.**

All interest and fees shall be computed on the basis of a year of 360 days and paid for the actual number of days elapsed (including the first day but excluding the last day).

ARTICLE 3
CONDITIONS

Section 3.01 ***Closing*****.**

This Agreement shall become effective when all the following conditions have been satisfied:

(a) the Administrative Agent shall have received executed counterparts of this Agreement and the other Financing Documents, each properly executed by the applicable Credit Parties and, in the case of this Agreement, the Lenders;

(b) the Administrative Agent shall have received evidence satisfactory to it that the Borrower's Existing Credit Agreement has been simultaneously repaid in full and terminated;

(c) the Administrative Agent shall have received the following, each of which shall be originals or facsimiles (followed promptly by originals), in form and substance reasonably satisfactory to the Administrative Agent:

(i) copies of the Organization Documents of the Borrower certified to be true and complete as of a recent date by the appropriate Governmental Authority of the state or other jurisdiction of its incorporation or organization, and certified by a secretary or assistant secretary of the Borrower to be true and correct as of the Closing Date;

(ii) such incumbency certificates and/or other certificates of responsible officers of the Borrower as the Administrative Agent may require evidencing the identity, authority and capacity of each responsible officer thereof authorized to act as a responsible officer in connection with this Agreement and the other Financing Documents to which the Borrower is a party; and

(iii) such documents and certifications as the Administrative Agent may reasonably require to evidence that the Borrower is duly organized or formed, and is validly existing, in good standing and qualified to engage in business in its state of organization or formation.

(d) the Administrative Agent shall have received an opinion of Gibson, Dunn & Crutcher LLP, special counsel for the Credit Parties dated the Closing Date, covering such matters incident to the transactions contemplated by this Agreement as the Administrative Agent shall reasonably request;

(e) the Borrower shall have pledged and deposited with the Administrative Agent, for the benefit of the LC Issuing Bank and the Lenders, cash in an amount equal to 105% of the Aggregate LC Exposure pursuant to the terms and conditions of the Assignment of Collateral Account;

(f) all outstanding Investments in any Subsidiary Guarantor owned by any Credit Party shall have been pledged pursuant to the Guarantee and Pledge Agreement and the Administrative Agent shall have received all certificates or other instruments representing such Investments, together with stock powers or other instruments of transfer with respect thereto endorsed in blank;

(g) all documents and instruments, including Uniform Commercial Code financing statements, required by law or reasonably requested by the Administrative Agent to be filed, registered or recorded to create the Liens intended to be created by the Security Documents and perfect or record such Liens to the extent, and with the priority, required by the Guarantee and Pledge Agreement, shall have been filed, registered or recorded or delivered to the Administrative Agent for filing, registration or recording;

(h) each Credit Party shall have obtained all consents and approvals required to be obtained by it in connection with the execution and delivery of all Security Documents to which it is a party, the performance of its obligations thereunder and the granting of the Liens granted by it thereunder;

(i) each Credit Party shall have taken all other action required under the Security Documents to perfect, register and/or record the Liens granted by it thereunder;

(j) the Borrower shall have paid or made arrangements satisfactory to the Administrative Agent for paying all expenses payable by the Borrower on or before the Closing Date pursuant to Section 9.03(a); and

(k) the Administrative Agent shall have received all documents it may reasonably request relating to the existence of the Borrower, the corporate authority for and the validity of the Financing Documents and any other matters relevant thereto, all in form and substance reasonably satisfactory to the Administrative Agent.

When this Agreement becomes effective, the Administrative Agent shall promptly notify the Borrower and the Lenders that it is effective, and such notice shall be conclusive and binding on all parties hereto.

Section 3.02 ***Issuances or Extensions of Letters of Credit*****.**

The obligation of the LC Issuing Bank to issue (or extend or allow the extension of the expiry date of) any Letter of Credit is each subject to the satisfaction of the following conditions:

(a) receipt by the LC Issuing Bank of a notice of proposed issuance or extension as required by Section 2.01(a), (d) or (f), as the case may be;

(b) the fact that, immediately after such issuance or extension of a Letter of Credit, the sum of the Aggregate LC Exposure will not exceed the aggregate amount of the Commitments;

(c) the fact that, immediately before and after such issuance or extension of a Letter of Credit, no Default or Event of Default shall have occurred and be continuing;

(d) the fact that the representations and warranties of the Borrower contained in the Financing Documents shall be true on and as of the date of such issuance or extension of a Letter of Credit; and

(e) the Required Lenders have not provided notice to the Administrative Agent that, in their good faith determination, there has been a material adverse change since December 31, 2003 in the business, operations, properties, financial condition or prospects of the Borrower and its Subsidiaries, considered as a whole.

Each issuance or extension of a Letter of Credit shall be deemed to be a representation and warranty by the Borrower on the date of such issuance or extension of a Letter of Credit as to the facts specified in clauses (b), (c) and (d) of this Section.

Section 3.03 ***Existing Letters of Credit*****.**

All Existing Letters of Credit shall be deemed for all purposes of this Agreement a Letter of Credit issued hereunder on the Closing Date, as to which each Lender has a participation to the extent of its Commitment Percentage thereof.

ARTICLE 4
REPRESENTATIONS AND WARRANTIES

The Borrower represents and warrants that:

Section 4.01 ***Corporate Existence and Power*****.**

The Borrower is a corporation duly incorporated, validly existing and in good standing under the laws of the State of Nevada, and has all corporate powers and all material governmental licenses, authorizations, consents and approvals required to carry on its business as now conducted.

Section 4.02 ***Corporate and Governmental Authorization*****.**

The execution, delivery and performance by the Borrower of the Financing Documents (i) are within its corporate powers, (ii) have been duly authorized by all necessary corporate action, (iii) require no action by or in respect of, or filing with, any governmental body, agency or official, (iv) do not contravene any provision of applicable law or regulation or of the articles of incorporation or by-laws of the Borrower, (v) do not constitute a breach of or default under any agreement, judgment, injunction, order, decree or other instrument binding upon the Borrower or any of its Subsidiaries, except for breaches and defaults which, in the aggregate, could not reasonably be expected to have a Material Adverse Effect or have an adverse effect on the validity or enforceability of any material provision of any Financing Document, or (vi) result in the creation or imposition of any Lien on any asset of the Borrower or any of its Subsidiaries.

Section 4.03 ***Binding Effect*****.**

This Agreement constitutes a valid and binding agreement of the Borrower and the Letters of Credit, when executed and delivered in accordance with this Agreement, will constitute valid and binding obligations of the Borrower, in each case enforceable against the Borrower in accordance with its terms.

Section 4.04 ***Financial Information*****.**

(a) The consolidated balance sheet of the Borrower and its Subsidiaries as of December 31, 2003 and the related consolidated statements of operations, cash flows and changes in stockholders' equity for the Fiscal Year then ended, reported on by KPMG LLP and set forth in the Borrower's 2003 Form 10-K, a copy of which has been delivered to each of the Lenders, fairly present, in conformity with GAAP, the consolidated financial position of the Borrower and its Subsidiaries as of such date and their consolidated results of operations and cash flows for such Fiscal Year.

(b) The unaudited condensed consolidated balance sheet of the Borrower and its Subsidiaries as of September 30, 2004 and the related unaudited condensed consolidated statements of operations and cash flows for the six months then ended, set forth in the Borrower's quarterly report on Form 10-Q for the Fiscal Quarter ended September 30, 2004, a copy of which has been delivered to each of the Lenders, fairly present, on a basis consistent with the financial statements referred to in subsection (a) of this Section, the consolidated financial position of the Borrower and its Subsidiaries as of such date and their consolidated results of operations and cash flows for such six-month period (subject to normal year-end adjustments).

Section 4.05 ***Litigation*****.**

Except as described in Schedule 4.05 hereto, there are no actions, investigations, suits or proceedings pending against, or to the knowledge of the Borrower threatened against, the Borrower or any of its Subsidiaries or any of their respective properties, before any court or arbitrator or any governmental body, agency or official in which there is a reasonable possibility of adverse decisions which in the aggregate could reasonably be expected to have a Material Adverse Effect.

Section 4.06 ***Compliance with ERISA*****.**

Each member of the ERISA Group has fulfilled its obligations under the minimum funding standards of ERISA and the Internal Revenue Code with respect to each Plan and is in compliance in all material respects with the presently applicable provisions of ERISA and the Internal Revenue Code with respect to each Plan. No member of the ERISA Group has (i) sought a waiver of the minimum funding standard under Section 412 of the Internal Revenue Code in respect of any Plan, (ii) failed to make any contribution or payment to any Plan or Multiemployer Plan, or made any amendment to any Plan, which has resulted or could result in the imposition of a Lien or the posting of a bond or other security under ERISA or the Internal Revenue Code or (iii) incurred any liability under Title IV of ERISA other than a liability to the PBGC for premiums under Section 4007 of ERISA.

Section 4.07 ***Compliance with Laws*****.**

The Borrower and its Subsidiaries are in compliance in all material respects with all applicable laws, rules and regulations (including without limitation health care laws, rules and regulations), other than such laws, rules or regulations (i) the validity or applicability of which the Borrower or such Subsidiary is contesting in good faith by appropriate proceedings or (ii) failures to comply with which could not, in the aggregate, reasonably be expected to have a Material Adverse Effect.

Section 4.08 ***Environmental Matters*****.**

The Borrower has reviewed the effect of Environmental Laws on the business, operations and properties of the Borrower and its Subsidiaries, and has in good faith attempted to identify and evaluate the associated liabilities and costs (including, without limitation, capital or operating expenditures required for clean-up or closure of properties presently or previously owned, capital or operating expenditures required to achieve or maintain compliance with environmental protection standards imposed by law or as a condition of any license, permit or contract, any related constraints on operating activities, including any periodic or permanent shutdown of any facility or reduction in the level of or change in the nature of operations conducted thereat, any costs or liabilities in connection with off-site disposal of wastes or Hazardous Substances, and actual or potential liabilities to third parties, including employees, and any related costs and expenses). On the basis of the foregoing review, the Borrower has reasonably concluded that such associated liabilities and costs, including the costs of compliance with Environmental Laws, are unlikely to have a Material Adverse Effect.

Section 4.09 ***Taxes*****.**

The Borrower and its Subsidiaries have filed all United States Federal income tax returns and all other material tax returns which are required to be filed by them and have paid all taxes shown to be due on such returns or pursuant to any assessment received by any of them (unless such assessment is being contested in good faith by appropriate proceedings). The charges, accruals and reserves on the books of the Borrower and its Subsidiaries in respect of taxes or other governmental charges are, in the opinion of the Borrower, adequate.

Section 4.10 *Material Subsidiaries*.

Each Material Subsidiary is a corporation duly incorporated, validly existing and in good standing under the laws of its jurisdiction of incorporation, and has all corporate powers and all material governmental licenses, authorizations, consents and approvals required to carry on its business as now conducted. The exact legal name and state of organization of the Borrower is as set forth on the signature page hereto.

Section 4.11 *Certain Laws Not Applicable*.

The Borrower is neither an "*investment company*" nor a Person directly or indirectly "*controlled*" by or "acting on behalf of" an "*investment company*" within the meaning of the Investment Company Act of 1940, as amended. The Borrower is neither a "*holding company*", nor an "*affiliate*" of a "*holding company*" or a "*subsidiary company*" of a "*holding company*", as such terms are defined in the Public Utility Holding Company Act of 1935, as amended.

Section 4.12 *Full Disclosure*.

All information heretofore furnished by the Borrower to the Administrative Agent or any Lender for purposes of or in connection with this Agreement or any transaction contemplated hereby is, and all such information hereafter furnished by the Borrower to the Administrative Agent or any Lender will be, taken as a whole, true and accurate in all material respects on the date as of which such information is stated or certified. The Borrower has disclosed to the Lenders in writing any and all facts which have or may (to the extent the Borrower can now reasonably foresee) have a Material Adverse Effect.

ARTICLE 5
COVENANTS

The Borrower agrees that, so long as any Lender has any Credit Exposure hereunder or any interest or fees accrued hereunder remain unpaid:

Section 5.01 *Information*.

The Borrower will deliver to each Lender:

(a) as soon as available and in any event within 105 days after the end of each Fiscal Year, an audited consolidated balance sheet of the Borrower and its Subsidiaries as of the end of such Fiscal Year and the related audited consolidated statements of operations, cash flows and changes in stockholders' equity for such Fiscal Year, setting forth in each case in comparative form the figures for the previous Fiscal Year, all reported on in a manner acceptable to the SEC by KPMG LLP or other independent public accountants of nationally recognized standing;

(b) as soon as available and in any event within 60 days after the end of each of the first three Fiscal Quarters of each Fiscal Year, a condensed consolidated balance sheet of the Borrower and its Subsidiaries as of the end of such Fiscal Quarter, the related condensed consolidated statements of operations for such Fiscal Quarter and for the portion of the Fiscal Year ended at the end of such Fiscal Quarter and the related condensed consolidated statement of cash flows for the portion of the Fiscal Year then ended, setting forth in the case of such condensed consolidated statements of operations and cash flows in comparative form the figures for the corresponding Fiscal Quarter and the corresponding portion of the previous Fiscal Year, all certified (subject to normal year-end adjustments) as to fairness of presentation and consistency with GAAP by a Senior Officer of the Borrower;

(c) concurrently with the delivery of each set of financial statements referred to in clauses (a) and (b) above, a certificate of a Senior Officer of the Borrower stating whether any Default exists on the date of such certificate and, if any Default then exists, setting forth the details thereof and the action which the Borrower is taking or proposes to take with respect thereto;

(d) simultaneously with the delivery of each set of financial statements referred to in clause (a) above, a statement by the firm of independent public accountants which reported on such statements that, in making the examination necessary for reporting on such financial statements, they did not obtain knowledge of any Default hereunder except as described in such statement;

(e) within five days after any officer of the Borrower obtains knowledge of any Default, if such Default is then continuing, a certificate of a Senior Officer of the Borrower setting forth the details thereof and the action which the Borrower is taking or proposes to take with respect thereto;

(f) promptly upon the mailing thereof to the shareholders of the Borrower generally, copies of all financial statements, reports and proxy statements so mailed, as well as a condensed consolidated balance sheet of each Subsidiary Guarantor as at the end of, and a condensed consolidated statement of operations of each Subsidiary Guarantor for, the fiscal period covered by such consolidated financial statements, certified by a Senior Officer as having been prepared by the Borrower in accordance with its customary practices and utilized in the preparation of the consolidated financial statements delivered concurrently therewith;

(g) promptly upon the filing thereof, copies of all registration statements (other than the exhibits thereto and any registration statements on Form S-8 or its equivalent) and reports on Forms 10-K, 10-Q and 8-K (or their equivalents) which the Borrower shall have filed with the SEC;

(h) if and when any member of the ERISA Group (i) gives or is required to give notice to the PBGC of any " *reportable event*" (as defined in Section 4043 of ERISA) with respect to any Plan which might constitute grounds for a termination of such Plan under Title IV of ERISA, or knows that the plan administrator of any Plan has given or is required to give notice of any such reportable event, a copy of the notice of such reportable event given or required to be given to the PBGC; (ii) receives notice of complete or partial withdrawal liability under Title IV of ERISA or notice that any Multiemployer Plan is in reorganization, is insolvent or has been terminated, a copy of such notice; (iii) receives notice from the PBGC under Title IV of ERISA of an intent to terminate, impose liability (other than for premiums under Section 4007 of ERISA or premium-related penalties) in respect of, or appoint a trustee to administer any Plan, a copy of such notice; (iv) applies for a waiver of the minimum funding standard under Section 412 of the Internal Revenue Code, a copy of such application; (v) gives notice of intent to terminate any Plan under Section 4041(c) of ERISA, a copy of such notice and other information filed with the PBGC; (vi) gives notice of withdrawal from any Plan pursuant to Section 4063 of ERISA, a copy of such notice; or (vii) fails to make any payment or contribution to any Plan or Multiemployer Plan or makes any amendment to any Plan which has resulted or could result in the imposition of a Lien or the posting of a bond or other security, a certificate of a Senior Officer of the Borrower setting forth details as to such occurrence and the action, if any, which the Borrower or applicable member of the ERISA Group is required or proposes to take; and

(i) from time to time such additional information regarding the financial position or business of the Borrower and its Subsidiaries as the Administrative Agent, at the request of any Lender, may reasonably request.

Section 5.02 ***Maintenance of Property; Insurance*****.**

(a) The Borrower and each Material Subsidiary will keep all property useful and necessary in its business in good working order and condition, ordinary wear and tear excepted.

(b) The Borrower and each Material Subsidiary will maintain, with financially sound and reputable insurance companies (which may be Affiliates of the Borrower or part of the Borrower's self-insurance program) insurance on all their properties in at least such amounts and against at least such risks as are usually insured against in the same general area and by companies engaged in the same or similar businesses and maintain professional liability and malpractice insurance against claims usually insured against by companies engaged in the same or similar businesses, and furnish to each Lender, upon written request by the Administrative Agent, full information as to the insurance carried.

Section 5.03 ***Conduct of Business; Maintenance of Existence*****.**

(a) The Borrower and its Material Subsidiaries will continue to engage primarily in business of the same general type as now conducted by the Borrower and its Material Subsidiaries.

(b) The Borrower and each Material Subsidiary will preserve, renew and keep in full force and effect its corporate existence and take all reasonable action to maintain its rights, privileges and franchises necessary or desirable in the normal conduct of business, *provided* that (i) the foregoing shall not prohibit any merger, consolidation or sale of assets expressly permitted by Section 5.06 and (ii) any Material Subsidiary may liquidate or dissolve if the Borrower in good faith determines that such liquidation or dissolution is in the best interests of the Borrower and its Subsidiaries and not materially adverse to the Lenders.

Section 5.04 ***Compliance with Laws*****.**

The Borrower and each Material Subsidiary will comply with all material applicable laws, ordinances, rules, regulations and requirements of governmental authorities (including without limitation Environmental Laws, ERISA and the rules and regulations thereunder and Public Law 92-603), and hold and maintain in full force and effect all certifications, governmental approvals, licenses and permits necessary or desirable to enable the Borrower and its Material Subsidiaries to conduct their respective businesses as now conducted, except where the failure to comply therewith or hold and maintain such certifications, governmental approvals, licenses or permits could not, in the aggregate, reasonably be expected to have a Material Adverse Effect.

Section 5.05 ***Inspection of Property, Books and Records*****.**

The Borrower, the Subsidiary Guarantors and each Material Subsidiary will keep proper books of record and account in which full, true and correct entries shall be made of all dealings and transactions in relation to its business and activities; and will permit representatives of the Administrative Agent or the Syndication Agent (at the request of any Lender) at such requesting Lender's expense to visit and inspect any of their respective properties, to examine and make abstracts (at such Lender's expense, unless an Event of Default shall have occurred and be continuing, in which case at the Borrower's expense) from any of their respective books and records and to discuss their respective affairs, finances and accounts with officers of the Borrower and with the accountants of the Borrower, all upon reasonable notice and at such reasonable times and as often as may reasonably be desired.

Section 5.06 ***Consolidations, Mergers and Sales of Assets*****.**

The Borrower will not merge or consolidate with any other Person, or sell or otherwise transfer all or substantially all of its assets to any other Person, unless after giving effect to such merger, consolidation, sale or other transfer, (i) no Default shall have occurred and be continuing and (ii) the corporation surviving such merger or consolidation (if other than the Borrower) or the Person acquiring such assets is organized under the laws of a state of the United States and assumes in writing all the obligations of the Borrower hereunder and said surviving corporation or acquiring Person delivers to each Lender an opinion of counsel reasonably satisfactory to the Required Lenders, in form and substance satisfactory to the Required Lenders, to the effect that the assumption of such obligations by such surviving corporation or acquiring Person is effective and is fully binding upon and enforceable against such surviving corporation or acquiring Person.

Section 5.07 ***Negative Pledge*****.**

After the Closing Date, neither the Borrower nor any Subsidiary will create, assume or suffer to exist any Lien on any asset now owned or hereafter acquired by it, except:

(a) any Lien existing prior to the Closing Date securing Debt;

(b) any Lien on bonds issued by the Metrocrest Hospital Authority (and related proceeds and other distributions) granted to secure the Borrower's obligations under the Metrocrest Reimbursement Agreement and the Securities Pledge and Security Agreement referred to therein;

(c) any Lien arising out of the refinancing, extension, renewal or refunding of any Debt secured by any Lien permitted by clause (a) above; *provided* that (i) the principal amount of such Debt is not increased and (ii) such Debt is not secured by any additional assets;

(d) if the letters of credit issued pursuant to the Metrocrest Reimbursement Agreement are replaced by other letters of credit issued for the same purpose, any Lien securing the Borrower's obligations under the reimbursement agreement relating to such replacement letters of credit; *provided* that (i) the aggregate amount of such letters of credit does not exceed $70,000,000 and (ii) the Borrower's obligations under the related reimbursement agreement are not secured or required to be secured by any assets except the assets by which the Borrower's obligations under the Metrocrest Reimbursement Agreement are secured or required to be secured;

(e) any Lien securing Non-Recourse Purchase Money Debt;

(f) any Lien on assets of a Person which becomes a Subsidiary after the Closing Date; provided that such Lien secures only (i) Debt of such Person that is outstanding when such Person becomes a Subsidiary and was not created in contemplation of such event or (ii) Debt incurred solely for the purpose of refinancing Debt described in the foregoing clause (i);

(g) carriers', warehousemen's, mechanics', transporters, materialmen's, repairmen's or other like Liens arising in the ordinary course of business;

(h) any Lien imposed by any governmental authority for taxes, assessments, governmental charges, duties or levies not delinquent or which are being contested in good faith and by appropriate proceedings; provided that adequate reserves with respect thereto are maintained on the books of the Borrower and its Subsidiaries in accordance with GAAP;

(i) Liens on cash and cash equivalents securing obligations of the Borrower and its Subsidiaries with respect to workers' compensation, malpractice and other insurance policies;

(j) Liens arising in the ordinary course of business (other than Liens permitted by clause (g), (h) or (i) above) which (i) do not secure Financial Obligations and (ii) do not secure monetary obligations in an aggregate outstanding amount exceeding $70,000,000;

(k) Liens on cash and cash equivalents securing Hedging Obligations, provided that the aggregate amount of cash and cash equivalents subject to such Liens may not exceed $100,000,000 at any time;

(l) any Lien on an asset leased by the Borrower or a Subsidiary under a capital lease securing its obligations as lessee under such capital lease;

(m) any Lien on any asset of a Subsidiary securing Debt owed to the Borrower;

(n) Liens on Collateral granted by the Credit Parties under the Security Documents; and

(o) Liens (other than Liens on capital stock of a Subsidiary) not otherwise permitted by the foregoing clauses of this Section securing Debt; provided that, immediately after any such Debt is incurred, the sum of (i) the aggregate outstanding principal amount of all Debt secured pursuant to this clause and (ii) without duplication, the aggregate outstanding principal amount of Debt of Subsidiaries incurred in reliance on clause (h) of Section 5.08 shall not exceed $175,000,000 at any time.

Section 5.08 *Debt of Subsidiaries*.

After the Closing Date, no Subsidiary will incur, assume or otherwise be liable in respect of any Debt, except:

(a) Debt outstanding at the close of business on November 30, 2000 in an aggregate principal or face amount not exceeding $400,000,000;

(b) Debt owing to the Borrower;

(c) Non-Recourse Purchase Money Debt;

(d) Debt of any Person which becomes a Subsidiary after the Closing Date; provided that (i) such Debt is outstanding when such Person becomes a Subsidiary and was not created in contemplation of such event or (ii) such Debt is incurred solely for the purpose of refinancing Debt described in the foregoing clause (i);

(e) Guarantees by any Subsidiary of Debt relating to any assets sold or otherwise disposed of by it; provided that such Debt was outstanding when such assets were disposed of and was not created in contemplation of the disposition thereof;

(f) Debt consisting of the obligations of any Subsidiary as lessee which are capitalized in accordance with GAAP;

(g) Guarantees by any Subsidiary Guarantor under the Guarantee and Pledge Agreement; and

(h) Debt of any Subsidiary not otherwise permitted by the foregoing clauses of this Section; provided that immediately after any such Debt is incurred, the sum of (i) the aggregate outstanding principal amount of all Debt of Subsidiaries permitted by this clause (h) and (ii) without duplication, the aggregate principal amount of secured Debt of the Borrower or any Subsidiary incurred in reliance on clause (o) of Section 5.07 shall not exceed $175,000,000 at any time.

Section 5.09 *Organizational Documents*.

On or before February 1, 2005, the Borrower will deliver to the Administrative Agent the following documents in form and substance reasonably satisfactory to the Administrative Agent:

(a) copies of the Organization Documents of each Subsidiary Guarantor certified to be true and complete as of a recent date by the appropriate Governmental Authority of the state or other jurisdiction of its incorporation or organization, where applicable, and certified by a secretary or assistant secretary of such Subsidiary Guarantor to be true and correct as of the Closing Date;

(b) (i) such certificates of resolutions or other action, incumbency certificates and/or other certificates of responsible officers of each Subsidiary Guarantor as the Administrative Agent may require evidencing the identity, authority and capacity of each responsible officer thereof authorized to act as a responsible officer in connection with this Agreement and the other Financing Documents to which such Subsidiary Guarantor is a party and (ii) such certificates of resolutions or other action of the responsible officer of the Borrower as the Administrative Agent may require evidencing the authority of each responsible officer thereof to act a responsible officer in connection with this Agreement and the other Financing Documents; and

(c) such documents and certifications as the Administrative Agent may reasonably require to evidence that each Subsidiary Guarantor is duly organized or formed, and is validly existing, in good standing and qualified to engage in business in its state of organization or formation.

Section 5.10 [*Reserved*]

Section 5.11 [*Reserved*]

Section 5.12 *Restricted Payments*.

Neither the Borrower nor any Subsidiary will declare or make (i) any dividend or other distribution on any shares of capital stock of the Borrower (except dividends payable solely in shares of its capital stock) or (ii) any payment on account of the purchase, redemption or other acquisition of any Equity Interests in the Borrower (any such dividend, distribution or payment, a "*Restricted Payment*"), unless (x) no Default has occurred and is continuing and (y) the aggregate amount of Restricted Payments made after the Closing Date is less than $50,000,000 (*provided* that, in determining such aggregate amount of Restricted Payments, the aggregate payment for a number of shares of common stock of the Borrower repurchased by it after the Closing Date up to but not exceeding the aggregate number of shares of such common stock issued after the Closing Date upon exercise of employee stock options, shall be deemed to be the positive difference, if any, between (1) the aggregate purchase price of such repurchased shares and (2) the aggregate exercise price of such stock options.

Section 5.13 *Transactions with Affiliates*.

The Borrower will not, and will not permit any Subsidiary to, directly or indirectly, pay any funds to or for the account of, make any investment (whether by acquisition of stock or indebtedness, by loan, advance, transfer of property, guarantee or other agreement to pay, purchase or service, directly or indirectly, any Debt, or otherwise) in, lease, sell, transfer or otherwise dispose of any assets, tangible or intangible, to, or participate in, or effect, any transaction with, any Affiliate except on an arms-length basis on terms at least as favorable to the Borrower or such Subsidiary as it could have obtained from a third party who was not an Affiliate; *provided* that the foregoing provisions of this Section shall not prohibit (x) any such Person from declaring or paying any lawful dividend or other payment ratably in respect of all of its capital stock of the relevant class so long as, after giving effect thereto, no Default shall have occurred and be continuing or (y) any such transaction between or among the Borrower and its Subsidiaries.

Section 5.14 ***Payment of Dividends by Material Subsidiaries*****.**

After the Closing Date neither the Borrower nor any of its Material Subsidiaries will enter into any agreement or arrangement which would limit in any way the ability of any Material Subsidiary to pay any dividend.

Section 5.15 ***Use of Proceeds*****.**

(a) The Letters of Credit will be used by the Borrower for the general corporate purposes of the Borrower and its Subsidiaries.

(b) No Letter of Credit will be used, directly or indirectly, for the purpose, whether immediate, incidental or ultimate, of buying or carrying any "*margin stock*" within the meaning of Regulation U in any manner which would (i) violate any applicable law or regulation or (ii) require any Form FRU-1 or any successor form to be executed.

Section 5.16 ***Prepayment of Debt*****.**

Neither the Borrower nor any Subsidiary shall prepay, repurchase, redeem or defease the principal of any Debt (other than the Letters of Credit) unless the aggregate principal amount of Debt (other than the Letters of Credit) prepaid, repurchased, redeemed or defeased by the Borrower and its Subsidiaries subsequent to the Closing Date is less than $450,000,000.

ARTICLE 6
DEFAULTS

Section 6.01 ***Events of Default*****.**

If one or more of the following events ("*Events of Default*") shall have occurred:

(a) any LC Reimbursement Obligation, any interest on any LC Reimbursement Obligation, any fee or any other amount payable under any Financing Document shall not be paid within three Domestic Business Days after it becomes due;

(b) the Borrower or any Subsidiary shall fail to comply with any covenant applicable to it contained in Section 5.01(e) and Sections 5.06 through 5.16, inclusive;

(c) the Borrower shall fail to observe or perform any covenant or agreement contained in the Financing Documents (other than those covered by clause (a) or (b) above) within 30 days after the earlier of (i) the date the Borrower first learns of such failure and (ii) the date written notice thereof has been given to the Borrower by the Administrative Agent at the request of the Required Lenders;

(d) any representation, warranty, certification or statement made by the Borrower in the Financing Documents or by the Borrower or any Subsidiary in any certificate, financial statement or other document delivered pursuant thereto shall prove to have been incorrect in any material respect when made (or deemed made);

(e) the Borrower and/or one or more Subsidiaries shall fail to make one or more payments in respect of Material Financial Obligations when due or within any applicable grace period;

(f) any event or condition shall occur which results in the acceleration of the maturity of any Material Financial Obligations, or enables (any applicable grace period having expired) the holder or holders of any Material Financial Obligations or any Person acting on their behalf to accelerate the maturity thereof;

(g) the Borrower or any Material Subsidiary (other than Redding Medical Center, Inc.) shall commence a voluntary case or other proceeding seeking liquidation, reorganization or other relief with respect to itself or its debts under any bankruptcy, insolvency or other similar law now or hereafter in effect or seeking the appointment of a trustee, receiver, liquidator, custodian or other similar official of it or any substantial part of its property, or shall consent to any such relief or to the appointment of or taking possession by any such official in an involuntary case or other proceeding commenced against it, or shall make a general assignment for the benefit of creditors, or shall fail generally to pay its debts as they become due, or shall take any corporate action to authorize any of the foregoing;

(h) an involuntary case or other proceeding shall be commenced against the Borrower or any Material Subsidiary (other than Redding Medical Center, Inc.) seeking liquidation, reorganization or other relief with respect to it or its debts under any bankruptcy, insolvency or other similar law now or hereafter in effect or seeking the appointment of a trustee, receiver, liquidator, custodian or other similar official of it or any substantial part of its property, and such involuntary case or other proceeding shall remain undismissed and unstayed for a period of 60 days; or an order for relief shall be entered against the Borrower or any Material Subsidiary (other than Redding Medical Center, Inc.) under the federal bankruptcy laws as now or hereafter in effect;

(i) any member of the ERISA Group shall fail to pay when due an amount or amounts aggregating in excess of $70,000,000 which it shall have become liable to pay under Title IV of ERISA; or notice of intent to terminate a Material Plan shall be filed under Title IV of ERISA by any member of the ERISA Group, any plan administrator or any combination of the foregoing; or the PBGC shall institute proceedings under Title IV of ERISA to terminate, to impose liability (other than for premiums under Section 4007 of ERISA or premium-related penalties) in respect of, or to cause a trustee to be appointed to administer any Material Plan; or a condition shall exist by reason of which the PBGC would be entitled to obtain a decree adjudicating that any Material Plan must be terminated; or there shall occur a complete or partial withdrawal from, or a default, within the meaning of Section 4219(c)(5) of ERISA, with respect to, one or more Multiemployer Plans which could cause one or more members of the ERISA Group to incur a current payment obligation in excess of $70,000,000;

(j) a judgment or order for the payment of money in excess of $70,000,000 (net of insurance to the extent that the insurer shall have admitted coverage thereof) shall be rendered against the Borrower or any Subsidiary and such judgment or order shall continue unsatisfied and unstayed for a period of 30 days;

(k) any person or group of persons (within the meaning of Section 13 or 14 of the Exchange Act) shall have acquired beneficial ownership (within the meaning of Rule 13d-3 promulgated by the SEC under the Exchange Act) of 20% or more of the outstanding shares of common stock of the Borrower; or Continuing Directors shall no longer constitute a majority of the Borrower's board of directors;

(m) any Lien purported to be created under any Security Document shall cease to be, or shall be asserted by any Credit Party not to he, a valid and perfected Lien on any Collateral, with the priority required by the applicable Security Document, except (i) as a result of a sale or other disposition of the applicable Collateral in a transaction permitted under the Financing Documents or (ii) as a result of the Administrative Agent's failure to maintain possession of any stock certificates or other documents delivered to it under the Guarantee and Pledge Agreement; or

(n) any Subsidiary Guarantor's Guarantee under the Guarantee and Pledge Agreement shall at any time fail to constitute a valid and binding agreement of such Subsidiary Guarantor or any party shall so assert in writing;

then, and in every such event, while such event is continuing, the Administrative Agent shall:

(i) if requested by Lenders having more than 50% in aggregate amount of the Commitments, by notice to the Borrower terminate the Commitments and they shall thereupon terminate; and

(ii) declare any LC Reimbursement Obligations, all interest accrued and unpaid thereon and any and all other indebtedness and obligations of any and every kind owing by the Credit Parties to the Administrative Agent, the LC Issuing Bank and/or any of the Lenders hereunder or under any other Financing Document to be immediately due and payable, without presentment, demand, protest or other notice of any kind, all of which are hereby expressly waived by the Borrower;

provided that, if any Event of Default specified in clause (g) or (h) above occurs with respect to the Borrower, then without any notice to the Borrower or any other act by the Administrative Agent, the LC Issuing Bank or the Lenders, any obligation of the LC Issuing Bank to issue Letters of Credit shall automatically terminate, the Commitments shall thereupon terminate, the unpaid LC Reimbursement Obligations and all interest and all other indebtedness or obligations of any and every kind owing by the Credit Parties to the Administrative Agent, the LC Issuing Bank and/or any of the Lenders hereunder or under any other Financing Document shall automatically become immediately due and payable without presentment, demand, protest or other notice of any kind, all of which are hereby waived by the Borrower.

Section 6.02 ***Notice of Default*****.**

The Administrative Agent shall give notice to the Borrower under clause (c) of Section 6.01 promptly upon being requested to do so by the Required Lenders and shall thereupon notify all the Lenders thereof.

ARTICLE 7
THE ADMINISTRATIVE AGENT

Section 7.01 ***Appointment and Authorization*****.**

Each of the Lenders and the LC Issuing Bank irrevocably appoints and authorizes the Administrative Agent (i) to sign and deliver the Security Documents and (ii) to take such action as agent on its behalf and to exercise such powers under the Financing Documents as are delegated to it by the terms thereof, together with all such powers as are reasonably incidental thereto.

Section 7.02 ***Administrative Agent and Affiliates*****.**

Bank of America shall have the same rights and powers under the Financing Documents as any other Lender and may exercise or refrain from exercising the same as though it were not the Administrative Agent and the term "Lender" shall, unless otherwise expressly indicated or unless the context otherwise requires, include the Person serving as Administrative Agent hereunder in its individual capacity. Bank of America and its Affiliates may accept deposits from, lend money to, and generally engage in any kind of business with the Borrower or any of the Borrower's Subsidiaries or Equity Affiliates as if it were not the Administrative Agent under any of the Financing Documents.

Section 7.03 ***Action by the Administrative Agent*****.**

The Administrative Agent shall not have any duties or obligations except those expressly set forth herein and in the other Financing Documents. Without limiting the generality of the foregoing, the Administrative Agent:

(a) shall not be subject to any fiduciary or other implied duties, regardless of whether a Default has occurred and is continuing;

(b) shall not have any duty to take any discretionary action or exercise any discretionary powers, except discretionary rights and powers expressly contemplated hereby or by the other Financing Documents that the Administrative Agent is required to exercise as directed in writing by the Required Lenders (or such other number or percentage of the Lenders as shall be expressly provided for herein or in the other Financing Documents), *provided* that the Administrative Agent shall not be required to take any action that, in its opinion or the opinion of its counsel, may expose the Administrative Agent to liability or that is contrary to any Financing Document or applicable law;

(c) shall not, except as expressly set forth herein and in the other Financing Documents, have any duty to disclose, and shall not be liable for the failure to disclose, any information relating to the Borrower or any of its Affiliates that is communicated to or obtained by the Person serving as the Administrative Agent or any of its Affiliates in any capacity.

The Administrative Agent shall not be liable for any action taken or not taken by it (i) with the consent or at the request of the Required Lenders (or such other number or percentage of the Lenders as shall be necessary, or as the Administrative Agent shall believe in good faith shall be necessary, under the circumstances as provided hereunder) or (ii) in the absence of its own gross negligence or willful misconduct. The Administrative Agent shall be deemed not to have knowledge of any Default unless and until notice describing such Default is given to the Administrative Agent by a Borrower, a Lender or the LC Issuing Bank.

The Administrative Agent shall not be responsible for or have any duty to ascertain or inquire into (i) any statement, warranty or representation made in or in connection with this Agreement or any other Financing Document, (ii) the contents of any certificate, report or other document delivered hereunder or thereunder or in connection herewith or therewith, (iii) the performance or observance of any of the covenants, agreements or other terms or conditions set forth herein or therein or the occurrence of any Default, (iv) the validity, enforceability, effectiveness or genuineness of this Agreement, any other Financing Document or any other agreement, instrument or document or (v) the satisfaction of any condition set forth in Section 3 or elsewhere herein, other than to confirm receipt of items expressly required to be delivered to the Administrative Agent.

Section 7.04 ***Consultation with Experts*****.**

The Administrative Agent may consult with legal counsel (who may be counsel for the Borrower), independent public accountants and other experts selected by it with reasonable care and shall not be liable for any action taken or omitted to be taken by it in good faith in accordance with the advice of such counsel, accountants or experts.

Section 7.05 ***Liability of the Administrative Agent*****.**

Neither the Administrative Agent, nor any of its Affiliates and their respective directors, officers, agents or employees shall be liable for any action taken or not taken by such Person in connection with any Financing Document (i) in the absence of its own gross negligence or willful misconduct or (ii) with the consent or at the request of the Required Lenders, *provided* that this clause (ii) shall not affect any rights the Borrower may have against the Lenders that made such request. Neither the Administrative Agent, nor its Affiliates and their respective directors, officers, agents or employees shall be responsible for or have any duty to ascertain, inquire into or verify (i) any statement, warranty or representation made in connection with any Financing Document; (ii) the performance or observance of any of the covenants or agreements of the Borrower in any Financing Document; (iii) the satisfaction of any condition specified in Article 3, except receipt of items required to be delivered to the Administrative Agent; or (iv) the validity, effectiveness or genuineness of any Financing Document or any other instrument or writing furnished in connection therewith. The Administrative Agent shall not incur any liability by acting in reliance upon any notice, consent, certificate, statement, or other writing (which may be a bank wire, telex, facsimile transmission or similar writing) believed by it to be genuine or to be signed by the proper party or parties. The Administrative Agent may perform any and all of its duties and exercise its rights and powers hereunder or under any other Financing Document by or through any one or more sub-agents appointed by the Administrative Agent. The Administrative Agent and any such sub-agent may perform any and all of its duties and exercise its rights and powers by or through their respective Related Parties. The exculpatory provisions of this Section shall apply to any such sub-agent and to the Related Parties of the Administrative Agent and any such sub-agent, and shall apply to their respective activities in connection with the syndication of the credit facilities provided for herein as well as activities as the Administrative Agent.

Section 7.06 ***Indemnification*****.**

The Lenders shall, ratably in accordance with their Credit Exposures, indemnify the Administrative Agent, the LC Issuing Bank and their respective Affiliates and their respective directors, officers, agents and employees (to the extent not reimbursed by the Borrower) against any cost, expense (including counsel fees and disbursements), claim, demand, action, loss or liability (except such as result from the relevant indemnitee's gross negligence or willful misconduct) that such indemnitees may suffer or incur in connection with the Financing Documents or any action taken or omitted by the relevant indemnitee thereunder.

Section 7.07 ***Credit Decision*****.**

Each Lender acknowledges that it has, independently and without reliance upon the Administrative Agent or other Lender, and based on such documents and information as it has deemed appropriate, made its own credit analysis and decision to enter into this Agreement. Each Lender also acknowledges that it will, independently and without reliance upon the Administrative Agent or other Lender, and based on such documents and information as it shall deem appropriate at the time, continue to make its own credit decisions in taking or not taking any action under the Financing Documents.

Section 7.08 ***Successor Administrative Agent*****.**

The Administrative Agent may resign at any time by giving notice thereof to the Lenders and the Borrower. Upon any such resignation, the Required Lenders shall have the right to appoint a successor Administrative Agent. If no successor Administrative Agent shall have been so appointed by the Required Lenders, and shall have accepted such appointment, within 30 days after the retiring Administrative Agent gives notice of resignation, then the retiring Administrative Agent may, on behalf of the Lenders, appoint a successor Administrative Agent, which shall be a commercial bank organized or licensed under the laws of the United States or of any State thereof and having a combined capital and surplus of at least $50,000,000; *provided* that if the Administrative Agent shall notify the Borrower and the Lenders that no qualifying Person has accepted such appointment, then such resignation shall nonetheless become effective in accordance with such notice and (1) the retiring Administrative Agent shall be discharged from its duties and obligations hereunder and under the other Financing Documents (except that in the case of any collateral security held by the Administrative Agent on behalf of the Lenders or the LC Issuing Bank under any of the Financing Documents, the retiring Administrative Agent shall continue to hold such collateral security until such time as a successor Administrative Agent is appointed) and (2) all payments, communications and determinations provided to be made by, to or through the Administrative Agent shall instead be made by or to each Lender and the LC Issuing Bank directly, until such time as the Required Lenders appoint a successor Administrative Agent as provided for above in this Section.. Upon the acceptance of its appointment as Administrative Agent hereunder by a successor Administrative Agent, such successor Administrative Agent shall thereupon succeed to and become vested with all the rights and duties of the retiring Administrative Agent, and the retiring Administrative Agent shall be discharged from its duties and obligations (excepting liabilities previously incurred) hereunder. After any retiring Administrative Agent's resignation hereunder as Administrative Agent, the provisions of this Article shall inure to its benefit as to any actions taken or omitted to be taken by it while it was Administrative Agent.

Section 7.09 ***Fees*****.**

The Borrower shall pay to the Administrative Agent for its own account fees in the amounts and at the times previously agreed upon between the Borrower and the Administrative Agent.

Section 7.10 ***Other Agents*****.**

The Syndication Agent, in its capacity as such, shall have no duties or obligations of any kind under the Financing Documents. The use of the term "Agent" in this Agreement is not intended to connote any fiduciary or other implied (or express) obligations arising under agency doctrine of any applicable law. Instead, such term is used merely as a matter of market custom, and, in the case of the Administrative Agent, such term is intended to create or reflect only an administrative relationship between independent contracting parties.

ARTICLE 8
CHANGE IN CIRCUMSTANCE

Section 8.01 ***Increased Cost and Reduced Return*.**

(a) If, on or after the date hereof, in the case of any Letter of Credit or any obligation to issue or participate in any Letter of Credit, the adoption of any applicable law, rule or regulation, or any change in any applicable law, rule or regulation, or any change in the interpretation or administration thereof by any governmental authority, central bank or comparable agency charged with the interpretation or administration thereof, or compliance by any Lender (or its Domestic Lending Office) or the LC Issuing Bank with any request or directive (whether or not having the force of law) made on or after the date of this Agreement by any such authority, central bank or comparable agency shall impose, modify or deem applicable any reserve (including, without limitation, any such requirement imposed by the Board of Governors of the Federal Reserve System), special deposit, insurance assessment or similar requirement against assets of, deposits with or for the account of, or credit (including Letters of Credit and participations therein) extended by, any Lender (or its Domestic Lending Office) or the LC Issuing Bank or shall impose on any Lender (or its Domestic Lending Office) or the LC Issuing Bank or on the London interbank market any other condition affecting its obligations hereunder in respect of Letters of Credit, and the result of any of the foregoing is to increase the cost to such Lender (or its Domestic Lending Office) or the LC Issuing Bank of issuing or participating in any Letter of Credit, or to reduce the amount of any sum received or receivable by such Lender (or its Domestic Lending Office) or the LC Issuing Bank under this Agreement, by an amount deemed by such Lender or the LC Issuing Bank to be material, then, within 15 days after demand by such Lender or the LC Issuing Bank (with a copy to the Administrative Agent), the Borrower shall pay to such Lender or the LC Issuing Bank such additional amount or amounts as will (subject to subsection (e) of this Section) compensate such Lender or the LC Issuing Bank for such increased cost or reduction.

(b) If any Lender shall have determined that, after the date hereof, the adoption of any applicable law, rule or regulation regarding capital adequacy, or any change in any such law, rule or regulation, or any change in the interpretation or administration thereof by any governmental authority, central bank or comparable agency charged with the interpretation or administration thereof, or any request or directive regarding capital adequacy (whether or not having the force of law) made on or after the date of this Agreement by any such authority, central bank or comparable agency, has or would have the effect of reducing the rate of return on capital of such Lender (or its Parent) as a consequence of such Lender's obligations hereunder to a level below that which such Lender (or its Parent) could have achieved but for such adoption, change, request or directive (taking into consideration its policies with respect to capital adequacy) by an amount deemed by such Lender to be material, then from time to time, within 15 days after demand by such Lender (with a copy to the Administrative Agent), the Borrower shall pay to such Lender such additional amount or amounts as will (subject to subsection (d) of this Section) compensate such Lender (or its Parent) for such reduction.

(c) Each Lender and the LC Issuing Bank will promptly notify the Borrower and the Administrative Agent of any event of which it has knowledge, occurring after the date hereof, which will entitle such Lender or the LC Issuing Bank to compensation pursuant to this Section and will designate a different Domestic Lending Office if such designation will avoid the need for, or reduce the amount of, such compensation and will not, in the judgment of such Lender or the LC Issuing Bank, be otherwise disadvantageous to it. A certificate of any Lender or the LC Issuing Bank claiming compensation under this Section and setting forth in reasonable detail the additional amount or amounts to be paid to it hereunder and the method of calculation thereof and shall be conclusive in the absence of manifest error. In determining such amount, such Lender or the LC Issuing Bank may use any reasonable averaging and attribution methods.

(d) No Lender shall be entitled to claim compensation pursuant to this Section for (i) Taxes or Other Taxes (as such terms are defined in Section 8.04) or (ii) any increased cost or reduction incurred or accrued more than 90 days before such Lender first notifies the Borrower of the change in law or other circumstance on which such claim is based.

Section 8.02 *Taxes*.

(a) For purposes of this Section, the following terms have the following meanings:

"*Taxes*" means any and all present or future taxes, duties, levies, imposts, deductions, charges or withholdings with respect to any payment by the Borrower pursuant to any Financing Document, and all liabilities with respect thereto, *excluding* (i) in the case of each Lending Party, taxes imposed on its income, and franchise or similar taxes imposed on it, by a jurisdiction under the laws of which it is organized or in which its principal executive office is located or in which its Domestic Lending Office is located and (ii) in the case of each Lender, any United States withholding tax imposed on such payments but only to the extent that such Lender is subject to United States withholding tax at the time such Lender first becomes a party to this Agreement.

"*Other Taxes*" means any present or future stamp or documentary taxes and any other excise or property taxes, or similar charges or levies, which arise from any payment made pursuant to any Financing Document, or from the execution or delivery of, or otherwise with respect to, any Financing Document.

(b) Any and all payments by any Borrower to or for the account of any Lending Party under any Financing Document shall be made without deduction for any Taxes or Other Taxes; *provided* that, if the Borrower shall be required by law to deduct any Taxes or Other Taxes from any such payment, (i) the sum payable shall be increased as necessary so that after making all required deductions (including deductions applicable to additional sums payable under this Section 8.02) such Lending Party receives an amount equal to the sum it would have received had no such deductions been made, (ii) the Borrower shall make such deductions, (iii) the Borrower shall pay the full amount deducted to the relevant taxation authority or other authority in accordance with applicable law and (iv) the Borrower shall furnish to the Administrative Agent, at its address referred to in Section 9.01, the original or a certified copy of a receipt evidencing payment thereof.

(c) The Borrower agrees to indemnify each Lending Party for the full amount of Taxes or Other Taxes (including, without limitation, any Taxes or Other Taxes imposed or asserted by any jurisdiction on amounts payable under this Section 8.04) paid by such Lending Party and any liability (including penalties, interest and expenses) arising therefrom or with respect thereto. This indemnification shall be paid within 15 days after such Lending Party makes demand therefor.

(d) Each Lending Party organized under the laws of a jurisdiction outside the United States, on or prior to its execution and delivery of this Agreement in the case of each Lending Party listed on the signature pages hereof and on or prior to the date on which it becomes a Lending Party in the case of each other Lending Party, and from time to time thereafter if requested in writing by the Borrower (but only so long as such Lending Party remains lawfully able to do so), shall provide the Borrower and the Administrative Agent with Internal Revenue Service form W-8ECI or W-8BEN, as appropriate, or any successor form prescribed by the Internal Revenue Service, certifying that such Lending Party is entitled to benefits under an income tax treaty to which the United States is a party which exempts such Lending Party from United States withholding tax or reduces the rate of withholding tax on payments of interest for the account of such Lending Party or certifying that the income receivable pursuant to the Financing Documents is effectively connected with the conduct of a trade or business in the United States.

(e) For any period with respect to which a Lending Party has failed to provide the Borrower and the Administrative Agent with the appropriate form pursuant to Section 8.02(d) (unless such failure is due to a change in treaty, law or regulation occurring after the date on which such form originally was required to be provided), such Lending Party shall not be entitled to indemnification under Section 8.02(b) or (c) with respect to Taxes imposed by the United States; *provided* that if a Lending Party, which is otherwise exempt from or subject to a reduced rate of withholding tax, becomes subject to Taxes because of its failure to deliver a form required hereunder, the Borrower shall take such steps as such Lending Party shall reasonably request to assist such Lending Party to recover such Taxes.

(f) If the Borrower is required to pay additional amounts to or for the account of any Lender pursuant to this Section 8.02, such Lender will change the jurisdiction of its Domestic Lending Office if, in the judgment of such Lender, such change (i) will eliminate or reduce any such additional payment which may thereafter accrue and (ii) is not otherwise disadvantageous to such Lender.

ARTICLE 9
MISCELLANEOUS

Section 9.01 *Notices*.

All notices, requests and other communications to any party hereunder shall be in writing (including bank wire, telex, facsimile transmission or similar writing) and shall be given to such party:

(x) in the case of the Borrower or the Administrative Agent, at its address, facsimile number or telex number set forth on Schedule 9.01 hereto,

(y) in the case of any Lender, at its address, facsimile number or telex number set forth in its Administrative Questionnaire or

(z) in the case of any party, such other address, facsimile number or telex number as such party may hereafter specify for the purpose by notice to the Administrative Agent and the Borrower.

Each such notice, request or other communication shall be effective (i) if given by telex, when such telex is transmitted to the telex number referred to in this Section and the appropriate answerback is received, (ii) if given by facsimile transmission, when transmitted to the facsimile number referred to in this Section and confirmation of receipt is received, (iii) if given by mail, 72 hours after such communication is deposited in the mails with first class postage prepaid, addressed as aforesaid or (iv) if given by any other means, when delivered at the address referred to in this Section; *provided* that notices to the Administrative Agent or the LC Issuing Bank under Article 2 or Article 8 shall not be effective until received.

Section 9.02 *No Waivers*.

No failure or delay by any Lending Party in exercising any right, power or privilege under any Financing Document shall operate as a waiver thereof nor shall any single or partial exercise thereof preclude any other or further exercise thereof or the exercise of any other right, power or privilege. The rights and remedies herein provided shall be cumulative and not exclusive of any rights or remedies provided by law.

Section 9.03 *Expenses; Indemnification*.

(a) The Borrower shall pay (i) all out-of-pocket expenses of the Administrative Agent, including reasonable fees and disbursements of special counsel for the Administrative Agent, in connection with the preparation and administration of the Financing Documents, any waiver or consent thereunder or any amendment thereof or any Default or alleged Default thereunder, (ii) all out-of-pocket expenses of BAS and CUSA (but not any fees and disbursements of counsel) in connection with the preparation of the Financing Documents and (ii) if an Event of Default occurs, all out-of-pocket expenses incurred by each Lending Party, including (without duplication) the fees and disbursements of outside counsel and the allocated cost of inside counsel, in connection with such Event of Default and any collection, bankruptcy, insolvency, workout or other enforcement proceedings resulting therefrom.

(b) The Borrower shall indemnify each Lending Party, BAS, CUSA and their respective Affiliates and the respective directors, officers, agents and employees of the foregoing (each an "*Indemnitee*") and hold each Indemnitee harmless from and against any and all liabilities, losses, damages, costs and expenses of any kind, including, without limitation, the reasonable fees and disbursements of counsel, which may be incurred by such Indemnitee in connection with any investigative, administrative or judicial proceeding (whether or not such Indemnitee shall be designated a party thereto) brought or threatened relating to or arising out of any Financing Document or any actual or proposed use by the Borrower or any of its Subsidiaries or Equity Affiliates of any Letters of Credit or any proceeds of the Loans; *provided* that no Indemnitee shall have the right to be indemnified hereunder for such Indemnitee's own gross negligence or willful misconduct as determined by a court of competent jurisdiction.

(c) To the fullest extent permitted by applicable law, the Borrower shall not assert, and hereby waives, any claim against any Indemnitee, on any theory of liability, for special, indirect, consequential or punitive damages (as opposed to direct or actual damages) arising out of, in connection with, or as a result of, this Agreement, any other Financing Document or any agreement or instrument contemplated hereby, the transactions contemplated hereby or thereby, any Letter of Credit or the use of the proceeds thereof.

Section 9.04 ***Set-offs; Sharing*****.**

(a) If (i) an Event of Default has occurred and is continuing and (ii) the requisite Lenders have requested the Administrative Agent to declare the LC Reimbursement Obligations to be immediately due and payable pursuant to Section 6.01, or the LC Reimbursement Obligations and other obligations under the Financing Documents have become immediately due and payable without notice as provided in Section 6.01, then each Lending Party and each of their respective Affiliates is hereby authorized by the Borrower at any time and from time to time, to the extent permitted by applicable law, without notice to the Borrower (any such notice being expressly waived by the Borrower), to set off and apply all deposits (general or special, time or demand, provisional or final) at any time held and other indebtedness at any time owing by such Lending Party or any such Affiliate to or for the account of the Borrower against any obligations of the Borrower to such Lending Party now or hereafter existing under this Agreement, regardless of whether any such deposit or other obligation is then due and payable or is in the same currency or is booked or otherwise payable at the same office as the obligation against which it is set off and regardless of whether such Lending Party shall have made any demand for payment under this Agreement. Each Lending Party agrees promptly to notify the Borrower after any such set-off and application made by such Lending Party; *provided* that any failure to give such notice shall not affect the validity of such setoff and application. The rights of the Lending Parties under this subsection are in addition to any other rights and remedies which they may have.

(b) Each Lender agrees that if it shall, by exercising any right of set-off or counterclaim or otherwise, receive payment of a proportion of the aggregate amount of principal and interest due with respect to the participations in LC Reimbursement Obligations held by it which is greater than the proportion received by any other Lender in respect of the aggregate amount of participations in LC Reimbursement Obligations held by such other Lender, the Lender receiving such proportionately greater payment shall purchase such participations in LC Reimbursement Obligations held by the other Lenders, and such other adjustments shall be made, as may be required so that all such payments of participations in LC Reimbursement Obligations held by the Lenders shall be shared by the Lenders pro rata.

(c) Nothing in this Section shall impair the right of any Lender to exercise any right of set-off or counterclaim it may have and to apply the amount subject to such exercise to the payment of indebtedness of the Borrower other than its indebtedness in respect of the LC Reimbursement Obligations.

(d) The Borrower agrees, to the fullest extent it may effectively do so under applicable law, that any holder of a participation in a LC Reimbursement Obligation, whether or not acquired pursuant to the foregoing arrangements, may exercise rights of set-off or counterclaim and other rights with respect to such participation as fully as if such holder of a participation were a direct creditor of the Borrower in the amount of such participation.

Section 9.05 ***Amendments and Waivers*****.**

Any provision of this Agreement may be amended or waived if, but only if, such amendment or waiver is in writing and is signed by the Borrower and the Required Lenders (and, if the rights or duties of the LC Issuing Bank are affected thereby, by the LC Issuing Bank, as the case may be); *provided* that no such amendment or waiver shall:

(i) unless signed by all the Lenders, increase or decrease any Commitment (except for a ratable decrease in all the Commitments), postpone the date fixed for the termination of any Commitment or, except as expressly provided in Section 2.01(f), extend the expiry date of any Letter of Credit, reduce the amount of any LC Reimbursement Obligation or any interest thereon, or postpone the Termination Date or any date fixed for any payment of any LC Reimbursement Obligation or any interest thereon;

(ii) unless signed by all the Lenders entitled to receive such fees, reduce or postpone the date fixed for any scheduled payment of fees hereunder; or

(iii) unless signed by all the Lenders, change any provision of this Section or any other provision of this Agreement specifying which Lenders may take any action that the Lenders or any of them are entitled to take hereunder.

Section 9.06 ***Successors and Assigns*****.**

(a) The provisions of this Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns, except that the Borrower may not assign or otherwise transfer any of its rights under the Financing Documents without the prior written consent of all the Lenders and the LC Issuing Bank.

(b) Any Lender may at any time grant to one or more banks or other institutions (each a " *Participant*") participating interests in its Commitment or any or all of its participations in the Letters of Credit. If any Lender grants such a participating interest to a Participant, whether or not upon notice to the Borrower and the Administrative Agent, such Lender shall remain responsible for the performance of its obligations hereunder, and the Borrower, the LC Issuing Bank and the Administrative Agent shall continue to deal solely and directly with such Lender in connection with such Lender's rights and obligations under the Financing Documents. Any agreement pursuant to which any Lender may grant such a participating interest shall provide that such Lender shall retain the sole right and responsibility to enforce the obligations of the Borrower and the LC Issuing Bank under the Financing Documents including, without limitation, the right to approve any amendment, modification or waiver of any provision thereof; *provided* that such participation agreement may provide that such Lender will not agree to any modification, amendment or waiver of this Agreement described in clause (i) or (ii) of Section 9.05 without the consent of the Participant. An assignment or other transfer which is not permitted by subsection (c) or (d) below shall be given effect for purposes of this Agreement only to the extent of a participating interest granted in accordance with this subsection (b).

(c) Any Lender may at any time after the Closing Date assign to an Eligible Assignee all, or a pro rata part of all, of its rights and obligations under the Financing Documents, and such Eligible Assignee shall assume such rights and obligations, pursuant to an Assignment and Assumption Agreement substantially in the form of Exhibit A hereto signed by such Eligible Assignee and such transferor Lender; *provided* that:

(A) if such Eligible Assignee is not an Affiliate of the transferor Lender and was not a Lender immediately prior to such assignment, then, unless the Administrative Agent and, so long as no Event of Default has occurred and is continuing, the Borrower otherwise agree, the portion of the transferor Lender's Commitment assigned to such Eligible Assignee shall be at least $5,000,000; and

(B) unless the Administrative Agent and, so long as no Event of Default has occurred and is continuing, the Borrower otherwise agree or the transferor Lender assigns its entire Commitment to such Eligible Assignee, the transferor Lender and/or its Affiliates shall retain, in the aggregate, a Commitment at least equal to $5,000,000.

When such Assignment and Assumption Agreement has been signed and delivered to the Administrative Agent and such Eligible Assignee has paid to such transferor Lender an amount equal to the purchase price agreed between such transferor Lender and such Eligible Assignee, such Eligible Assignee shall be a Lender party to this Agreement and shall have all the rights and obligations of a Lender to the extent set forth in such Assignment and Assumption Agreement, and the transferor Lender shall be released from its obligations hereunder to a corresponding extent, and no further consent or action by any party shall be required. Upon the consummation of any assignment pursuant to this subsection (c), the transferor Lender, the Administrative Agent and the Borrower shall make appropriate arrangements so that, if required, a new Note is issued to the Eligible Assignee. In connection with any such assignment, either the transferor Lender or the Eligible Assignee shall pay to the Administrative Agent an administrative fee for processing such assignment in the amount of $3,500. If the Eligible Assignee is not incorporated under the laws of the United States or a State thereof, it shall deliver to the Borrower and the Administrative Agent certification as to exemption from deduction or withholding of any United States federal income taxes in accordance with Section 8.02(d).

(d) Any Lender may at any time assign all or any portion of its rights under the Financing Documents to a Federal Reserve Bank. No such assignment shall release the transferor Lender from its obligations thereunder.

(e) No Eligible Assignee, Participant or other transferee of any Lender's rights shall be entitled to receive any greater payment under or by reason of Section 8.01 or 8.02 than such Lender would have been entitled to receive with respect to the rights transferred, unless such transfer is made with the Borrower's prior written consent or by reason of the provisions of Section 8.01 or 8.02 requiring such Lender to designate a different Domestic Lending Office under certain circumstances or, in the case of an Eligible Assignee, at a time when the circumstances giving rise to such greater payment did not exist. Subject to the foregoing limitation, any Lender claiming compensation or indemnification pursuant to Section 8.01 or 8.02 may include in its claim similar compensation or indemnification for any Participant having a participating interest in such Lender's rights.

Section 9.07 ***No Reliance on Margin Stock as Collateral*****.**

Each of the Lenders represents to the Administrative Agent and each of the other Lenders that it in good faith is not relying upon any "*margin stock*" (as defined in Regulation U) as collateral in the extension or maintenance of the credit provided for in this Agreement.

Section 9.08 ***Confidentiality*****.**

Each Lending Party agrees to keep any information delivered or made available by the Borrower to it confidential from anyone other than persons employed or retained by such Lending Party who are, or are expected to be, engaged in evaluating, approving, structuring or administering the credit facility provided herein; *provided* that nothing herein shall prevent any Lending Party from disclosing such information (a) to any other Lending Party, (b) to any other Person if reasonably incidental to the administration of the credit facility provided herein, (c) upon the order of any court or administrative agency, (d) upon the request or demand of any regulatory agency or authority, (e) which had been publicly disclosed other than as a result of a disclosure by any Lending Party prohibited by this Agreement, (f) in connection with any litigation to which such Lending Party or any of its Affiliates may be a party, (g) to the extent necessary in connection with the exercise of any remedy hereunder, (h) to such Lending Party's legal counsel and independent auditors, (i) to any Affiliate of such Lending Party, solely in connection with this Agreement or any other transaction or proposed transaction between such Lending Party and/or its Affiliates and the Borrower and/or its Affiliates, and (j) subject to provisions substantially similar to those contained in this Section, to any actual or proposed Participant or Eligible Assignee.

Section 9.09 ***WAIVER OF JURY TRIAL*****.**

THE BORROWER AND EACH LENDING PARTY HEREBY IRREVOCABLY WAIVE ANY AND ALL RIGHT TO TRIAL BY JURY IN ANY LEGAL PROCEEDING ARISING OUT OF OR RELATING TO THE FINANCING DOCUMENTS OR THE TRANSACTIONS CONTEMPLATED THEREBY.

Section 9.10 ***GOVERNING LAW; SUBMISSION TO JURISDICTION*****.**

EACH OF THE FINANCING DOCUMENTS SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH THE LAWS OF THE STATE OF NEW YORK. THE BORROWER HEREBY SUBMITS TO THE NONEXCLUSIVE JURISDICTION OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK AND OF ANY NEW YORK STATE COURT SITTING IN NEW YORK CITY FOR PURPOSES OF ALL LEGAL PROCEEDINGS ARISING OUT OF OR RELATING TO THE FINANCING DOCUMENTS OR THE TRANSACTIONS CONTEMPLATED THEREBY. THE BORROWER IRREVOCABLY WAIVES, TO THE FULLEST EXTENT PERMITTED BY LAW, ANY OBJECTION WHICH IT MAY NOW OR HEREAFTER HAVE TO THE LAYING OF THE VENUE OF ANY SUCH PROCEEDING BROUGHT IN SUCH A COURT AND ANY CLAIM THAT ANY SUCH PROCEEDING BROUGHT IN SUCH A COURT HAS BEEN BROUGHT IN AN INCONVENIENT FORUM.

Section 9.11 ***Counterparts; Integration*****.**

This Agreement may be signed in any number of counterparts, each of which shall be an original, with the same effect as if the signatures thereto and hereto were upon the same instrument. This Agreement constitutes the entire agreement and understanding among the parties hereto and supersedes any and all prior agreements and understandings, oral or written, relating to the subject matter hereof.

Section 9.12 ***USA PATRIOT Act Notice.***

Each Lender that is subject to the Act (as hereinafter defined) and the Administrative Agent (for itself and not on behalf of any Lender) hereby notifies the Borrower that pursuant to the requirements of the USA Patriot Act (Title III of Pub. L. 107-56 (signed into law October 26, 2001)) (the "*Act*"), it is required to obtain, verify and record information that identifies the Borrower, which information includes the name and address of the Borrower and other information that will allow such Lender or the Administrative Agent, as applicable, to identify the Borrower in accordance with the Act.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed by their respective authorized officers as of the day and year first above written.

Borrower:

TENET HEALTHCARE CORPORATION

By: /s/ F. SCOTT KELLMAN

Name: F. Scott Kellman
Title: Senior Vice President, Corporate Finance and Treasurer

Administrative Agent:

BANK OF AMERICA, N.A.,
as Administrative Agent

By: /s/ KEVIN R. WAGLEY

Name: Kevin R. Wagley
Title: Senior Vice President

Lenders:

BANK OF AMERICA, N.A.,
as LC Issuing Bank and Lender

By: /s/ KEVIN R. WAGLEY

Name: Kevin R. Wagley
Title: Senior Vice President

CITICORP USA, INC.,
as Syndication Agent and Lender

By: /s/ MYLES KASSIN

Name: Myles Kassin
Title: Vice President

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Exhibit 10(h)

[Letterhead of Tenet Healthcare Corporation]

March 10, 2004

Personal & Confidential

Mr. W. Randolph Smith
2908 Masters Circle
Plano, TX 75093

Dear Randy:

This letter is intended to confirm the substance of our conversation on February 5, 2004 regarding your transition of duties and continued employment with Tenet Healthcare Corporation ("Tenet"). Tenet acknowledges that, as a result of its Restructure and the material change in your job duties (the "Recent Duties Change"), for purposes of the TESPP, you could resign for "good reason" and be entitled to the benefits accorded a "Qualifying Termination" under the Tenet Executive Severance Protection Plan ("TESPP"). I have asked you not to resign, however, and to assist in the Restructure until the end of the year. As an inducement to do so, Tenet has offered the following proposal:

1. You will remain a part of the executive management team, retaining your current title and will report to the CEO through the earliest date to occur ("Last Day Worked") of (a) December 31, 2004 or (b) the date that Tenet divests of 27 hospital facilities. Your new duties will consist at a minimum of managing the operations of the hospitals currently being divested from Tenet. You will remain in your current location at Tenet Dallas.

2. Through your Last Day Worked, your base salary will remain at no less than its current level, payable biweekly. You will continue to receive benefits, including; health and welfare, disability, 401k, auto allowance, etc., at a level no worse than you currently enjoy.

3. You will be eligible to participate in Tenet's Annual Incentive Plan ("AIP") for FY 2003 on terms similar to other senior executives at your level. Also, if you remain employed through your Last Day Worked, you will be eligible to participate in the AIP Plan for FY 2004 on a similar basis as other executives at your level with the target award being 70% of base pay, regardless of the fact that your employment may have terminated prior to the date that you would otherwise be required to remain employed pursuant to the terms of the AIP.

4. You will continue to be eligible to receive stock incentive awards through December 31, 2004, however, any award granted in 2004 will be forfeited if you resign your employment prior to your Last Day Worked unless such resignation is for a "good reason" (as defined in the TESPP) other than the Recent Duties Change.

5. You will continue as a participant in Tenet's Supplemental Executive Retirement Plan ("SERP") through your Last Day Worked and thereafter through any period during which you are entitled to receive salary continuation payments.

6. The Recent Duties Change entitles you to terminate your employment at any time and for any reason. Such termination will be deemed a Qualifying Termination. In addition, your termination of employment by Tenet at any time and for any reason will also be deemed a Qualifying Termination. In either case, subject to signing Tenet's standard release agreement, you will be eligible to receive all benefits to which you are entitled under the terms of the TESPP, including salary continuation and target bonus, for a period of two years commencing on the date of termination.

7. Because you will have reached age 55 with ten years of service before the end of the salary continuation period under the TESPP, your status upon termination of employment will be deemed an "Early Retirement" for purposes of SERP and you will be eligible to receive early retirement benefits pursuant to the terms of the SERP.

8. If you remain employed through your Last Day Worked, or if you resign from employment by Tenet for a "good reason" (as defined in the TESPP) other than the Recent Duties Change, even though you will not reach age 60 by the end of the salary continuation period under the TESPP, which age is considered normal retirement under Tenet's 2001 Stock Incentive Plan, the compensation committee has approved treating your retirement as "normal retirement" for purposes of the Stock Incentive Plan so that you will be entitled to retain all of your options, and exercise them, through the last day of the term of the options.

As a condition of your continuing employment, you agree to abide by all of Tenet's Human Resources policies, including Tenet's Fair Treatment process which includes final and binding Arbitration as a resolution of any grievance that results from your employment or termination of employment with Tenet.

Randy, assuming these terms are agreeable, please sign this letter indicating your acceptance and return to me.

Sincerely,

/s/ TREVOR FETTER

Trevor Fetter

ACCEPTED AND AGREED TO:

/s/ W. RANDOLPH SMITH

W. Randolph Smith—President, Western Division
3/12/2004

[Letterhead of Tenet Healthcare Corporation]

January 11, 2005

Personal and Confidential

Mr. W. Randolph Smith
7324 Park Lane Drive
Dallas, TX 75320

Dear Randy,

This letter is intended to confirm our understanding regarding the continuing terms of your employment and the termination of your employment with Tenet. In an earlier letter dated March 10, 2004, we agreed that your Last Day Worked would be the earlier of (a) December 31, 2004 or (b) the date that Tenet divests of 27 hospital facilities. We have now agreed to extend this date from December 31, 2004 to March 31, 2005. The same terms and conditions outlined in the earlier letter shall continue to apply to this extension with the following clarification regarding two points.

First, since you remained employed through December 31, 2004, you will be eligible to participate in Tenet's Annual Incentive Plan ("AIP") for FY 2004 based on the performance of the Divestiture Division with the target award being 70% of base pay.

Second, as set forth in the earlier letter, because you will have reached age 55 with ten years of service before the end of the salary continuation period under the TESPP, your status upon termination of employment will be deemed an "Early Retirement" for purposes of the SERP and you will be eligible to receive early retirement benefits pursuant to the terms of the SERP. Please be aware that the Compensation Committee has resolved to amend and restate the Tenet SERP effective as of November 3, 2004 to eliminate the ability to request a lump sum distribution with respect to all participants under the Tenet SERP.

Randy, assuming that this accurately sets forth our continued understanding, please sign this letter and return it to me.

Sincerely,

/s/ JOSEPH A. BOSCH

Joe Bosch
Sr. Vice President, Human Resources

ACCEPTED AND AGREED TO:

/s/ W. RANDOLPH SMITH

W. Randolph Smith

1/20/2005

Date

QuickLinks

LETTER TO W. RANDOLPH SMITH

Exhibit 10(i)

[Letterhead of Tenet Healthcare Corporation]

Personal & Confidential

February 16, 2005

Mr. Robert Shapard
6405 Lake Forest Drive
Plano, Texas 75024

Dear Bob:

I am pleased to confirm the details of our offer to you to become Tenet's Chief Financial Officer. Your start date with the company will be March 1, 2005 and you will officially assume the CFO duties on March 10, 2005. As you are aware, this offer is contingent on approval by Tenet Healthcare Corporation's Compensation Committee. Ultimately, the offer is also contingent on completion of a satisfactory reference check as well as passing a routine drug screening.

I am excited at the prospect of you joining my senior management team and me at Tenet. As we have discussed, I am energized and committed to building a new Tenet. The Chief Financial Officer position plays an important part in Tenet's success with responsibilities for Accounting, Treasury, Operations Finance, Acquisitions and Divestitures. As we have discussed, this position will report to me as the Chief Executive Officer, and your principal office will be at our headquarters in Dallas. I've outlined the major terms of the offer below.

1. *Compensation and Benefits*:

a. *Base Compensation*: Your starting base salary rate will be $600,000 per year, payable bi-weekly. Your next salary review will be in early 2006 when other senior executives are reviewed by the Compensation Committee.

b. *Annual Incentive Plan*: Your target award percentage in Tenet's Annual Incentive Plan (AIP) will be 70% of salary. The AIP is a function of exceptional individual and company performance. You will be eligible for a full year bonus for calendar year 2005.

c. *Car Allowance*: You will receive an annual automobile allowance of $18,100 paid bi-weekly.

d. *ExecuPlan Medical*: You will participate in Tenet's ExecuPlan, which provides reimbursement for out-of-pocket health and dental expenses at a $5,000 annual level.

e. *Initial Stock Incentives*: Your position is eligible for stock incentives. Stock incentive awards are considered periodically by the company's Compensation Committee of the Board of Directors. Stock incentive awards have typically vested over three years with one-third vesting at the end of each year. You are being recommended for an initial grant of 75,000 restricted stock units and 300,000 non-qualified stock options which would be granted at fair market value and made effective upon the Compensation Committee's approval.

f. *Annual Stock Incentives*: You will be eligible for an annual stock based incentive grant in March 2006. Based on the most recent guidelines approved by the Board the typical grant for your position is approximately 133,000 options and 27,000 RSUs.

g. *Benefits*: After 31 days of employment, you will be eligible to enroll in the TenetSelect benefit program which provides health, life, dental, vision and disability insurance coverage.

h. *Severance Protection Agreement*: You will receive severance protection in the event of a qualifying termination in accordance with the terms of the Tenet Executive Severance Protection Plan.

i. *SERP*: You will be named to the Supplemental Executive Retirement Plan (SERP) which provides enhanced retirement, disability and life insurance benefits.

2. *Employment Status*: As a condition of employment, you agree to abide by all of Tenet's Human Resources policies including Tenet's Fair Treatment process which includes final and binding Arbitration as a resolution of any grievance that results from your employment or termination of employment with Tenet Healthcare Corporation.

Finally, your employment with the company will be on an at-will basis which means that either you or the company may terminate the employment relationship with or without notice or with or without cause at any time. The term "cause" as used above shall include, but not be limited to, dishonesty, fraud, willful misconduct, self dealing or violation of the company's Standards of Conduct, breach of fiduciary duty (whether or not involving personal profit), failure, neglect or refusal to perform your duties in any material respect, violation of law (except traffic violations or similar minor infractions), violation of the company's Human Resources Operations or other Policies, or any material breach of this agreement; provided, however, that a failure to achieve or meet business objectives as defined by the company shall not be considered "cause" so long as you have devoted your best and good faith efforts and full attention to the achievement of those business objectives.

Bob, assuming these terms are agreeable, and we receive approval from our Compensation Committee, please sign this letter indicating your acceptance and return to me.

This is a terrific opportunity for you and Tenet. We are enthusiastic about you accepting this position. Please call me if you have any questions.

Sincerely,

/s/ TREVOR FETTER

Trevor Fetter

ACCEPTED AND AGREED TO:

/s/ ROBERT SHAPARD 2/18/05

Robert Shapard Date

In order to prepare your benefits package for your orientation, please provide the following information:

Social Security Number: [Omitted] Birth Date: 9/22/55

cc: Peter Crist
Peter Urbanowicz

TENET EXECUTIVE SEVERANCE PROTECTION PLAN
(Robert Shapard)

The Tenet Executive Severance Protection Plan (the "Plan") will provide Covered Executives (as defined herein) of the Company with certain cash severance payments and/or other benefits in the event of a termination of the Executive's employment as a result of a Qualifying Termination (as defined herein) or under certain other circumstances following a Change of Control (as defined herein). The Plan will become effective upon the execution and delivery of an Acknowledgement and Agreement by the Covered Executive agreeing to be bound by the terms of the Plan. Once accepted, the Plan will supercede and replace any and all prior and existing plans, arrangements, and agreements between the Covered Executive and the Company regarding benefits following a Qualifying Termination and/or a Change of Control except for any benefits which are set forth in the Company's SERP plan but not clearly delineated in the Plan itself.

1. *Covered Executive(s).*

The benefits of the Plan will be provided to eligible executives who have a Qualifying Termination and execute Tenet's standard Severance Agreement at the time of the termination, and to eligible executives under defined circumstances following a Change of Control. Eligibility to participate in the Plan will be offered to all executives holding the positions of Senior Vice President, Executive Vice President, and Reporting Officer.

Executives described in this paragraph are "Covered Executive(s)".

2. *Qualifying Terminations.*

A Covered Executive is entitled to severance benefits under the Plan if:

(a) The Executive is terminated involuntarily by the Company without cause. The term "cause" shall include the following: dishonesty, fraud, willful misconduct, self dealing or violation of the Company's Standards of Conduct, breach of fiduciary duty (whether or not involving personal profit), conflict of interest, failure, neglect or refusal to perform one's job duties in any material respect, violation of law (except traffic violations or similar minor infractions) or other wrongful conduct of a similar nature and degree. Notwithstanding, a failure to meet or achieve business objectives, as defined by the Company, shall not be considered cause so long as the Executive has devoted his/her best efforts and attention to the achievement of those objectives.

(b) The Executive resigns following a "good reason," meaning: (i) a material reduction in the Executive's job duties; (ii) a reduction of ten percent (10%) or more in the Executive's combined base salary and target annual bonus, or (iii) a material reduction in the Executive's retirement or supplemental retirement plan benefits. In the case of (ii) and (iii) above, such reduction shall not constitute good reason if it results from a general across-the-board reduction for executives at a similar job level within the Company.

Terminations described in this paragraph are "Qualifying Termination(s)".

3. *Cash Severance Payments.*

Following a Qualifying Termination, a Covered Executive will be entitled to receive severance payments at an annual rate equivalent to the Executive's annual salary and at the time of the Qualifying Termination for a period of two (2) years from the date immediately following the expiration of a six (6) month period following the date of termination. This six (6) month "waiting period" is required to comply with the American Jobs Creation Act of 2004 and Section 409A of the Internal Revenue Code. The 2-year period is referred to as the "Severance Period." Cash payments will be made on the Company's ordinary payroll schedule, subject to the Executive's continued compliance with the restrictive covenants described below (the "Restrictive Covenants").

4. *Benefit Continuation*.

Following a Qualifying Termination and the expiration of a six (6) month period following the date of termination, a Covered Executive will receive during the Severance Period (a) health and welfare benefits (but excluding Long Term Disability Insurance) on the same terms as such benefits are provided to executives at the same level employed by the Company during the Severance Period, (b) car allowance in the same amount as was provided the Executive at the time of the Qualifying Termination, and (c) ExecuPlan benefits. If a Covered Executive obtains employment prior to or during the Severance Period, his/her receipt of the benefits provided in (a)-(c) above will be mitigated to the extent equivalent coverage is provided by the Executive's new employer.

5. *Age and Service Credit for Retirement Plans.*

Covered Executives who are participants in the Company's Supplemental Executive Retirement Plan (SERP) at the time of a Qualifying Termination will receive age and service credit for purposes of SERP for the Severance Period. Any actual payment of retirement benefits under SERP will be made in accordance with the terms of the SERP plan, but not before the end of the Severance Period.

6. *Option Acceleration*.

a. *Qualifying Termination*. In the event of a Qualifying Termination, any options granted a Covered Executive after January 8, 2003 and any options granted the Executive prior to January 8, 2003 with an option price greater than $16.90 will accelerate and become fully vested. All of an Executive's vested options will then be exercisable until the end of the Severance Period unless by their terms they expire sooner or unless the Covered Executive has attained, or would have attained "Normal Retirement Age" under the Tenet Healthcare Corporation Stock Incentive Plan had he/she remained employed during the Severance Period, in which case the executive will be treated as a retiree under the Stock Incentive Plan and any vested options will continue to be exercisable for the remainder of their term. Any options that are not subject to acceleration under this paragraph will continue to vest according to their terms and will continue to be exercisable according to the terms of their original grant. No Covered Executive will be entitled to any new stock option grant following the date of termination or during the Severance Period.

b. *Following a Change Of Control*. In the event of a Change of Control, as defined herein at Paragraph 13, those executives who are eligible to participate in the Plan but have not had a Qualifying Termination will be entitled to the immediate acceleration and vesting of all their unvested options if such options are not assumed and/or substituted with equivalent options in connection with the Change of Control. In such case, the vested options shall then be exercisable according to the terms of the option plan.

7. *Restricted Unit Acceleration.*

In the event of a Qualifying Termination, any restricted units of Tenet Healthcare Corporation stock issued to Covered Executive will accelerate and become fully vested.

8. *IRC Section 280G Gross-Up*.

Notwithstanding any term to the contrary in any existing Company plan or agreement, the Company will provide Covered Executives with gross-up payments for any excise taxes resulting from Internal Revenue Code Section 280G incurred as a result of severance benefits provided under this Severance Plan or any other Company benefit plan.

9. *Restrictive Covenants*.

A Covered Executive's right to receive any severance benefits under this Plan following a Qualifying Termination is expressly conditioned upon the Covered Executive's executing a severance agreement at the time of termination in a form acceptable to the Company. The

severance agreement will contain certain restrictive covenants concerning confidentiality, non-disparagement, and cooperation as well as a general release of the Company. In addition, the severance agreement will impose restrictions on the Executive with respect to the solicitation of customers, employees and suppliers for a period of 2 years in the case of Covered Executives who are among the four Reporting Officers listed above, and one (1) year in the case of other Covered Executives.

The agreements and covenants of the Covered Executive in such severance agreement are referred to herein as the "Restrictive Covenants".

10. *Deferred Compensation*.

Any deferred compensation to which a Covered Executive is entitled under the Company's executive deferred compensation plan or any other similar plan or agreement will be distributed at the time of a Qualifying Termination based on the participant's then current distribution election on the condition that said election complies with the American Jobs Creation Act of 2004 and Section 409A of the Internal Revenue Code.

11. *Integration with Existing Agreements*.

In order to achieve one uniform severance plan for senior executives of the Company, this Executive Severance Protection Plan, once accepted by a Covered Executive, will replace and supersede any and all existing arrangements, agreements, contracts and/or plans, whether oral or in writing, which the Executive might have with the Company, as they relate either to severance benefits to which the Executive is entitled following an event constituting a Qualifying termination, or as they relate to any benefits to which the executive may be entitled following a Change of Control. This includes, but is not limited to, any benefits set forth in the existing 1996 Santa Barbara Relocation Plan and the October 1995 Change of Control Severance Plan. It does not include, however, any benefits which are set forth in the Company's SERP (described in paragraph 5 above), but which are not clearly delineated in this Severance Protection Plan.

12. *Expiration of Severance Protection Coverage.*

To the extent permitted by law, eligibility for participation in this program by a Covered Executive shall cease upon the first day of the Tenet fiscal year in which the participant will reach age 65.

13. *Change of Control Legal Payments.*

The Company agrees to reimburse any Executive for any legal fees and expenses the Executive reasonably incurs in seeking to obtain benefits under this Plan in the event there is a Change of Control and the Company fails to provide the benefits prescribed herein to which the Executive is entitled.

14. *Change of Control*

(a) A "Change of Control" of the Company shall be deemed to have occurred if: (i) any Person is or becomes the beneficial owner directly or indirectly of securities of the Company representing 20% or more of the combined Voting Stock of the Company or; (ii) individuals who, as of April 1, 1994, constitute the Board of Directors of the Company (the "Incumbent Board") cease for any reason to constitute at least a majority of the Board of Directors; provided, however, that (a) any individual who becomes a director of the Company subsequent to April 1, 1994, whose election, or nomination for election by the Company's stockholders, was approved by a vote of at least a majority of the directors then comprising the Incumbent Board shall be deemed to have been a member of the Incumbent Board and (b) no individual who was elected initially (after April 1, 1994) as a director as a result of an actual or threatened election contest, as such terms are used in Rule 14a-11 of Regulation 14A promulgated under the Securities Exchange Act of 1934, as amended, or any other actual or threatened solicitations of proxies or consents by or on behalf of any person

other than the Incumbent Board shall be deemed to have been a member of the Incumbent Board.

(b) "Person" shall mean an individual, firm, corporation or other entity or any successor to such entity, together with all Affiliates and Associates of such Person, but "Person" shall not include the Company, any subsidiary of the Company, any employee benefit plan or employee stock plan of the Company or any subsidiary of the Company, or any Person organized, appointed, established or holding Voting Stock by, for or pursuant to the terms of such a plan.

(c) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended.

(d) "Voting Stock" with respect to corporation shall mean shares of that corporation's capital stock having general voting power, with "voting power" meaning the power under ordinary circumstances (and not merely upon the happening of a contingency) to vote in the election of directors.

15. *Successors and Assigns*

The Tenet Executive Severance Protection Plan is intended to be a binding agreement and thus shall be binding on the Company's successors and assigns as it relates to the rights of any eligible executive who has executed a written Acknowledgement and Agreement signed by the Company agreeing to be covered by this Plan. The Company, in its sole discretion, retains the right to alter or terminate the Plan with respect to the future participation in the Plan of any new or yet to be covered executive.

QuickLinks

LETTER TO ROBERT SHAPARD
TENET EXECUTIVE SEVERANCE PROTECTION PLAN (Robert Shapard)

Exhibit 10(m)

TENET HEALTHCARE CORPORATION

FOURTH AMENDED AND RESTATED

SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN

As of November 5, 2003

Originally Dated November 1, 1984

Amended May 21, 1986

Amended April 25, 1994

Amended July 25, 1994

Amended January 28, 1997

Restated as of May 31, 1998

Amended and Restated as of October 9, 2001

Amended and Restated as of July 1, 2003

TENET HEALTHCARE CORPORATION
FOURTH AMENDED AND RESTATED
SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN

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ARTICLE I

STATEMENT OF PURPOSE

The Supplemental Executive Retirement Plan (the "Plan") has been adopted by Tenet Healthcare Corporation (the "Company") to attract, retain, motivate and provide financial security to highly compensated or management employees (the "Participants") who render valuable services to the Company and its "Subsidiaries," as defined in Article II. It is intended that this Plan shall not constitute a "qualified plan" subject to the limitations of section 401(a) of the Internal Revenue Code, nor shall it constitute a "funded plan," for purposes of such requirements. It also is intended that this Plan shall be exempt from the participation and vesting requirements of Part 2 of Title I of the Employee Retirement Income Security Act of 1974, as amended (the "Act"), the funding requirements of Part 3 of Title I of the Act, and the fiduciary requirements of Part 4 of Title I of the Act by reason of the exclusions afforded plans that are unfunded and maintained by an Company primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees.

End of Article 1

ARTICLE II

DEFINITIONS

When a word or phrase appears in this Plan with the initial letter capitalized, and the word or phrase does not commence a sentence, the word or phrase shall generally be a term defined in this Article II. The following words and phrases with the initial letter capitalized shall have the meaning set forth in this Article II, unless a different meaning is required by the context in which the word or phrase is used.

2.1 **Act** means the Employee Retirement Income Security Act of 1974, as amended, and the regulations and rulings thereunder.

2.1 **Acquisition** refers to a company of which substantially all of its assets or a majority of its capital stock are acquired by, or which is merged with or into, the Company or a Subsidiary.

2.3 **Actual Final Average Earnings** means the Participant's highest average monthly Earnings for any 60 consecutive months during the ten (10) years, or actual employment period if less, preceding Termination of Employment.

2.4 **Agreement** means a written agreement substantially in the form of Exhibit A between the Company and a Participant.

2.5 **Alternate Payee** means any spouse, former spouse, child, or other dependent of a Participant who is recognized by a DRO as having a right to receive all, or a portion of, the benefits payable under the Plan with respect to such Participant.

2.6 **Board** means the Board of Directors of the Company.

2.7 **Code** means the Internal Revenue Code of 1986, as amended.

2.8 **Commencement Date** means for purposes of determining the amount of the lump sum payment under Section 4.5, the following date:

(a) if benefits have commenced to be paid under the Plan, the date on which monthly benefits began to be paid to the Participant (or his or her Surviving Spouse or Eligible Children under the Plan if the Participant died before the payment of monthly benefits began); or

(b) if benefits have not commenced to be paid to the Participant under the Plan, the date of the Participant's election to receive the lump sum payment.

2.9 **Company** means Tenet Healthcare Corporation.

2.10 **Compensation Committee** means the Compensation Committee of the Board of Directors of the Company.

2.11 **Change of Control** means, with respect to the Company, the occurrence of either of the following events:

(a) any person as such term is used in Sections 13(c) and 14(d)(2) of the Securities Exchange Act of 1934, as amended, is or becomes the beneficial owner directly or indirectly of securities of the Company representing twenty percent (20%) or more of the combined voting power of the Company's then outstanding securities; or

(b) individuals who constitute the Incumbent Board cease for any reason to constitute at least a majority of the Board; provided, however, that (i) any individual who becomes a director of the Company subsequent to April 1, 1994, whose election, or nomination for election by the Company's stockholders, was approved by a vote of at least a majority of the directors then comprising the Incumbent Board shall be deemed to have been a member of the Incumbent

Board, and (ii) no individual who was elected initially (after April 1, 1994) as a director as a result of an actual or threatened election contest, as such terms are used in Rule 14a-11 of Regulation 14A promulgated under the Securities Exchange Act of 1934, as amended, or any other actual or threatened solicitations of proxies or consents by or on behalf of any person other than the Incumbent Board shall be deemed to have been a member of the Incumbent Board.

2.12 **Date of Employment** means the date on which a person began to perform Services directly for the Company or a Subsidiary as a result of an Acquisition or becoming an Employee.

2.13 **Date of Enrollment** means the date on or after June 1, 1984 on which an Employee first becomes a Participant in the Plan, provided that any Employee who becomes a Participant prior to June 1, 1985 shall be deemed to have a Date of Enrollment of the later of the Participant's Date of Employment or June 1, 1984.

2.14 **Disability** means any Termination of Employment during the life of a Participant and prior to Normal Retirement or Early Retirement by reason of a Participant's total and permanent disability. For this purpose, a Participant shall be totally and permanently disabled if the Participant qualifies for (a) disability benefits under the Company's Group Long-Term Disability Plan or under any similar plan provided by the Company or a Subsidiary, as now in effect or as hereinafter amended (the "LTD Plans") or (b) Social Security disability benefits.

2.15 **DRO** means a domestic relations order that is a judgment, decree, or order (including one that approves a property settlement agreement) that relates to the provision of child support, alimony payments or marital property rights to a spouse, former spouse, child or other dependent of a Participant and is rendered under a state (within the meaning of section 7701(a)(10) of the Code) domestic relations law (including a community property law) and that:

(a) Creates or recognizes the existence of an Alternate Payee's right to, or assigns to an Alternate Payee the right to receive all or a portion of the benefits payable with respect to a Participant under the Plan;

(b) Does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan;

(c) Does not require the Plan to provide increased benefits (determined on the basis of actuarial value);

(d) Does not require the payment of benefits to an Alternate Payee that are required to be paid to another Alternate Payee under another order previously determined to be a DRO; and

(e) Clearly specifies: (i) the name and last known mailing address of the Participant and of each Alternate Payee covered by the DRO; (ii) the amount or percentage of the Participant's benefits to be paid by the Plan to each such Alternate Payee, or the manner in which such amount or percentage is to be determined; (iii) the number of payments or payment periods to which such order applies; and (iv) that it is applicable with respect to this Plan.

2.16 **Early Retirement** means any Termination of Employment during the life of a Participant prior to the attainment of Normal Retirement Age and after attaining Early Retirement Age.

2.17 **Early Retirement Age** means the date the Participant attains age fifty-five (55) and has completed ten (10) Years of Service or attains age sixty-two (62) with no minimum Years of Service.

2.18 **Early Retirement Benefit** means the benefit payable under Section 3.2.

2.19 **Earnings** means the base salary paid to a Participant by the Company or a Subsidiary, **excluding** bonuses, car and other allowances and other cash and non-cash compensation. However, for all

Participants actively at work on or after February 1, 1997 as full-time, regular employees, "Earnings" means the base salary, any annual cash award paid under the Company's annual incentive plan and any discretionary awards made under the Company's deferred compensation plans by the Company or a Subsidiary to such Participant (referred to in Section 3.1 as "Bonus"), but shall **exclude** car and other allowances and other cash and non-cash compensation.

2.20 **Effective Date** means November 5, 2003, except as specifically provided otherwise herein.

2.21 **Eligible Children** means all natural or adopted children of a Participant under the age of twenty-one (21), including any child conceived prior to the death of a Participant.

2.22 **Employee** means any person who regularly performs services on a full-time basis (that is, works a minimum of thirty-two (32) hours a week) for the Company or a Subsidiary and receives a salary plus employee benefits normally made available to persons of similar status. The term "Employee" shall not include any person who is employed by the Company or a Subsidiary in the capacity of an independent contractor, an agent or a leased employee even if such person is determined by the Internal Revenue Service, the Department of Labor or a court of competent jurisdiction to be a common law employee of the Company or a Subsidiary.

2.23 **Employment or Service** means any continuous period during which an Employee is actively engaged in performing services for the Company and its Subsidiaries plus the term of any leave of absence approved by the PAC.

2.24 **Existing Retirement Benefit Plans Adjustment Factor** means the assumed benefit the Participant would be eligible for under Social Security and all Retirement Plans regardless of whether the Participant participates in such plans. This Factor shall be applied only to the base salary component of Final Average Earnings and is a projection of the benefits payable under the Social Security regulations in effect June 1, 1984, and Retirement Plans in effect on June 1, 1984, or the Participant's Date of Enrollment in the Plan, if later. Once established for a Participant, this Factor will not thereafter be altered to reflect any reduction in benefits under Social Security. At the direction of the Compensation Committee, this Factor may be adjusted from time to time to reflect changes under the following conditions:

(a) a Participant is transferred to different Retirement Plans;

(b) the Company's or the Subsidiary's, as applicable, contribution to a Retirement Plan is increased or decreased from the percentage used for the original calculation of the Participant's Factor; or

(c) the Participant becomes eligible for other Retirement Plans adopted by the Company or a Subsidiary which would provide benefits greater or less than the Retirement Plan considered in calculating the Participant's original Factor.

2.25 **Final Average Earnings** means the **lesser** of (a) Actual Final Average Earnings, or (b) if the Participant has completed at least sixty (60) months of service, Projected Final Average Earnings; however, for a Participant who is actively at work as an Employee on or after February 1, 1997 "Final Average Earnings" means Actual Final Average Earnings.

2.26 **Incumbent Board** means the Board in effect as of April 1, 1994.

2.27 **Normal Retirement** means any Termination of Employment during the life of a Participant on or after attaining Normal Retirement Age.

2.28 **Normal Retirement Age** means the date on which the Participant attains age sixty-five (65).

2.29 **Normal Retirement Benefit** means the benefit payable under Section 3.1.

2.30 **PAC** means the Pension Administration Committee of the Company established by the Compensation Committee, and whose members have been appointed by the Compensation Committee. The PAC shall have the responsibility to administer the Plan and make final determinations regarding claims for benefits, as described in Article V.

2.31 **Participant** means any Employee selected to participate in this Plan by the Compensation Committee, in its sole and absolute discretion.

2.32 **Plan Administrator** means the individual or entity appointed by the PAC to handle the day-to-day administration of the Plan, including but not limited to determining the amount of a Participant's benefits and complying with all applicable reporting and disclosure obligations imposed on the Plan. If the PAC does not appoint an individual or entity as Plan Administrator, the PAC shall serve as the Plan Administrator.

2.33 **Plan Year** means the fiscal year of this Plan, which shall commence on January 1 each year and end on December 31 of such year.

2.34 **Prior Service Credit Percentage** means the percentage to be applied to a Participant's Years of Service with the Company and its Subsidiaries prior to his or her Date of Enrollment in the Plan, in accordance with the following formula:

Years of Service After Date of Enrollment	Prior Service Credit Percentage
During 1st year	25
During 2nd year	35
During 3rd year	45
During 4th year	55
During 5th year	75
After 5th year	100

In the event of the death or Disability of a Participant while an Employee at any age or the Normal or Early Retirement of a Participant after age sixty (60), the Participant's Prior Service Credit Percentage will be one hundred (100).

2.35 **Projected Earnings** means (a) the actual Earnings of the Participant on the Date of Enrollment plus an assumed increase of eight percent (8%) per annum, or (b) for Participants who are Employees actively at work on April 1, 1994, with the corporate office or a division of the Company or a Subsidiary that has not been declared to be a discontinued operation, the actual Earnings of the Participant on April 1, 1994, plus an assumed increase of eight percent (8%) per annum.

2.36 **Projected Final Average Earnings** means the average of a Participant's Projected Earnings during the sixty (60) months preceding the Participant's Termination of Employment.

2.37 **Retirement Benefit** means an Early Retirement Benefit or Normal Retirement Benefit payable pursuant to Article III.

2.38 **Retirement Plans** means any qualified defined benefit pension plan or qualified defined contribution plan maintained by the Company and its Subsidiaries.

2.39 **Subsidiary** means any corporation, partnership, venture or other entity in which the Company owns fifty percent (50%) of the capital stock or otherwise has a controlling interest as determined by the Compensation Committee, in its sole and absolute discretion.

2.40 **Surviving Spouse** means the person legally married to a Participant for at least one (1) year prior to the Participant's death or Termination of Employment.

2.41 **Termination of Employment** means the ceasing of the Participant's Employment for any reason whatsoever, whether voluntarily or involuntarily.

2.42 **Termination without Cause** means, for purposes of Section 3.8, the termination of a Participant by the Company or a Subsidiary without cause or a voluntary termination of employment by the Participant within two (2) years of a Change in Control following:

(a) a material downward change in job functions, duties, or responsibilities which reduce the rank or position of the Participant;

(b) a reduction in the Participant's annual base salary;

(c) a material reduction in the Participant's annual incentive plan bonus payment other than for financial performance as it broadly applies to all similarly situated active Participants in the same plan;

(d) a material reduction in the Participant's retirement or supplemental retirement benefits that does not broadly apply to all active Participant's in the same plan; or

(e) a transfer of a Participant's office to a location that is more than fifty (50) miles from the Participant's current principal office location.

2.43 **Trust** means the 1994 Tenet Healthcare Corporation Supplemental Executive Retirement Plan Trust, dated May 25, 1994 and amended and restated on July 25, 1994, the assets of which are to be used for the payment of Retirement Benefits under this Plan.

2.44 **Trustee** means the individual or entity appointed as trustee under the Trust.

2.45 **Year** means a period of twelve (12) consecutive calendar months.

2.46 **Year of Service means** each complete year (up to a maximum of twenty (20)) of continuous Service (up to age sixty-five (65)) as an Employee of the Company and its Subsidiaries beginning with the Date of Employment with the Company and its Subsidiaries. Years of Service shall be deemed to have begun as of the first day of the calendar month of Employment and to have ceased on the last day of the calendar month of Employment. Years of Service prior to an Employee's Date of Enrollment in the Plan will be credited on a pro-rated basis pursuant to Section 2.34.

End of Article II

ARTICLE III

RETIREMENT BENEFITS

3.1 Normal Retirement Benefit.

(a) Calculation of Normal Retirement Benefit. Upon a Participant's Normal Retirement, the Participant shall be entitled to receive a monthly Normal Retirement Benefit for the Participant's lifetime which is determined in accordance with the Benefit Formula set forth below, adjusted by the Vesting Percentage in Section 3.3. Except as provided below, the amount of such monthly Normal Retirement Benefit will be determined by using the following formula:

X = [A1 x [B1 + [B2 X C]] x [2.7% - D] x E] + [A2 x [B1 + [B2 X C] x 2.7% x E]

X	=	Normal Retirement Benefit
A1	=	Final Average Earnings (From Base Salary)
A2	=	Final Average Earnings (From Bonus)
B1	=	Years of Service After Date of Enrollment
B2	=	Years of Service Prior to Date of Enrollment
C	=	Prior Service Credit Percentage
D	=	Existing Retirement Benefit Plans Adjustment Factor
E	=	Vesting Percentage

Note: B1 and B2 Years of Service combined cannot exceed twenty (20) years.

(b) Death After Commencement of Normal Retirement Benefits. If a Participant who is receiving a Normal Retirement Benefit dies, his or her Surviving Spouse or Eligible Children shall be entitled to receive (in accordance with Sections 3.5 and 3.6) a benefit equal to fifty percent (50%) of the Participant's Normal Retirement Benefit.

(c) Death After Normal Retirement Age But Before Normal Retirement. If a Participant who is eligible for Normal Retirement dies while an Employee after attaining age sixty-five (65), his or her Surviving Spouse or Eligible Children shall be entitled to receive (in accordance with Sections 3.5 and 3.6) the installments of the Normal Retirement Benefit which would have been payable to the Surviving Spouse or Eligible Children in accordance with Section 3.1(b) as if the Participant had retired from the Company or a Subsidiary on the day before he or she died.

3.2 Early Retirement Benefit.

(a) Calculation of Early Retirement Benefit. Upon a Participant's Early Retirement, the Participant shall be entitled to receive a monthly Early Retirement Benefit for the Participant's lifetime commencing on the first day of the calendar month following the date he or she attains Normal Retirement Age (age sixty-five (65)), calculated in accordance with Section 3.1 and Section 3.3 with the following adjustments:

(i) Only the Participant's actual Years of Service, adjusted appropriately for the Prior Service Credit Percentage, as of the date of Early Retirement shall be used.

(ii) For purposes of determining the Actual Final Average Earnings and Projected Final Average Earnings, only the Participant's Earnings and Projected Earnings as of the date of Early Retirement shall be used.

(iii) To arrive at the payments to commence at Normal Retirement Age for a Participant whose termination occurs prior to February 1, 1997 the amount calculated under

Section 3.2(a)(i) and Section 3.2(a)(ii) will be reduced by 0.42% for each month Early Retirement commences before age sixty-two (62).

(iv) To arrive at the payments to commence at Normal Retirement Age for a Participant who is actively at work as an Employee on or after February 1, 1997, the amount calculated under Section 3.2(a)(i) and Section 3.2(a)(ii) will be reduced by 0.25% for each month Early Retirement commences before age sixty-two (62).

(b) **Early Payment of Benefits**. Upon the written request of a Participant prior to his or her Termination of Employment, the Plan Administrator, in its sole and absolute discretion, may authorize payment of the Early Retirement Benefit at a date prior to the Participant's attainment of age sixty-five (65); provided, however, that in such event the amount calculated under Section 3.2(a)(i) and Section 3.2(a)(ii) shall be further reduced as follows:

(i) for a Participant who is actively at work as an Employee before February 1, 1997, the amount of the reduction shall be 0.42% for each month that the date of the commencement of payment precedes the date on which the Participant will attain age sixty-two (62); and

(ii) for a Participant who is actively at work as an Employee on or after February 1, 1997, the amount of further reduction under Section 3.2(a)(i) and Section 3.2(a)(ii) shall be 0.25% for each month that the date of commencement of payment precedes the date on which the Participant will attain age sixty-two (62).

(c) **Death After Early Retirement Benefits Commence**. If a Participant dies after commencement of the payment of his or her Early Retirement Benefit, his or her Surviving Spouse or Eligible Children shall be entitled to receive (in accordance with Sections 3.5 and 3.6) a benefit equal to fifty percent (50%) of the Participant's Early Retirement Benefit.

(d) **Death After Early Retirement But Before Benefit Commencement**. If a Participant dies after his or her Early Retirement but before benefits have commenced, or while on Disability, his or her Surviving Spouse or Eligible Children shall be entitled to receive (in accordance with Sections 3.5 and 3.6) a benefit equal to fifty percent (50%) of the benefit that would have been payable on the date of the Participant's death had he or she elected to have benefits commence on that date.

(e) **Death of Employee After Attainment of Early Retirement Age but Before Early Retirement**. If a Participant dies after attaining Early Retirement Age but before taking Early Retirement or while on Disability, his or her Surviving Spouse or Eligible Children shall be entitled to receive (in accordance with Sections 3.5 and 3.6) a benefit equal to fifty percent (50%) of the Participant's Early Retirement Benefit determined as if the Participant had retired on the day prior to his or her death with payments commencing on the first of the month following the Participant's death. The benefits payable to a Surviving Spouse or Eligible Children under this Section 3.2(e) shall be no less than the benefits payable to a Surviving Spouse or Eligible Children under Section 3.4 (regarding the Termination Benefit) as if the Participant had died immediately prior to age fifty-five (55).

3.3 **Vesting of Retirement Benefit**. A Participant's interest in his or her Normal or Early Retirement Benefit shall, subject to Section 7.5 (regarding Conditions Precedent), vest in accordance with the following schedule:

Years of Service	Vesting Percentage
Less than 5	0
5 but less than 6	25
6 but less than 7	30
7 but less than 8	35
8 but less than 9	40
9 but less than 10	45
10 but less than 11	50
11 but less than 12	55
12 but less than 13	60
13 but less than 14	65
14 but less than 15	70
15 but less than 16	75
16 but less than 17	80
17 but less than 18	85
18 but less than 19	90
19 but less than 20	95
20 or more	100

Notwithstanding the foregoing, a Participant who is at least sixty (60) years old and who has completed at least five (5) Years of Service will be fully vested, subject to Section 7.5 (regarding Conditions Precedent), in his or her Retirement Benefit. Except as required otherwise by applicable law, no Years of Service will be credited for Service after age sixty-five (65) or for more than twenty (20) years.

3.4 **Termination Benefit**. Upon any Termination of Employment of the Participant before Normal Retirement or Early Retirement for reasons other than death or Disability, and to subject to Section 3.3(b) (regarding Early Payment of Benefits), such Participant shall be entitled to a Retirement Benefit, commencing at Normal Retirement Age (age sixty-five (65)), calculated under Section 3.1 and 3.3 but with the following adjustments:

(a) **Calculation of Years of Service**. Only the Participant's actual Years of Service, adjusted appropriately for the Prior Service Credit Percentage, as of the date of his or her Termination of Employment shall be used.

(b) **Calculation of Earnings**. For purposes of determining the Actual Final Average Earnings and the Projected Final Average Earnings, as used in Section 3.1, only the Participant's Earnings and Projected Earnings prior to the date of his or her Termination of Employment shall be used.

(c) **Death After Commencement of Payments**. If a Participant dies after commencement of the payment of his or her Retirement Benefit under this Section 3.4, his or her Surviving Spouse or Eligible Children shall be entitled at Participant's death to receive (in accordance with Sections 3.5 and 3.6) a benefit equal to fifty percent (50%) of the Participant's Retirement Benefit.

(d) **Death after Termination of Employment**. If a Participant, who has a vested interest under Section 3.3, dies after Termination of Employment but at death is not receiving any Retirement Benefits under this Plan, his or her Surviving Spouse or Eligible Children shall be entitled to receive (in accordance with Sections 3.5 and 3.6) commencing on the date when

the Participant would have attained Normal Retirement Age, a benefit equal to fifty percent (50%) of the Retirement Benefit which would have been payable to the Participant at Normal Retirement Age.

(e) **Death while an Employee**. If a Participant, who has a vested interest under Section 3.3, dies while still actively employed by the Company or a Subsidiary or while on Disability before he or she was eligible for Early Retirement, his or her Surviving Spouse or Eligible Children shall be entitled at the Participant's death to receive a benefit equal to fifty percent (50%) of the Participant's Retirement Benefit (in accordance with Sections 3.5 and 3.6) calculated as if the Participant was age fifty-five (55) and eligible for Early Retirement on the day before the Participant's death; provided, however, that the combined reductions for Early Retirement and early payment shall not exceed twenty-one percent (21%) of the amount calculated under Sections 3.2(a)(i) and (ii).

(f) **Actuarial Reduction**. To arrive at the amount of the payments to commence at Normal Retirement Age, the amount calculated under Section 3.4(a), Section 3.4(b), Section 3.4(c), and Section 3.4(d) will be reduced by the maximum percentage reduction for Early Retirement at age fifty-five (55) (*i.e.*, twenty-one percent (21%)).

3.5 **Duration of Benefit Payment**.

(a) **Participant Benefit Payments**. The Normal or Early Retirement Benefit under the Plan shall be payable to the Participant in the form of a monthly benefit payable for life.

(b) **Surviving Spouse Benefit Payments**. The benefit payable to a Surviving Spouse under the Plan shall be paid in the form of a monthly benefit payable for life; provided, that all benefits payable to the Surviving Spouse are subject to actuarial reduction if the Surviving Spouse is more than three (3) years younger than the Participant.

(c) **Eligible Children Benefit Payments**. The benefit payable to a Participant's Eligible Children under the Plan shall be paid in the form of a monthly benefit payable until each such child reaches age twenty-one (21).

3.6 **Recipients of Benefit Payments**.

(a) **Death without Surviving Spouse**. If a Participant dies without a Surviving Spouse but is survived by any Eligible Children, then the Participant's benefits will be paid to his or her Eligible Children. The total monthly benefit payable will be equal to the monthly benefit that a Surviving Spouse would have received without actuarial reduction. This benefit will be paid in equal shares to all Eligible Children until the youngest of the Eligible Children attains age twenty-one (21).

(b) **Death of Surviving Spouse**. If the Surviving Spouse dies after the death of the Participant but is survived by Eligible Children then the total monthly benefit previously paid to the Surviving Spouse will be paid in equal shares to all Eligible Children until the youngest of the Eligible Children attains age twenty-one (21). When any of the Eligible Children reaches twenty-one (21), his or her share of the total monthly benefit will be reallocated equally to the remaining Eligible Children.

(c) **Death without Surviving Spouse or Eligible Children**. If the Participant dies without a Surviving Spouse or Eligible Children, no additional benefits will be paid under this Plan with respect to that Participant.

3.7 Disability.

(a) Disability Benefit. Any Participant, who is under Disability upon reaching Normal Retirement Age will be paid the Normal Retirement Benefit in accordance with Section 3.1 based on his vested interest as determined under Section 3.3 and Section 3.7(b).

(b) Continued Accrual of Vesting Service. Upon a Participant's Disability while an Employee of the Company, the Participant will continue to accrue Years of Service for purposes of vesting under this Plan during his or her Disability until the earliest of his or her:

(i) Recovery from Disability;

(ii) Attainment of Normal Retirement Age; or

(iii) Death.

(c) Not Eligible for Early Retirement Benefit. If a Participant is receiving Disability payments under a LTD Plan (as defined in Section 2.14), he or she shall not be entitled to receive an Early Retirement benefit under this Plan.

(d) Calculation of Earnings. For purposes of calculating the foregoing benefits, the Participant's Actual Final Average Earnings and Projected Final Average Earnings shall be determined using his or her Earnings and Projected Earnings up to the date of Disability.

3.8 Change of Control.

(a) Calculation of Benefits. In the event of a Change of Control while this Plan remains in effect, each Participant will be fully vested in his or her Retirement Benefit without regard to the Participant's Years of Service and the amount of such benefit will be calculated by granting the Participant Prior Service Credit under Sections 3.1 and 3.2 for all Years of Service prior to his or her Date of Enrollment. Further, the Participant will be entitled to receive the Normal Retirement Benefit described in Section 3.1 and calculated pursuant to this Section 3.8(a), on or after age sixty (60) with no reduction by virtue of Section 3.2(a)(iii) and Section 3.2(b).

(b) Benefits for Certain Employees as of April 1, 1994. For a Participant who is an Employee actively at work on April 1, 1994, with the corporate office or a division of the Company or a Subsidiary which has not been declared to be a discontinued operation, who has not yet begun to receive benefit payments under the Plan and who incurs a Termination without Cause, the provisions of Section 3.8(a) above shall not apply and instead a Participant's Early or Normal Retirement Benefit under this Plan will be determined by:

(i) granting the Participant full Prior Service Credit under Sections 3.1 and 3.2 for all Years of Service prior to his or her Date of Enrollment;

(ii) crediting the Participant with three (3) additional Years of Service (with total Years of Service not to exceed twenty (20) years); and

(iii) replacing the definition of Earnings under Article II with the following "the base salary and the annual cash bonus paid to a Participant by the Company or a Subsidiary, **excluding** (A) any cash bonus paid under the LTIP, (B) any car and other allowances and (C) other cash and non-cash compensation."

Further, the Participant will be fully vested in such Early or Normal Retirement Benefit without regard to his or her Years of Service.

The Participant will be entitled to receive such Retirement Benefit (1) on or after the age of sixty (60), without reduction, (2) after the age of fifty-five (55) with a reduction of 0.25% per month for each month for which the benefit commences to be paid before to the Participant's

attaining the age of sixty (60), or (3) after the age of fifty(50) with the foregoing reduction from age sixty (60) to age fifty-five (55) and with a reduction to 0.56% per month for each month for which the benefit commences to be paid prior to the Participant's attaining the age of fifty-five (55). No other reductions set forth in Section 3.2(a)(iii) and Section 3.2(b) will apply.

(c) **Benefits for Active Employees**. For a Participant who (i) is an active Employee, (ii) has not yet begun to receive benefit payments under the Plan, and (iii) incurs a Termination without Cause within two (2) years following a Change of Control while this Plan remains in effect, the provisions of Section 7.5(b)(ii) (Regarding Conditions Precedent) shall not apply.

3.9 **Golden Parachute Cap**. In no event shall the total present value of all payments under this Plan that are payable to a Participant and are contingent upon a Change of Control in accordance with the rules set forth in section 280G of the Code and the Treasury Regulations thereunder, when added to the present value of all other payments, other than payments that are made pursuant to this Plan, that are payable to a Participant and are contingent upon a Change of Control, exceed an amount equal to two hundred ninety-nine percent (299%) of the Participant's "base amount" as that term is defined in section 280G of the Code. For purposes of making a calculation under this Section 3.9, the determination of the portion of a payment that shall be treated as contingent upon a Change of Control shall be made in accordance with Proposed Treasury Regulations section 1.280G-1Q/A-24 or any successor regulations issued with respect thereto.

End of Article III

ARTICLE IV

PAYMENT

4.1 **Commencement of Payments**. Benefit payments under this Plan shall begin not later than the first day of the calendar month following the occurrence of an event which entitles a Participant (or a Surviving Spouse or Eligible Children) to benefits under this Plan.

4.2 **Withholding; Unemployment Taxes**. Any taxes required to be withheld by the Federal or any state or local government shall be withheld from payments under this Plan to the extent required by the law in effect at the time payments are made.

4.3 **Recipients of Payments**. All Retirement Benefit payments to be made by the Company under the Plan shall be made to the Participant during his or her lifetime. All subsequent payments under the Plan shall be made by the Plan to the Participant's Surviving Spouse or Eligible Children.

4.4 **No Other Benefits**. No other benefits shall be payable under this Plan to the Participant or his or her Surviving Spouse or Eligible Children by reason of the Participant's Termination of Employment or otherwise, except as specifically provided herein.

4.5 **Lump Sum Distributions**. At any time following the Participant's Termination of Employment which occurs within two (2) years after a Change of Control or following the Participant's Early Retirement or a Normal Retirement, the Participant, or his or her Surviving Spouse, who has a vested interest in the Plan may elect to receive a lump sum payment, in an amount determined below. The election to receive a lump sum payment must be filed with the Plan Administrator. The PAC will make a determination regarding the request for a lump sum payment within sixty (60) days after such election is filed with the Plan Administrator.

(a) **Calculation of Forfeiture Amount**. The lump sum payment shall be determined in accordance with the following provisions of this Section 4.5, and then shall be reduced by a penalty equal to ten percent (10%) of such payment which shall be forfeited to the Plan. However, the penalty shall not apply if the PAC determines, based on the advice of counsel or a final determination by the Internal Revenue Service or any court of competent jurisdiction, that by reason of the foregoing elective provisions of this Section 4.5 any Participant, Surviving Spouse or Eligible Child has recognized or will recognize gross income for federal income tax purposes under this Plan in advance of the payment to him or her of such lump sum. The PAC (or the Plan Administrator if directed to do so by the PAC) shall notify all Participants (and Surviving Spouses or Eligible Children of deceased Participants) of any such determination. Wherever any such determination is made, the Plan shall refund all penalties which were imposed hereunder on account of making lump sum payments at any time during or after the first year to which such determination applies (*i.e.*, the first year when gross income is recognized for federal income tax purposes). Interest shall be paid on any such refunds based on an interest factor determined under Section 4.5(e). The PAC may also reduce or eliminate the penalty if it determines that this action will not cause any Participant to recognize gross income for federal income tax purposes under this Plan in advance of payment to him or her of Plan benefits.

(b) **Exception for Hardship**. The ten percent (10%) penalty in Section 4.5(a) shall not apply if a retired Participant (or the Surviving Spouse or Eligible Children of a deceased Participant) receives a lump sum distribution due to a financial hardship. The PAC shall determine whether a financial hardship exists in its sole discretion, but in good faith and on a uniform, nondiscriminatory and reasonable basis. A hardship distribution shall be a cash payment not to exceed the amount necessary to relieve the hardship, including any additional taxes that will be incurred by reason of such hardship distribution.

(c) **Calculation of Lump Sum**. The amount of such lump sum payment shall be determined as follows:

(i) When monthly benefit payments have not yet commenced under the Plan and the Participant is living on the Commencement Date, the lump sum payment (prior to the ten percent (10%) penalty described in Section 4.5(a)) shall equal the lump sum value of the Participant's Early Retirement Benefit or Normal Retirement Benefit as of the Commencement Date. The amount described in this Section 4.5(c)(i) shall include, in addition, in the case of a Participant who has a spouse or Eligible Children on the Commencement Date, the lump sum value, determined as of such date, of any benefit payable to a Surviving Spouse or Eligible Children by reason of the Participant's death on or after such date assuming such spouse would qualify as a Surviving Spouse on and after such date. The lump sum amount representing the value of the benefits described in the preceding two sentences shall be computed (A) first by reducing the amount of the Participant's monthly benefit payable under Section 3.2 hereof, if the Participant's Commencement Date occurs before the Participant's Normal Retirement date, (B) then determining the survivor benefit which would be payable to a Surviving Spouse or Eligible Children in respect of such monthly benefit under Section 3.1(c) or Section 3.2(c) whichever is applicable, and (C) next commuting such benefits to their lump sum equivalent at the Commencement Date by reference to the factor described in Section 4.5(e). In computing the Participant's monthly benefit under clause (A) of the preceding sentence, if the Commencement Date occurs before the earliest date when the Participant may commence to receive his or her Early Retirement Benefit, the Participant's Early Retirement Benefit shall be computed as the annual actuarial equivalent of the Early Retirement Benefit which would be payable to him or her at the earliest date when benefits could commence under the Early Retirement provisions of Section 3.2, in the form of a single life annuity.

(ii) When monthly benefit payments under the Plan have previously commenced, the lump sum payment (prior to the ten percent (10%) reduction described in Section 4.5(a)) shall be equal to the difference between (A) minus (B) below, determined as of the Participant's Commencement Date, accumulated to the date of the lump sum payment using the same interest rate which is used in calculating the amounts (A) and (B):

(A) The lump sum value of the monthly benefits payable to the Participant (including any benefit payable to the Participant's Surviving Spouse or Eligible Children) determined as of the Participant's Commencement Date in the same manner as described in the Section 4.5(c)(i).

(B) The lump sum value of the monthly benefits previously paid to the Participant discounted to the Participant's Commencement Date.

(d) **Election by Surviving Spouse**. When a Surviving Spouse of a deceased Participant elects to receive a lump sum payment, the amount of the lump sum payment shall be determined by the PAC in a manner similar to that used for a Participant, except that the lump sum payment shall only reflect the benefit which would be payable to a Surviving Spouse and Eligible Children.

(e) **Interest Rate**. All lump sum equivalents hereunder shall be determined by reference to the factor described in this Section 4.5(e). Such factor is the interest rate used by the Pension Benefit Guaranty Corporation as of the Commencement Date for purposes of determining the present value of a lump sum distribution on plan termination.

End of Article IV

ARTICLE V

SPOUSAL CLAIMS

5.1 Spousal Claims.

(a) An Alternate Payee may be awarded all or a portion of the Participant's benefits pursuant to the terms of a DRO, in which case such benefits will be payable to the Alternate Payee at the same time and in the same form of payment as the Participant's.

(b) Any taxes or other legally required withholdings from payments to such Alternate Payee shall be deducted and withheld by the Company, benefit provider or funding agent. The Alternate Payee shall be provided with a tax withholding election form for purposes of federal and state tax withholding, if applicable.

(c) The Plan Administrator shall have sole and absolute discretion to determine whether a judgment, decree or order is a DRO, to determine whether a DRO shall be accepted for purposes of this Section 5.1 and to make interpretations under this Section 5.1, including determining who is to receive benefits, all calculations of benefits and determinations of the form of such benefits, and the amount of taxes to be withheld. The decisions of the Plan Administrator shall be binding on all parties with an interest.

(d) Any benefits payable to an Alternate Payee pursuant to the terms of a DRO shall be subject to all provisions and restrictions of the Plan and any dispute regarding such benefits shall be resolved pursuant to the Plan claims procedure in Article VI.

5.2 Legal Disability. If a person entitled to any payment under this Plan shall, in the sole judgment of the Plan Administrator, be under a legal disability, or otherwise shall be unable to apply such payment to his or her own interest and advantage, the Plan Administrator, in the exercise of its discretion, may direct the Company or payor of the benefit to make any such payment in any one or more of the following ways:

(a) Directly to such person;

(b) To his or her legal guardian or conservator; or

(c) To his or her spouse or to any person charged with the duty of his or her support, to be expended for his or her benefit and/or that of his or her dependents.

The decision of the Plan Administrator shall in each case be final and binding upon all persons in interest, unless the Plan Administrator shall reverse its decision due to changed circumstances.

5.3 Assignment. Except as provided in Section 5.1, no Participant, Surviving Spouse or Eligible Child shall have any right to assign, pledge, transfer, convey, hypothecate, anticipate or in any way create a lien on any amounts payable hereunder. No amounts payable hereunder shall be subject to assignment or transfer or otherwise be alienable, either by voluntary or involuntary act, or by operation of law, or subject to attachment, execution, garnishment, sequestration or other seizure under any legal, equitable or other process, or be liable in any way for the debts or defaults of Participants or their Surviving Spouses or Eligible Children. The Company may assign all or a portion of this Plan to any Subsidiary which employs any Participant.

End of Article V

ARTICLE VI

ADMINISTRATION OF THE PLAN

6.1 **The PAC**. The overall administration of the Plan will be the responsibility of the PAC.

6.2 **Powers of the PAC**. The PAC shall have sole and absolute discretion regarding the exercise of its powers and duties under this Plan. In order to effectuate the purposes of the Plan, the PAC will have the following powers and duties:

(a) To appoint the Plan Administrator;

(b) To review and render decisions respecting a denial of a claim for benefits under the Plan;

(c) To construe the Plan and to make equitable adjustments for any mistakes or errors made in the administration of the Plan;

(d) To carry out the duties expressly reserved to it under the Plan; and

(e) To determine and resolve, in its sole and absolute discretion, all questions relating to the administration of the Plan and the Trust (i) when differences of opinion arise between the Company, a Subsidiary, the Plan Administrator, the Trustee, a Participant, or any of them, and (ii) whenever it is deemed advisable to determine such questions in order to promote the uniform and nondiscriminatory administration of the Plan for the greatest benefit of all parties concerned.

The foregoing list of express powers is not intended to be either complete or conclusive, and the PAC will, in addition, have such powers as it may reasonably determine to be necessary or appropriate in the performance of its powers and duties under the Plan.

6.3 **Appointment of Plan Administrator**. The PAC will appoint the Plan Administrator, who will have the responsibility and duty to administer the Plan on a daily basis. The PAC may remove the Plan Administrator with or without cause at any time. The Plan Administrator may resign upon written notice to the PAC.

6.4 **Duties of Plan Administrator**. The Plan Administrator shall have sole and absolute discretion regarding the exercise of its powers and duties under this Plan. The Plan Administrator will have the following powers and duties:

(a) To direct the administration of the Plan in accordance with the provisions herein set forth;

(b) To adopt rules of procedure and regulations necessary for the administration of the Plan, provided such rules are not inconsistent with the terms of the Plan;

(c) To determine all questions with regard to rights of Participants under the Plan including, but not limited to, questions involving the amount of a Participant's benefits;

(d) To enforce the terms of the Plan and any rules and regulations adopted by the PAC;

(e) To review and render decisions respecting a claim for a benefit under the Plan;

(f) To furnish the Company or a Subsidiary with information required for tax or other purposes;

(g) To engage the service of counsel (who may, if appropriate, be counsel for the Company or a Subsidiary), actuaries, and agents whom it may deem advisable to assist it with the performance of its duties;

(h) To prescribe procedures to be followed by distributees in obtaining benefits;

(i) To receive from the Company or a Subsidiary and from Participants such information as is necessary for the proper administration of the Plan;

(j) To create and maintain such records and forms as are required for the efficient administration of the Plan;

(k) To make all determinations and computations concerning the benefits to which any Participant is entitled under the Plan;

(l) To give the Trustee specific directions in writing with respect to:

(i) the making of distribution payments, giving the names of the payees, the amounts to be paid and the time or times when payments will be made; and

(ii) the making of any other payments which the Trustee is not by the terms of the trust agreement authorized to make without a direction in writing by the Plan Administrator or the Company;

(m) To comply with all applicable lawful reporting and disclosure requirements of the Act;

(n) To comply (or transfer responsibility for compliance to the Trustee) with all applicable federal income tax withholding requirements for benefit distributions; and

(o) To construe the Plan, in its sole and absolute discretion, and make equitable adjustments for any mistakes and errors made in the administration of the Plan.

The foregoing list of express duties is not intended to be either complete or conclusive, and the Plan Administrator will, in addition, exercise such other powers and perform such other duties as it may deem necessary, desirable, advisable or proper for the supervision and administration of the Plan.

6.5 **Indemnification of the PAC and Plan Administrator**. To the extent not covered by insurance, or if there is a failure to provide full insurance coverage for any reason, and to the extent permissible under corporate by-laws and other applicable laws and regulations, the Company agrees to hold harmless and indemnify the PAC and Plan Administrator against any and all claims and causes of action by or on behalf of any and all parties whomsoever, and all losses therefrom, including, without limitation, costs of defense and reasonable attorneys' fees, based upon or arising out of any act or omission relating to or in connection with the Plan other than losses resulting from the PAC's, or any such person's, fraud or willful misconduct.

6.6 **Claims for Benefits**.

(a) **Initial Claim**. In the event that an Employee, Participant, Surviving Spouse or Eligible Child claims to be eligible for benefits, or claims any rights under this Plan, he or she must complete and submit such claim forms and supporting documentation as shall be required by the Plan Administrator, in its sole and absolute discretion. Likewise, any Participant, Surviving Spouse or Eligible Child who feels unfairly treated as a result of the administration of the Plan, must file a written claim, setting forth the basis of the claim, with the Plan Administrator. In connection with the determination of a claim, or in connection with review of a denied claim, the claimant may use representation and may examine this Plan, and any other pertinent documents generally available to Participants that are specifically related to the claim.

A written notice of the disposition of any such claim shall be furnished to the claimant within ninety (90) days after the claim is filed with the Plan Administrator. Such notice shall refer, if appropriate, to pertinent provisions of this Plan, shall set forth in writing the reasons for denial of the claim if a claim is denied (including references to any pertinent provisions of this Plan) and, where appropriate, shall describe any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary. If the claim is denied, in whole or in part, the claimant shall also be notified of

the Plan's claim review procedure and the time limits applicable to such procedure, including the claimant's right to arbitration following an adverse benefit determination on review as provided below. All benefits provided in this Plan as a result of the disposition of a claim will be paid as soon as practicable following receipt of proof of entitlement, if requested.

(b) **Request for Review**. Within ninety (90) days after receiving the written notice of the Plan Administrator's disposition of the claim, the claimant may file with the PAC a written request for review of his or her claim. In connection with the request for review, the claimant shall be entitled to be represented by counsel and shall be given, upon request and free of charge, reasonable access to all pertinent documents for the preparation of his claim. If the claimant does not file a written request for review within ninety (90) days after receiving written notice of the Plan Administrator's disposition of the claim, the claimant shall be deemed to have accepted the Plan Administrator's written disposition, unless the claimant shall have been physically or mentally incapacitated so as to be unable to request review within the ninety (90) day period.

(c) **Decision on Review**. After receipt by the PAC of a written application for review of his claim, the PAC will review the claim taking into account all comments, documents, records and other information submitted by the claimant regarding the claim without regard to whether such information was considered in the initial benefit determination. The PAC will notify the claimant of its decision by delivery or by certified or registered mail to his last known address. A decision on review of the claim shall be made by the PAC at its next meeting following receipt of the written request for review. If no meeting of the PAC is scheduled within forty-five (45) days of receipt of the written request for review, then the PAC shall hold a special meeting to review such written request for review within such forty-five (45)-day period. If special circumstances require an extension of the forty-five (45)-day period, the PAC shall so notify the claimant and a decision shall be rendered within ninety (90) days of the receipt of the request for review. In any event, if a claim is not determined by the PAC within ninety (90) days of receipt of written submission for review, it shall be deemed to be denied.

The decision of the PAC will be provided to the claimant as soon as possible but no later than five (5) days after the benefit determination is made. The decision will be in writing and will include the specific reasons for the decision presented in a manner calculated to be understood by the claimant and will contain references to all relevant Plan provisions on which the decision was based. Such decision will also advise the claimant that he may receive upon request, and free of charge, reasonable access to and copies of all documents, records and other information relevant to his claim and will inform the claimant of his right to arbitration in the case of an adverse decision regarding his appeal. The decision of the PAC will be final and conclusive.

6.7 **Arbitration**. In the event the claims review procedure described in Section 6.6 of the Plan does not result in an outcome thought by the claimant to be in accordance with the Plan document, he or she may appeal to a third party neutral arbitrator. The claimant must appeal to an arbitrator within sixty (60) days after receiving the PAC's denial or deemed denial of his or her request for review and before bringing suit in court.

The arbitrator shall be mutually selected by the claimant and the PAC from a list of arbitrators provided by the American Arbitration Association ("AAA"). If the parties are unable to agree on the selection of an arbitrator within 10 days of receiving the list from the AAA, the AAA shall appoint an arbitrator. The arbitrator's review shall be limited to interpretation of the Plan document in the context of the particular facts involved. The claimant, the PAC and the Company agree to accept the award of the arbitrator as binding, and all exercises of power by the arbitrator hereunder shall be final, conclusive and binding on all interested parties, unless found by a court

of competent jurisdiction, in a final judgment that is no longer subject to review or appeal, to be arbitrary and capricious. The costs of arbitration will be paid by the Company; the costs of legal representation for the claimant or witness costs for the claimant will be borne by the claimant; provided, that, as part of his award, the Arbitrator may require the Company to reimburse the claimant for all or a portion of such amounts.

The arbitrator shall have no power to add to, subtract from, or modify any of the terms of the Plan, or to change or add to any benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under the Plan. Nonetheless, the arbitrator shall have absolute discretion in the exercise of its powers in this Plan. Arbitration decisions will not establish binding precedent with respect to the administration or operation of the Plan.

6.8 **Receipt and Release of Necessary Information**. In implementing the terms of this Plan, the PAC and Plan Administrator, as applicable, may, without the consent of or notice to any person, release to or obtain from any other insuring entity or other organization or person any information, with respect to any person, which the PAC or Plan Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the PAC or Plan Administrator, as applicable, such information as may be necessary to determine eligibility for and amount of benefit, as a condition of claiming and receiving such benefit.

6.9 **Overpayment and Underpayment of Benefits**. The Plan Administrator may adopt, in its sole and absolute discretion, whatever rules, procedures and accounting practices are appropriate in providing for the collection of any overpayment of benefits. If a Participant, Surviving Spouse or Eligible Child receives an underpayment of benefits, the Plan Administrator shall direct that payment be made as soon as practicable to make up for the underpayment. If an overpayment is made to a Participant, Surviving Spouse or Eligible Child, for whatever reason, the Plan Administrator may, in its sole and absolute discretion, withhold payment of any further benefits under the Plan until the overpayment has been collected or may require repayment of benefits paid under this Plan without regard to further benefits to which the Participant, Surviving Spouse or Eligible Child may be entitled.

End of Article VI

ARTICLE VII

CONDITIONS RELATED TO BENEFITS

7.1 **No Right to Assets**. Neither a Participant nor any other person shall acquire by reason of the Plan any right in or title to any assets, funds or property of the Company and its Subsidiaries whatsoever including, without limiting the generality of the foregoing, any specific funds or assets which the Company, in its sole discretion, may set aside in anticipation of a liability hereunder. The Company has established the Trust, however, to assist in the payment of benefits under this Plan. Without limiting the generality of the foregoing, Section 1(d) of the Trust provides as follows:

> Plan participants and their beneficiaries shall have no preferred claim on, or any beneficial ownership interest in, any assets of the Company. Any rights created under the Plan and this Agreement shall be mere unsecured contractual rights of Plan participants and their beneficiaries against Company. Any assets held by the Trust will be subject to the claims of Company's general creditors under federal and state law in the event of Insolvency, as defined in Section 3(a) herein.

A Participant shall have only an unsecured contractual right to the amounts, if any, payable hereunder.

7.2 **No Employment Rights**. Nothing herein shall constitute a contract of continuing employment or in any manner obligate the Company and its Subsidiaries to continue the service of a Participant, or obligate a Participant to continue in the service of the Company and its Subsidiaries, and nothing herein shall be construed as fixing or regulating the compensation paid to a Participant.

7.3 **Right to Terminate or Amend**. Except during any two (2) year period after any Change of Control of the Company, the Company reserves the sole right to terminate the Plan at any time and to terminate an Agreement with any Participant at any time. In the event of termination of the Plan or of a Participant's Agreement, a Participant shall be entitled to only the vested portion of his or her accrued benefits under Article III of the Plan as of the time of the termination of the Plan or his or her Agreement. All further vesting and benefit accrual shall cease on the date of Plan or Agreement termination. Benefit payments would be in the amounts specified and would commence at the time specified in Article III as appropriate.

The Company further reserves the right in its sole discretion to amend the Plan in any respect except that Plan benefits cannot be reduced during any two (2)-year period after any Change of Control of the Company. No amendment of the Plan (whether there has or has not been a Change of Control of the Company) that reduces the value of the benefits previously accrued and vested by the Participant shall be effective.

7.4 **Offset**. If at the time payments or installments of payments are to be made hereunder, any Participant or his or her Surviving Spouse or both are indebted to the Company and its Subsidiaries, then the payments remaining to be made to the Participant or his or her Surviving Spouse or both may, at the discretion of the PAC, be reduced by the amount of such indebtedness; provided, however, than an election by the PAC not to reduce any such payment or payments shall not constitute a waiver of any claim for such indebtedness.

7.5 **Conditions Precedent**. No Retirement Benefits will be payable hereunder to any Participant:

(a) whose Employment with the Company or a Subsidiary is terminated because of his or her willful misconduct or gross negligence in the performance of his or her duties; or

(b) who within three (3) years after Termination of Employment becomes an employee with or consultant to any third party engaged in any line of business in competition with the Company and its Subsidiaries (i) in a line of business in which Participant has performed Services for the Company and its Subsidiaries, or (ii) that accounts for more than ten percent (10%) of the gross revenues of the Company and its Subsidiaries taken as a whole.

End of Article VII

ARTICLE VIII

MISCELLANEOUS

8.1 **Gender and Number**. Wherever appropriate herein, the masculine may mean the feminine and the singular may mean the plural or vice versa.

8.2 **Notice**. Any notice or filing required to be given or delivered to the PAC or Plan Administrator shall include delivery to or filing with a person or persons designated by the PAC or Plan Administrator, as applicable, for the disbursement and the receipt of administrative forms. Delivery shall be deemed to have occurred only when the form or other communication is actually received. Headings and subheadings are for the purpose of reference only and are not to be considered in the construction of this Plan.

8.3 **Validity**. In the event any provision of this Plan is held invalid, void or unenforceable, the same shall not affect, in any respect whatsoever, the validity of any other provision of this Plan.

8.4 **Applicable Law**. This Plan shall be governed and construed in accordance with the laws of the State of California.

8.5 **Successors in Interest**. This Plan shall inure to the benefit of, be binding upon, and be enforceable by, any corporate successor to the Company or successor to substantially all of the assets of the Company.

8.6 **No Representation on Tax Matters**. The Company makes no representation to Participants regarding current or future income tax ramifications of the Plan.

IN WITNESS WHEREOF, this amended and restated Plan has been executed on this 6th day of November, 2003, effective as of the date set forth above, except as specifically provided otherwise herein.

TENET HEALTHCARE CORPORATION

By: /s/ DEBRA L. ANDONIE-WALL

Debra L. Andonie-Wall
Senior Director, Retirement Plans

EXHIBIT A

TENET HEALTHCARE CORPORATION
SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN
AGREEMENT WITH PARTICIPANT

THIS AGREEMENT is made as of , 200 by and between TENET HEALTHCARE CORPORATION, a Nevada corporation ("Tenet"), and ("Participant").

WHEREAS, Tenet has adopted the Tenet Healthcare Corporation Supplemental Executive Retirement Plan (the "Plan") for a select group of highly compensated or management employees of Tenet and its Subsidiaries (as defined in the Plan); and

WHEREAS, Tenet has determined that Participant is currently eligible to participate in the Plan; and

WHEREAS, the Plan requires that an agreement be entered into between Tenet and Participant setting out certain terms and benefits of the Plan as they apply to the Participant;

NOW, THEREFORE, Tenet and the Participant hereby agree as follows:

1. The Plan is hereby incorporated into and made a part of this Agreement as though set forth in full herein. The parties shall be bound by and have the benefit of each and every provision of the Plan.

2. The Participant was born on , and his or her present employment with Tenet or a Subsidiary thereof, (i) for purposes of determining Years of Service under the Plan began on and (ii) for purposes of determining Vesting under Section 3.3 of the Plan began on .

The Participant's spouse, , was born on . Participant's Eligible Children under the age of 21 and their dates of birth are as follows:

Name	Birth Date
	, 19
	, 19
	, 19
	, 19

Participant agrees to notify the Director of Retirement Benefits of Tenet promptly from time to time of any change in his or her spouse or Eligible Children.

3. The Participant's "Existing Retirement Benefit Plans Adjustment Factor" under Article II of the Plan is X.XXXX percent.

4. Payments under this Plan shall begin not later than the first day of the calendar month following the occurrence of an event which entitles a Participant (or a Surviving Spouse or Eligible Children) to payments under this Plan.

5. This Agreement shall inure to the benefit of and be binding upon Tenet and its successors and assigns and the Participant and his or her beneficiaries.

IN WITNESS WHEREOF, the parties hereto have entered into this Agreement on , 2003.

PARTICIPANT

TENET HEALTHCARE CORPORATION

By

Executive Vice President

QuickLinks

TENET HEALTHCARE CORPORATION FOURTH AMENDED AND RESTATED SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN
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TENET HEALTHCARE CORPORATION SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN AGREEMENT WITH PARTICIPANT

Exhibit 10(n)

SIXTH AMENDED AND RESTATED

TENET 2001 DEFERRED

COMPENSATION PLAN

SIXTH AMENDED AND RESTATED TENET 2001 DEFERRED COMPENSATION PLAN

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SIXTH AMENDED AND RESTATED
TENET 2001 DEFERRED COMPENSATION PLAN

ARTICLE I
PREAMBLE AND PURPOSE

1.1 **Preamble.** This Sixth Amended and Restated Tenet 2001 Deferred Compensation Plan (the "Plan") of Tenet Healthcare Corporation (the "Company"), adopted on September 10, 2003 by the Compensation Committee (the "Committee") and subsequently amended by the Committee effective April 1, 2004 to eliminate the matching contribution of stock units for directors who chose to invest their basic compensation deferrals in stock units, amends and restates the Tenet 2001 Deferred Compensation Plan adopted by the Committee on October 10, 2000 as amended and restated by the Committee on July 22, 2003, October 8, 2002, December 4, 2001, July 24, 2001 and May 22, 2001. The Plan is intended to permit the Company and its participating Affiliates, as defined herein (collectively, the "Employer"), to attract and retain a select group of management or highly compensated employees and Directors, as defined herein.

Effective as of December 5, 1995, the Company adopted the Tenet Executive Deferred Compensation and Supplemental Savings Plan (as the same has been amended from time to time, the "Supplemental Plan"). Effective as of January 31, 2001, the Company transferred to this Plan amounts held for the benefit of certain participants in the Supplemental Plan, other than those balances held for the benefit of physician-employees who participate in the Supplemental Plan and participants who are in pay-out status as of December 31, 2000, under the Supplemental Plan. Effective as of December 31, 2002, the Committee authorized the merger of the Supplemental Plan into this Plan.

The Employer may adopt one or more trusts to serve as a possible source of funds for the payment of benefits under this Plan.

1.2 **Purpose.** Through this Plan, the Employer intends to permit the deferral of compensation and to provide additional benefits to Directors and a select group of management or highly compensated employees of the Employer. Accordingly, it is intended that this Plan shall not constitute a "qualified plan" subject to the limitations of section 401(a) of the Code, nor shall it constitute a "funded plan," for purposes of such requirements. It also is intended that this Plan shall be exempt from the participation and vesting requirements of Part 2 of Title I of the Act, the funding requirements of Part 3 of Title I of the Act, and the fiduciary requirements of Part 4 of Title I of the Act by reason of the exclusions afforded plans that are unfunded and maintained by an employer primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees.

End of Article I

ARTICLE II
DEFINITIONS AND CONSTRUCTION

2.1 **Definitions.** When a word or phrase appears in this Plan with the initial letter capitalized, and the word or phrase does not commence a sentence, the word or phrase shall generally be a term defined in this Section 2.1. The following words and phrases with the initial letter capitalized shall have the meaning set forth in this Section 2.1, unless a different meaning is required by the context in which the word or phrase is used.

(a) **"Account"** means one or more of the bookkeeping accounts maintained by the Company or its agent on behalf of a Participant, as described in more detail in Section 4.3.

(b) **"Act"** means the Employee Retirement Income Security Act of 1974, as amended from time to time.

(c) **"Affiliate"** means a corporation that is a member of a controlled group of corporations (as defined in section 414(b) of the Code) that includes the Company, any trade or business (whether or not incorporated) that is in common control (as defined in section 414(c) of the Code) with the Company, or any entity that is a member of the same affiliated service group (as defined in section 414(m) of the Code) as the Company.

(d) **"Alternate Payee"** means any spouse, former spouse, child, or other dependent of a Participant who is recognized by a DRO as having a right to receive all, or a portion of, the benefits payable under the Plan with respect to such Participant.

(e) **"Annual Incentive Plan Award"** means the amount payable to an Employee each year, if any, under the Company's 2001 Annual Incentive Plan, as the same may be amended, restated, modified, renewed or replaced from time to time. For 2002, the period of time over which performance would be measured for determining Annual Incentive Plan Awards was modified and the Company determined such awards on a discretionary basis.

(f) **"Basic Deferral"** means the Compensation deferral made by a Participant pursuant to Section 4.1(a).

(g) **"Beneficiary"** means the person designated by the Participant to receive a distribution of his/her benefits under the Plan upon the death of the Participant. If the Participant is married, his/her spouse shall be his/her Beneficiary, unless his/her spouse consents in writing to the designation of an alternate Beneficiary. In the event that a Participant fails to designate a Beneficiary, or if the Participant's Beneficiary does not survive the Participant, the Participant's Beneficiary shall be his/her surviving spouse, if any, or if the Participant does not have a surviving spouse, his/her estate. The term "Beneficiary" also shall mean a Participant's spouse or former spouse who is entitled to all or a portion of a Participant's benefit pursuant to Section 6.1.

(h) **"Board"** means the Board of Directors of the Company.

(i) **"Bonus"** means (i) a bonus paid to a Participant in the form of an Annual Incentive Plan Award, or (ii) any other bonus payment designated by the PAC as an eligible bonus under the Plan.

(j) **"Bonus Deferral"** means the Bonus deferral made by a Participant pursuant to Section 4.1(b).

(k) **"Change of Control"** of the Company shall be deemed to have occurred if either (i) any person, as such term is used in sections 13(c) and 14(d)(2) of the Securities and Exchange Act of 1934, as amended (the "Exchange Act"), is or becomes the beneficial owner, directly or indirectly, of securities of the Company representing 20% or more of the combined voting power of the Company's then outstanding securities, or (ii) individuals who, as of August 1, 2000, constitute the Board of the Company (the "Incumbent Board") cease for any reason to constitute at least a majority of the Board at any time; provided, however, that (a) any individual who becomes a director of the Company subsequent to August 1, 2000, whose election, or nomination for election by the Company's stockholders, was approved by a vote of at least a majority of directors then comprising the Incumbent Board shall be deemed to have bee individual who is elected initially (after August 1, 2000) as a director as a result of an actual or threatened election contest, as such terms are used in Rule 14a-11 of Regulation 14A promulgated under the Exchange Act or any other actual or threatened solicitations of proxies or consent by or on behalf of any person other than the Incumbent Board shall be deemed to have been a member of the Incumbent Board.

(l) **"Code"** means the Internal Revenue Code of 1986, as amended from time to time.

(m) **"Company"** means Tenet Healthcare Corporation.

(n) **"Compensation"** means base salaries, commissions, and certain other amounts of cash compensation payable to the Participant during the Plan Year. Compensation shall exclude cash bonuses, foreign service pay, hardship withdrawal allowances and any other pay intended to reimburse the Employee for the higher cost of living outside the United States, Annual Incentive Plan Awards, automobile allowances, ExecuPlan payments, housing allowances, relocation payments, deemed income, income payable under stock incentive plans, Christmas gifts, insurance premiums, and other imputed income, pensions, retirement benefits, and contributions to and payments from the 401(k) Plan and this Plan. The term "Compensation" for Directors shall mean any cash compensation from retainers, meeting fees and committee fees paid during the Plan Year.

(o) **"Compensation Committee"** means the Compensation Committee of the Board, which has the authority to amend and terminate the Plan as provided in Article X. The Compensation Committee also will be responsible for determining the amount of the Discretionary Contribution, if any, to be made by the Employer.

(p) **"Compensation Deferrals"** means the Basic Deferrals, Supplemental Deferrals and Discretionary Deferrals made pursuant to Section 4.1 of the Plan.

(q) **"Covered Person"** means a covered employee within the meaning of section 162(m)(3) of the Code or an Employee designated as a Covered Person by the Compensation Committee.

(r) **"Director"** means a member of the Board who is not an Employee.

(s) **"Disability"** means the total and permanent incapacity of a Participant, due to physical impairment or mental incompetence, to perform the usual duties of his/her employment with the Employer. Disability shall be determined by the Plan Administrator on the basis of (i) evidence that the Participant has become entitled to receive benefits from an Employer sponsored long-term disability plan, or in the case of a Director, a long-term disability plan that covers such Director, or (ii) evidence that the Participant has become entitled to receive primary benefits as a disabled employee under the Social Security Act in effect on such date of Disability.

(t) **"Discretionary Contribution"** means the contribution made by the Employer on behalf of a Participant as described in Section 4.2(b).

(u) **"Discretionary Deferral"** means the Compensation deferral described in Section 4.1(d) made by a Participant.

(v) **"DRO"** means a domestic relations order that is a judgment, decree, or order (including one that approves a property settlement agreement) that relates to the provision of child support, alimony payments or marital property rights to a spouse, former spouse, child or other dependent of a Participant and is rendered under a state (within the meaning of section 7701(a)(10) of the Code) domestic relations law (including a community property law) and that:

(i) Creates or recognizes the existence of an Alternate Payee's right to, or assigns to an Alternate Payee the right to receive all or a portion of the benefits payable with respect to a Participant under the Plan;

(ii) Does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan;

(iii) Does not require the Plan to provide increased benefits (determined on the basis of actuarial value);

(iv) Does not require the payment of benefits to an Alternate Payee that are required to be paid to another Alternate Payee under another order previously determined to be a DRO; and

(v) Clearly specifies: the name and last known mailing address of the Participant and of each Alternate Payee covered by the DRO; the amount or percentage of the Participant's benefits to be paid by the Plan to each such Alternate Payee, or the manner in which such amount or percentage is to be determined; the number of payments or payment periods to which such order applies; and that it is applicable with respect to this Plan.

(w) **"Effective Date"** means March 31, 2003, except as provided otherwise herein. Further, the elimination of Section 4.2(c) of the Plan regarding the Supplemental Contribution (*i.e.*, the 15% matching contribution) for Directors who choose to invest their Basic Deferrals in Stock Units is effective April 1, 2004.

(x) **"Election Form"** means the written forms provided by the PAC or the Plan Administrator pursuant to which the Participant consents to participation in the Plan and makes elections with respect to deferrals, requested investment crediting rates and distributions hereunder. Such Participant consent and elections may be done either in writing or on-line through an electronic signature.

(y) **"Eligible Employee"** means (i) each Employee who is eligible for the Company's Annual Incentive Plan Award for the applicable Plan Year, (ii) each Director, and (iii) all aviation personnel who are designated as captains. In addition, the term "Eligible Employee" shall include any Employee designated as an Eligible Employee by the PAC. As provided in Section 3.1, the PAC may at any time, in its sole and absolute discretion, limit the classification of Employees who are eligible to participate in the Plan for a Plan Year and/or may modify or terminate an Eligible Employee's participation in the Plan without the need for an amendment to the Plan.

(z) **"Emergency"** means a Foreseeable Emergency or Unforeseeable Emergency that makes a Participant eligible for a Financial Necessity Distribution under Section 5.5.

(aa) **"Employee"** means each select member of management or highly compensated employee receiving remuneration, or who is entitled to remuneration, for services rendered to the Employer, in the legal relationship of employer and employee.

(bb) **"Employer"** means the Company and each Affiliate which has adopted the Plan as a participating employer. An Affiliate may evidence its adoption of the Plan either by a formal action of its governing body or by commencing deferrals and taking other administrative actions with respect to this Plan on behalf of its employees. An entity shall cease to be a participating employer as of the date such entity ceases to be an Affiliate; provided, however, that the Participants of that former Affiliate will not be deemed to have separated from employment with the Employer for purposes of this Plan until that entity ceases to be related to the Company under either section 414(b) or (c) of the Code, applying for such purpose an ownership interest of at least 50 percent. Similarly, if a Participant in the Plan is transferred to an Affiliate (regardless if it is a participating employer) or an entity in which the Company holds an ownership interest o percent, such Participant will not be deemed to have separated from employment for purposes of the Plan until the Company's ownership interest in such Affiliate or entity falls below 50 percent (as determined under either section 414(b) or (c) of the Code, applying for such purpose an ownership interest of at least 50 percent). In any of these scenarios, at the time the Company's ownership in the former participating employer, former Affiliate or other entity, as applicable, falls below 50 percent, the Participants employed by such former participating employer, former Affiliate or other entity, as applicable, will be deemed to have separated from employment with the Employer for purposes of Article V. The provisions of this Section 2.1(bb) shall be effective as of January 1, 2000.

(cc) **"Fair Market Value"** means the closing price of a share of Stock on the New York Stock Exchange on the date as of which fair market value is to be determined.

(dd) **"Foreseeable Emergency"** means a severe financial hardship to the Participant resulting from an event that, although foreseeable, is outside the Participant's control, as determined by the Plan Administrator in its sole and absolute discretion. Such potentially foreseeable but uncontrollable events include the following:

(i) expenses for medical care described in section 213(d) of the Code incurred by the Participant, the Participant's spouse, or any dependents of the Participant (as defined in section 152 of the Code) or necessary for those persons to obtain medical care described in section 213(d) of the Code; and

(ii) such other events deemed by the Plan Administrator, in its sole and absolute discretion, to constitute a Foreseeable Emergency.

(ee) **"401(k) Plan"** means the Tenet Healthcare Corporation 401(k) Retirement Savings Plan, as such plan may be amended, restated, modified, renewed or replaced from time to time.

(ff) **"Matching Contribution"** means the contribution made by the Employer pursuant to Section 4.2(a) on behalf of a Participant who either makes Supplemental Deferrals to the Plan as described in Section 4.1(c), or is not eligible for an employer matching contribution under the 401(k) Plan.

(gg) **"Non-Scheduled Withdrawal"** means an election by a Participant in accordance with Section 5.4 to receive a withdrawal of amounts from his/her Account prior to the time at which such Participant otherwise would be entitled to such amounts.

(hh) **"Open Enrollment Period"** means the period prior to the beginning of the Plan Year during which an Eligible Employee may make his/her elections concerning Compensation Deferrals pursuant to Article IV, and distribution elections in accordance with Article V.

(ii) **"PAC"** means the Pension Administration Committee of the Company established by the Compensation Committee of the Board, and whose members have been appointed by such Compensation Committee. The PAC shall have the responsibility to administer the Plan and make final determinations regarding claims for benefits, as described in Article VIII.

(jj) **"Participant"** means each Eligible Employee who has been designated for participation in this Plan and each Employee or former Employee whose participation in this Plan has not terminated.

(kk) **"Plan"** shall have the meaning set forth in Section 1.1 above.

(ll) **"Plan Administrator"** means the individual or entity appointed by the PAC to handle the day-to-day administration of the Plan, including but not limited to determining a Participant's eligibility for benefits and the amount of such benefits and complying with all applicable reporting and disclosure obligations imposed on the Plan. If the PAC does not appoint an individual or entity as Plan Administrator, the PAC shall serve as the Plan Administrator.

(mm) **"Plan Year"** means the fiscal year of this Plan, which shall commence on January 1 each year and end on December 31 of such year.

(nn) **"Scheduled Withdrawal Date"** means the distribution date elected by the Participant for an in-service withdrawal of amounts of Basic Deferrals and Bonus Deferrals deferred in a given Plan Year, and earnings or losses attributable thereto, as set forth on the Election Form for such Plan Year.

(oo) **"Special Enrollment Period"** means the 30 day period after an Employee is hired/retained and advised of his/her eligibility to participate in the Plan during which the Eligible Employee may make his/her elections concerning Compensation Deferrals pursuant to Article IV, and distribution elections in accordance with Article V. The Plan Administrator may also designate certain periods as Special Enrollment Periods in the event that a new plan option is added or similar plan changes warrant the same.

(pp) **"Stock"** means the common stock, par value $0.075 per share, of the Company.

(qq) **"Stock Unit"** means a non-voting, non-transferable unit of measurement that is deemed for bookkeeping and distribution purposes only to represent one outstanding share of Stock.

(rr) **"Supplemental Deferral"** means the Compensation Deferral described in Section 4.1(c).

(ss) **"Supplemental Plan"** shall have the meaning set forth in Section 1.1 of this Plan.

(tt) **"Unforeseeable Emergency"** means a severe financial hardship to the Participant resulting from (i) a sudden and unexpected illness or accident of the Participant or one of the Participant's dependents (as defined under section 152(a) of the Code), (ii) loss of the Participant's property due to casualty, or (iii) such other similar extraordinary and unforeseeable circumstances arising as a result of an unforeseeable event or events beyond the control of the Participant, as determined by the Plan Administrator in its sole and absolute discretion.

2.2 **Construction.** If any provision of this Plan is determined to be for any reason invalid or unenforceable, the remaining provisions of this Plan shall continue in full force and effect. All of the provisions of this Plan shall be construed and enforced in accordance with the laws of the State of California and shall be administered according to the laws of such state, except as otherwise required by the Act, the Code or other applicable federal law. The term "delivered to the PAC or Plan Administrator," as used in this Plan, shall include delivery to a person or persons designated by the PAC or Plan Administrator, as applicable, for the disbursement and the receipt of administrative forms. Delivery shall be deemed to have occurred only when the form or other communication is actually received. Headings and subheadings are for the purpose of reference only and are not to be considered in the construction of this Plan.

End of Article II

ARTICLE III
PARTICIPATION AND FORFEITABILITY OF BENEFITS

3.1 **Eligibility and Participation.** It is intended that eligibility to participate in the Plan shall be limited to Eligible Employees, as determined by the PAC, in its sole and absolute discretion. Prior to the beginning of each Plan year, each Eligible Employee will be contacted and informed that he/she may elect to defer portions of his/her Compensation and/or Bonus and shall be provided with an Election Form, investment crediting rate preference designation and such other forms as the PAC or the Plan Administrator shall determine. An Eligible Employee shall become a Participant by completing all required forms and making a deferral election during an Open Enrollment Period pursuant to Section 4.1. Eligibility to become a Participant for any Plan Year shall not entitle an Eligible Employee to continue as an active Participant for any subsequent Plan Year.

The PAC may at any time, in its sole and absolute discretion, limit the classification of Employees eligible to participate in the Plan and/or may limit or terminate an Eligible Employee's participation in the Plan. Any action taken by the PAC that limits the classification of Employees eligible to participate in the Plan or that modifies or terminates an Eligible Employee's participation in the Plan shall be set forth in Exhibit A attached hereto. Exhibit A may be modified from time to time without a formal amendment to the Plan, in which case a revised Exhibit A shall be attached hereto.

If an Eligible Employee is hired/retained during the Plan Year and designated by the PAC to be a Participant for such year, such Eligible Employee may elect to participate during the Special Enrollment Period for the remainder of such Plan Year, by completing all required forms and making a deferral election pursuant to Section 4.1. Designation as a Participant for the Plan Year in which he/she is hired/retained shall not entitle the Eligible Employee to continue as an active Participant for any subsequent Plan Year.

A Participant under this Plan who separates from employment with the Employer, or who ceases to be a Director, will continue as an inactive Participant under this Plan until the Participant has received payment of all amounts payable to him/her under this Plan. In the event that an Eligible Employee shall cease active participation in the Plan because the Eligible Employee is no longer described as a Participant pursuant to this Section 3.1, or because he/she shall cease making deferrals of Compensation and/or Bonuses, the Eligible Employee shall continue as an inactive Participant under this Plan until he/she has received payment of all amounts payable to him/her under this Plan.

3.2 **Forfeitability of Benefits.** Except as provided in Section 5.4 and Section 6.1, a Participant shall at all times have a nonforfeitable right to amounts credited to his/her Account pursuant to Section 4.3, subject to the distribution provisions of Article V. As provided in Section 7.2, however, each Participant shall be only a general creditor of his/her Employer with respect to the payment of any benefit under this Plan.

End or Article III

ARTICLE IV
DEFERRAL, COMPANY CONTRIBUTIONS, ACCOUNTING AND INVESTMENT CREDITING RATES

4.1 **Deferral.** An Eligible Employee who is designated by the PAC to be an Eligible Employee for a Plan Year may become a Participant for such Plan Year by electing to defer Compensation and/or his/her Bonus during the Open Enrollment Period pursuant to an Election Form. Such Election Form shall be submitted to the Company not later than a date to be set by the Plan Administrator and shall be effective with respect to deferral elections with the first paycheck dated on or after the next following January 1. In the case of an Eligible Employee who is hired/retained during the Plan Year, the Election Form shall be entered into within the Special Enrollment Period and shall only be effective with respect to deferral elections with respect to Compensation and/or Bonuses earned after the date such Election Form is received by the Plan Administrator. A Participant's Election Form shall only be effective with respect to a single Plan Year and shall be irrevocable for the duration of such Plan Year. Deferral elections for each subsequent Plan Year of participation shall be made during the Open Enrollment Period pursuant to a new Election Form.

Compensation deferred by a Participant may be distributed, at the Participant's election, either in a lump sum or, in certain instances as described herein, in equal monthly installments over a period of not less than one year nor more than 15 years. On each Election Form, the Participant shall specify the method in which Compensation and/or Bonuses deferred under the Plan shall be paid. If the Participant, during the Open Enrollment Period, elects a different method of payment on a subsequent Election Form, such form of payment election shall supersede any prior payment elections made on an earlier Election Form, provided such election has been in effect for 12 months.

Four types of deferrals may be made under the Plan:

(a) **Basic Deferral**. Each Eligible Employee may elect to defer a stated dollar amount, or designated full percentage, of Compensation to the Plan up to a maximum percentage of 75% (100% for Directors) of the Eligible Employee's Compensation for such Plan Year. The Employer shall not make any Matching Contributions with respect to any Basic Deferrals made to the Plan.

(b) **Bonus Deferral**. Each Eligible Employee may elect to defer a stated dollar amount, or designated full percentage, of his/her Bonus to the Plan up to a maximum percentage of 100% (97% if a Supplemental Deferral is elected pursuant to Section 4.1(c)) of the Employee's Bonus for such Plan Year. Bonus Deferrals generally will be made in the form of cash; provided, however, that if the Company modifies the Annual Incentive Plan to provide for the payment of awards in Stock, Bonus Deferrals may be made in the form of Stock. Any Bonus Deferrals made in the form of Stock shall be converted to Stock Units, based on the number of shares so deferred, credited to the Stock Unit Account and distributed to the Participant at the time specified herein in an equivalent number of whole shares of Stock as provided in Section 4.4(b).

The Employer shall not make any Matching Contributions with respect to any Bonus Deferrals made to the Plan.

During the first quarter of 2003, the method of determining Annual Incentive Awards under the 2001 Annual Incentive Plan was modified and Participants' corresponding 2003 Bonus Deferrals were cancelled. In connection therewith the Company determined the Annual Incentive Plan Award for the seventh month period beginning June 1, 2002 through December 31, 2002 on a discretionary basis and the ability to defer such award as a Bonus Deferral was added as a provision to this Plan. Accordingly, a Special Enrollment Period occurred during 2003 to enable Bonus Deferrals to be made with respect to such discretionary award. Future Bonus Deferrals of Annual Incentive Plan Awards payable under the 2001 Annual Incentive Plan shall be made by Eligible Employees in accordance with Sections 3.1 and 4.1 of this Plan.

(c) **Supplemental Deferral**. Each Eligible Employee may elect to make Supplemental Deferrals to the Plan in accordance with the following provisions of this Section 4.1(c).

(i) **Statutory Limits.** Each Eligible Employee who is also a participant in the 401(k) Plan may elect to automatically have 3% of his/her Compensation deferred under the Plan when he/she reaches any of the following statutory limitations under the 401(k) Plan: (A) the limitation on Compensation under section 401(a)(17) of the Code, as such limit is adjusted for cost of living increases, (B) the limitation imposed on elective deferrals under section 402(g) of the Code, as such limit is adjusted for cost of living increases, (C) the limitations on contributions and benefits under section 415 of the Code, or (D) the limitations on contributions imposed by the 401(k) Plan administrator in order to satisfy the limitations on contributions under sections 401(k) and 401(m) of the Code. The ability to make Supplemental Deferrals under this Section 4.1(c)(i) contributions" under the 401(k) Plan.

(ii) **Bonus.** Each Eligible Employee who is also a participant in the 401(k) Plan may elect to automatically have 3% of his/her Bonus deferred under the Plan as a Supplemental Deferral whether or not the Eligible Employee has reached the statutory limitations under the 401(k) Plan described in Section 4.1(c)(i). This Supplemental Deferral shall be applied to that portion of the Eligible Employee's Bonus in excess of that deferred as a Bonus Deferral under Section 4.1(b). For example, if the Eligible Employee elects to defer 50% of his/her Bonus under Section 4.1(b) and also elects to make a Supplemental Deferral under this Section 4.1(c), 50% of the Eligible Employee's Bonus will be deferred under Section 4.1(b) and 3% of the Eligible Employee's Bonus will be deferred under this Section 4.1(c).

(iii) **401(k) Plan Before-Tax Savings Contribution Eligibility.** Each Eligible Employee who elects to participate in this Plan prior to the date on which he/she becomes eligible to make before-tax savings contributions to the 401(k) Plan, may elect, until such 401(k) Plan before-tax contribution eligibility date, to defer 3% of his/her Compensation under the Plan as a Supplemental Deferral for such Plan Year. Upon the Eligible Employee's 401(k) Plan before-tax contribution eligibility date, his/her Supplemental Deferrals under this Section 4.1(c)(iii) shall cease and any subsequent Supplemental Deferrals shall only be made by the Employee pursuant to Section 4.1(c)(i) or Section 4.1(c)(ii), as applicable.

(d) **Discretionary Deferral**. The PAC may authorize an Eligible Employee to defer a stated dollar amount, or designated full percentage, of Compensation to the Plan as a Discretionary Deferral. The PAC, in its sole and absolute discretion, may limit the amount or percentage of Compensation an Eligible Employee may defer to the Plan as a Discretionary Deferral. The Employer shall not make any Matching Contributions pursuant to Section 4.2(a) with respect to any Discretionary Deferrals, but may elect to make a Discretionary Contribution to the Plan with respect to such Discretionary Deferrals in the form of a discretionary matching contribution as described in Section 4.2(b).

4.2 Company Contributions.

(a) **Matching Contribution**. The Employer shall make a Matching Contribution to the Plan each Plan Year on behalf of each Participant who makes a Supplemental Deferral to the Plan. Such Matching Contribution shall equal 100% of the Participant's Supplemental Deferrals for such Plan Year. In addition, the Employer shall make a Matching Contribution to the Plan for the Plan Year on behalf of each Participant who is eligible to participate in the 401(k) Plan but is not eligible to receive an employer matching contribution under the 401(k) Plan by reason of the one year eligibility service requirement. Such Matching Contribution shall equal 3% of the Participant's Compensation earned during the period beginning on the date on which such Participant elects to make Supplemental Deferrals to the Plan in accordance with Section 4.1(c)(iii).

(b) **Discretionary Contribution**. The Employer may elect to make a Discretionary Contribution to a Participant's Account in such amount, and at such time, as shall be determined by the Compensation Committee. If a Participant who is a Covered Person receives a Discretionary Contribution, that Participant shall not be permitted to receive that Discretionary Contribution until such Participant's employment with the Employer is terminated; provided, however, that if such Participant has elected to receive a distribution upon the occurrence of a Change of Control and a Change of Control occurs, such Participant shall be entitled to receive such Change of Control distribution in accordance with Section 5.9 of this Plan.

4.3 Accounting for Deferred Compensation.

(a) **Cash Account**. If a Participant has made an election to defer his/her Compensation and/or Bonus and has made a request for amounts deferred to be invested pursuant to Section 4.4(a), the Company may, in its sole and absolute discretion, establish and maintain a cash Account for the Participant under this Plan. Each cash Account shall be adjusted at least quarterly to reflect the Basic Deferrals, Bonus Deferrals, Supplemental Deferrals, Discretionary Deferrals, Matching Contributions and Discretionary Contributions credited thereto, earnings or losses credited on such Basic Deferrals, Bonus Deferrals, Supplemental Deferrals, Discretionary Deferrals, Matching Contributions and Discretionary Contributions, and any payment or withdrawal of such Basic Deferrals, Bonus Deferrals, Supplemental Deferrals, Discretionary Deferrals and, Matching Contributions and Discretionary Contributions. The amounts of Basic Deferrals, Bonus Deferrals, Supplemental Deferrals, Discretionary Deferrals and Matching Contributions shall be credited to the Participant's cash Account within five business days of the date on which such Compensation and/or Bonus would have been paid to the Participant had the Participant not elected to defer such amount pursuant to the terms and provisions of the Plan. Any Discretionary Contributions shall be credited to each Participant's cash Account at such times as determined by the Compensation Committee. In the sole and absolute discretion of the Plan Administrator, more than one cash Account may be established for each Participant to facilitate record-keeping convenience and accuracy. Each such cash Account shall be credited and adjusted as provided in this Plan.

(b) **Stock Unit Account**. If a Participant has made an election to defer his/her Compensation and/or Bonus and has made a request for cash deferrals to be invested in Stock Units pursuant to Section 4.4(b), the Company may, in its sole and absolute discretion, establish and maintain a Stock Unit Account and credit the Participant's Stock Unit Account, within five business days of the date on which such Compensation and/or Bonus otherwise would have been payable, with a number of Stock Units determined by dividing an amount equal to the Basic Deferrals, Bonus Deferrals, Supplemental Deferrals, Discretionary Deferrals, Matching Contributions and Discretionary Contributions made as of such date by the Fair Market Value of a share of Stock on the fifth day following the date such Compensation and/or Bonus otherwise would have been payable. In the sole and absolute discretion of the Plan Administrator, more than one Stock Unit Account may be established for each Participant to facilitate record-keeping convenience and accuracy. Bonus Deferrals made in Stock will be credited to the Stock Unit Account as provided in Section 4.1(b).

(i) The Stock Units credited to a Participant's Stock Unit Account shall be used solely as a device for determining the number of shares of Stock eventually to be distributed to the Participant in accordance with this Plan. The Stock Units shall not be treated as property of the Participant or as a trust fund of any kind. No Participant shall be entitled to any voting or other stockholder rights with respect to Stock Units credited under this Plan.

(ii) If the outstanding shares of Stock are increased, decreased, or exchanged for a different number or kind of shares or other securities, or if additional shares or new or different shares or other securities are distributed with respect to such shares of Stock or other securities, through merger, consolidation, spin-off, sale of all or substantially all the assets of the Company, reorganization, recapitalization, reclassification, stock dividend, stock split, reverse stock split or other distribution with respect to such shares of Stock or other securities, an appropriate and proportionate adjustment shall be made by the Compensation Committee in the number and kind of Stock Units credited to a Participant's Stock Unit Account.

(c) **Accounts Held in Trust**. Amounts credited to Participants' Accounts may be secured by one or more trusts, as provided in Section 7.1, but shall be subject to the claims of the general creditors of each such Participant's Employer. Although the principal of such trust and any earnings or losses thereon shall be separate and apart from other funds of the Employer and shall be used for the purposes set forth therein, neither the Participants nor their Beneficiaries shall have any preferred claim on, or any beneficial ownership in, any assets of the trust prior to the time such assets are paid to the Participant or Beneficiaries as benefits and all rights created under this Plan shall be unsecured contractual rights of Plan Participants and Beneficiaries against the Employer. Any assets held in the trust with respect to a Participant shall be subject to the claims of the general creditors of that Participant's Employer under federal and state law in the event of insolvency. The assets of any trust established pursuant to this Plan shall never inure to the benefit of the Employer and the same shall be held for the exclusive purpose of providing benefits to that Employer's Participants and their beneficiaries.

4.4 **Investment Crediting Rates.** At the time of making a deferral election described in Section 4.1, the Participant shall request on an Election Form the type of investment crediting rate option with which the Participant would like the Company, in its sole and absolute discretion, to credit the Participant: one of several investment crediting rate options payable in cash or an investment crediting rate option based on the performance of the price of the Company's Stock and payable in the Company's Stock.

(a) **Cash Investment Crediting Rate Options**. A Participant may request on an Election Form the type of investment in which the Participant would like amounts deferred by the Participant to be deemed invested for purposes of determining the amount of earnings or losses to be credited or losses to be debited to his/her cash Account. The Participant shall specify his/her preference from among the following possible investment crediting rate options:

(i) An annual rate of interest equal to 1% below the prime rate of interest as quoted by Bloomberg, compounded daily; or

(ii) One or more benchmark mutual funds.

A Participant may change, on a daily basis, the investment crediting rate preference under this Section 4.4(a) by filing an election in such manner as shall be determined by the PAC. Notwithstanding any request made by a Participant, the Company, in its sole and absolute discretion, shall determine the investment rate with which to credit amounts deferred by Participants under this Plan, provided, however, that if the Company chooses an investment crediting rate other than the investment crediting rate requested by the Participant, such investment crediting rate cannot be less than (i) above.

(b) **Stock Units**. A Participant may request on an Election Form to have amounts deferred by him/her invested in Stock Units. Deferrals invested in Stock Units are irrevocable and shall be distributed in an equivalent whole number of shares of Stock pursuant to the provisions of Article V. Any fractional share interests shall be paid in cash with the last distribution.

(c) **Deemed Election**. In his/her request(s) pursuant to this Section 4.4, the Participant may request that all or any multiple of his/her Account (in whole percentage increments) be deemed invested in one or more of the investment crediting rate preferences provided under the Plan as communicated from time to time by the PAC. Although a Participant may express an investment crediting rate preference, the Company shall not be bound by such request. If a Participant fails to set forth his/her investment crediting rate preference under this Section 4.4, he/she shall be deemed to have elected an annual rate of interest equal to 1% below the prime rate of interest as quoted by Bloomberg, compounded daily. The PAC shall select from time to time, in its sole and absolute discretion, the possible investment crediting rate options to be offered on a Participant's deferrals and contributions for any Plan Year.

(d) **Transferred Accounts**. The Company retains the right in its sole and absolute discretion to transfer a Participant's Supplemental Plan account balance, as the Company deems appropriate, from the Supplemental Plan to this Plan. In the event that the Company determines that a transfer of a Participant's Supplemental Plan account balance to this Plan is appropriate, a Participant shall be permitted to express an investment crediting rate preference with respect to such transferred amounts. In the event a Participant's Supplemental Plan account balance is transferred from the Supplemental Plan to this Plan, such transferred amount shall be treated in all other respects as if such amount were initially deferred pursuant to the terms of this Plan.

(e) **Company Contributions**. Contributions to the Plan made by the Employer and allocated to a Participant's Account pursuant to Section 4.2 shall be invested in accordance with the investment crediting rate requested by such Participant on his/her Election Form for the relevant Plan Year.

End of Article IV

ARTICLE V
DISTRIBUTION OF BENEFITS

5.1 General Rules. A Participant may elect to receive payment on Basic Deferrals and Bonus Deferrals, and earnings or losses thereon, at any of the following times:

(a) As soon as practicable after termination of a Participant's employment, retirement, Disability or death;

(b) In the first January following, or in the second January following, but not later than the second January following, the Participant's termination of employment, retirement, Disability or death; or

(c) At a specified future date while still in the employ of the Employer.

Generally, Supplemental Deferral, Discretionary Deferral and Employer contribution Account balances and earnings or losses thereon, are distributable only upon a Participant's termination of employment, termination as a Director, retirement, Disability or death.

All distributions from the Plan shall be taxable as ordinary income when received and subject to appropriate withholding of income taxes. In the case of distributions in Stock, the appropriate number of shares of Stock may be sold to satisfy such withholding obligations pursuant to administrative procedures adopted by the Plan Administrator.

5.2 Distributions Resulting from Termination. In the case of a Participant who terminates employment with the Employer for any reason, or ceases service as a Director, and has an Account balance of $100,000 or less, as determined by the Plan Administrator pursuant to administrative procedures, such Participant shall be paid the balance in his/her Account in a lump sum in accordance with Section 5.1. Such lump sum will be made in cash or in Stock or in a combination thereof depending on the Participant's investment crediting rates as provided in Section 4.4(b).

A Participant who has an Account balance in excess of $100,000 may elect to receive a distribution in the form of either a lump sum, as described in the preceding paragraph, or in substantially equal installments over a period of not less than one nor more than 15 years. Installment distributions may be made in cash or in Stock or in a combination thereof depending on the Participant's investment crediting rates as provided in Section 4.4(b). To the extent that installments will be made solely in cash, such installments will be made on a monthly basis. Installments of Stock or installments of cash and Stock, will be made on an annual basis.

Such Participant's Election Form that has been in effect for at least 12 months and made during a Special Enrollment Period or an Open Enrollment Period, as applicable, shall govern the form of distribution. In the event a Participant elects installments, such installment payments will begin in accordance with Section 5.1(a) or 5.1(b). All amounts held for a Participant's or Beneficiary's benefit shall be revalued annually based on procedures established by the Plan Administrator if paid in installments.

A Participant who is currently receiving installment distributions may elect to accelerate the distribution of his/her Account, subject to the following conditions:

(a) The Participant may request to accelerate the distribution of his/her Account in the form of either (i) a lump sum or (ii) a shorter period of installments that will be paid or commence to be paid, as applicable, on a future date that is no earlier that the first day of the 13th month following the Plan Administrator's receipt of the Participant's acceleration request; or

(b) The Participant may request an immediate lump sum distribution of his/her Account at any time provided that such distribution will be subject to a penalty equal to 10% of the lump sum distribution.

5.3 Scheduled In-Service Withdrawals. In the case of a Participant who, while still in the employ of the Employer, has elected a Scheduled Withdrawal Date for distribution of his/her Basic Deferrals and Bonus Deferrals, and earnings or losses thereon, such Participant shall receive a lump sum payment that must occur at least two calendar years after the end of the Plan Year in which the Basic and Bonus Deferrals occurred. A Participant may extend the Scheduled Withdrawal Date with respect to Basic Deferrals and Bonus Deferrals for any Plan Year, provided (i) such extension occurs at least one year before the Scheduled Withdrawal Date, (ii) such extension is for a period of not less than two years from the Scheduled Withdrawal Date, (iii) the Participant may not extend the Scheduled Withdrawal Date more than two times, and (iv) any such extension shall be effective only if consented to by the PAC. All such lump sum January of the year specified on the election form.

If a Participant retires, terminates employment, incurs a Disability or dies prior to any Scheduled Withdrawal Date, the Scheduled In-Service Withdrawal will be disregarded and waived and the Participant's Account balance will be distributed after the Participant's retirement, death, Disability or termination of employment in the same form of distribution elected with respect to retirement, death, Disability or termination.

5.4 Non-Scheduled Withdrawals. A Participant (regardless of whether an active Employee Participant, an inactive Employee Participant or a terminated Employee Participant) shall be permitted to elect a Non-Scheduled Withdrawal, subject to the following restrictions:

(a) The election to take a Non-Scheduled Withdrawal shall be made by filing a form provided by the Plan Administrator or its designee prior to the end of any calendar month.

(b) The amount of the Non-Scheduled Withdrawal shall in all cases not exceed 90% of the gross amount of a Participant's Account balance.

(c) The amount described in subsection (b) above shall be paid in a lump sum as soon as practicable after the end of the month in which the Non-Scheduled Withdrawal election is made.

(d) If a Participant receives a Non-Scheduled Withdrawal from his/her Account, the Participant shall permanently forfeit an amount equal to 10% of the gross amount of the Non-Scheduled Withdrawal and the Employer shall have no obligation to the Participant or his/her Beneficiary with respect to such forfeited amount.

(e) If a Participant who is an active Employee that is deferring Compensation under this Plan receives a Non-Scheduled Withdrawal of any part of his/her Account, the Participant will be ineligible to participate in the Plan for the balance of the Plan Year and the next following Plan Year.

(f) If a Participant who is an active Employee that is not deferring Compensation under this Plan receives a Non-Scheduled Withdrawal of any part of his/her Account, the Participant will be ineligible to participate in the Plan for the next following Plan Year.

The Plan Administrator shall be responsible for reviewing all requests for Non-Scheduled Withdrawals and shall have the sole and absolute authority and discretion to approve or deny such requests in accordance with the terms of the Plan.

5.5 Financial Necessity Distributions.

(a) **Unforeseeable Emergency**. Upon application by the Participant, the Plan Administrator, in its sole and absolute discretion, may direct payment of all or a portion of the Basic Deferrals, Bonus Deferrals and/or Discretionary Deferrals credited to the Account of a Participant prior to his/her separation from employment or termination as a Director in the event of an Unforeseeable Emergency. Any such application shall set forth the circumstances constituting such Unforeseeable Emergency.

In addition to the deferrals specified in this Section 5.5(a), upon application by the Participant, the Plan Administrator, in its sole and absolute discretion, may direct payment of all or a portion of the Supplemental Deferrals credited to the Account of the Participant prior to his/her separation from employment or termination as a Director in the event of an Unforeseeable Emergency. Such application and payment shall be subject to the same conditions and limitations as a request for any other payment of deferrals under this Section 5.5.

(b) **Foreseeable Emergency**. Upon application by the Participant, the Plan Administrator, in its sole and absolute discretion, may direct payment of all or a portion of the Basic Deferrals, Bonus Deferrals and/or Discretionary Deferrals credited to the Account of a Participant prior to his/her separation from employment or termination as a Director in the event of an Foreseeable Emergency. Any such application shall set forth the circumstances constituting such Foreseeable Emergency.

(c) **General Rules Regarding Financial Necessity Distributions** . The Plan Administrator may not direct payment of any Basic Deferrals, Bonus Deferrals, Supplemental Deferrals, and/or Discretionary Deferrals credited to the Account of a Participant to the extent that such an Emergency is or may be relieved (i) by reimbursement or compensation by insurance or otherwise, or (ii) by cessation of Basic Deferrals, Bonus Deferrals and/or Discretionary Deferrals under this Plan. In the event that the Plan Administrator, in its sole and absolute discretion, shall determine that such Emergency may be alleviated by such cessation of deferrals under the Plan, the Plan Administrator shall deny such financial necessity distribution and require the cancellation of the Participant's Basic Deferral, Bonus Deferral and/or Discretionary Deferral elections for the Plan Year in which an Emergency shall occur. Conversely, if the Plan Administrator, in its sole and absolute discretion, shall determine that such Emergency may not be alleviated by such cessation of Basic Deferrals, Bonus Deferrals and/or Discretionary Deferrals, it may approve such financial necessity distribution. Any distribution from the Plan due to Emergency shall be permitted only to the extent necessary to satisfy such Emergency, in the sole and absolute discretion of the Plan Administrator, both with respect to the determination as to whether an Emergency exists and also with respect to determination of the amount distributable. The Plan Administrator may permit a financial necessity distribution under this Section 5.5, but as a result the Participant will be ineligible to participate in the Plan for the balance of the Plan Year, if currently an active Participant, and the next following Plan Year.

5.6 **Elective Distributions.** A Participant may elect to receive a distribution of amounts credited to his/her Account upon a determination by the Internal Revenue Service or a state taxing authority of competent jurisdiction that amounts credited to such Account are subject to inclusion in the gross income of such Participant or Beneficiary for federal or state income tax purposes. Neither the PAC nor the Plan Administrator shall have any obligation to determine whether any such determination is or has been made with respect to any Participant and shall assume that no such determination has been made until advised by the Participant, in writing, that such determination has been made and that either such determination is final and binding, or that obtaining judicial review of such determination is not reasonably likely to result in a reversal of such determination or is economically prohibitive.

5.7 **Death of a Participant.** If a Participant dies while employed by the Employer, the Participant's Account balance will be paid to the Participant's Beneficiary in the manner elected by the Participant.

In the event a terminated Participant dies while receiving installment payments, the remaining installments shall be paid to the Participant's Beneficiary as such payments become due in accordance with Section 5.1.

In the event a terminated Participant dies before receiving his/her lump sum payment or before he/she begins receiving installment payments, the lump sum payment or installment payments shall be paid to the Participant's Beneficiary as such payments become due in accordance with Section 5.1.

5.8 **Disability of a Participant.** In the event of the Disability of the Participant, the Participant shall be entitled to a distribution of the Participant's Account balance in the manner elected in advance by the Participant and, if applicable, in accordance with Section 6.2.

5.9 **Change of Control.** A Participant may, during a Special Enrollment Period or an Open Enrollment Period, as applicable, file an Election Form in which the Participant elects to receive a lump sum distribution of his/her Account balance in the event that a Change of Control, as defined in Section 2.1(k), occurs. The Participant's election with respect to a distribution of his/her Account in the event of a Change of Control must have been in effect for 12 months prior to the time of the Change of Control. If elected, payment will be made as soon as practicable, but in any event not more than six months, after the occurrence of a Change of Control.

Notwithstanding any provision in this Plan to the contrary, to the extent that any portion of the lump sum distribution is characterized as a parachute payment within the meaning of Proposed Regulations section 1.280G-1 Q/A-24, or any similar Regulations, then in no event shall the present value of such parachute payment, when added to the present value of all other parachute payments received as a result of a Change of Control, exceed 299% of the Participant's "base amount" as that term is defined in section 280G of the Code.

If a Participant has elected to receive a lump sum distribution of his/her Account balance in the event of a Change of Control, a portion of which distribution is characterized as a parachute payment, and such portion, when added to the present value of all other parachute payments to be received as a result of a Change of Control, exceeds an amount equal to 299% of the Participant's base amount, then the Participant may, within the 30 day period following the Change in Control, elect (a) to revoke the election made pursuant to this Section 5.9, or (b) to receive in a lump sum distribution that portion of his/her Account balance which does not result in a parachute payment with the remainder being distributed in accordance with the Participant's election under Section 5.1.

5.10 Withholding. Any taxes or other legally required withholdings from Compensation and Bonus deferrals and/or payments to Participants or Beneficiaries hereunder shall be deducted and withheld by the Employer, benefit provider or funding agent as required pursuant to applicable law. To the extent amounts are payable under this Plan in Stock, the appropriate number of shares of Stock may be sold to satisfy such withholding obligation. A Participant or Beneficiary shall be provided with a tax withholding election form for purposes of federal and state tax withholding, if applicable.

5.11 Suspension of Benefits. If a Participant terminates service and begins receiving installment distributions and such Participant is reemployed by the Employer, then such Participant's installment distributions shall be suspended during the period of his/her reemployment. Upon the Participant's subsequent termination of service, such installment distributions shall recommence in the same form as they were being paid before the reemployment, unless during the period of the Participant's reemployment he/she is eligible to participate in the Plan and elects a different form of payment on his/her Election Form in accordance with this Article V.

End of Article V

ARTICLE VI
PAYMENT LIMITATIONS

6.1 Spousal Claims.

(a) In the event that an Alternate Payee is entitled to all or a portion of a Participant's Accounts pursuant to the terms of a DRO, such Alternate Payee shall have the following distribution rights with respect to such Participant's Account(s):

(i) payment of benefit in a lump sum, in cash or Stock, based on the Participant's investment crediting rates under the Plan as provided in Section 4.4 and the terms of the DRO, as soon as practicable following the acceptance of the DRO by the Plan Administrator;

(ii) payment of benefit in a lump sum in cash or Stock, based on the Participant's investment crediting rates under the Plan as provided in Section 4.4 and the terms of the DRO, in the first January following, or in the second January following, but not later than the second January following, the acceptance of the DRO by the Plan Administrator;

(iii) payment of benefit in substantially equal installments, in cash and/or Stock, based on the Participant's investment crediting rates under the Plan as provided in Section 4.4 and the terms of the DRO, over a period of not less than one nor more than 15 years from the date the DRO is accepted by the Plan Administrator, but only if the Alternate Payee has an Account balance in excess of $100,000; and

(iv) payment of benefit in substantially equal installments, in cash and/or Stock, based on the Participant's investment crediting rates under the Plan as provided in Section 4.4 and the terms of the DRO, over a period of not less than one nor more than 15 years beginning the first January following, or the second January following, the date the DRO is accepted by the Plan Administrator, but only if the Alternate Payee has an Account balance in excess of $100,000.

To the extent that installments will be made solely in cash, such installments will be made on a monthly basis. Installments of Stock or installments of cash and Stock, will be made on an annual basis.

An Alternate Payee who desires to elect any of the distributions described in subsections (ii), (iii) or (iv) above, must complete and deliver to the Plan Administrator all required forms and make such election within 30 days from the date she/he is notified that she/he is eligible to participate in the Plan. Any Alternate Payee who does not complete and deliver to the Plan Administrator all required forms and/or does not elect any of the distributions described in subsections (ii), (iii) or (iv) above shall receive his/her distributions in a lump sum according to subsection (i) above.

(b) Any taxes or other legally required withholdings from payments to such Alternate Payee shall be deducted and withheld by the Employer, benefit provider or funding agent. To the extent amounts are payable under this Plan in Stock, the appropriate number of shares of Stock may be sold to satisfy such withholding obligation. The Alternate Payee shall be provided with a tax withholding election form for purposes of federal and state tax withholding, if applicable.

(c) The Plan Administrator shall have sole and absolute discretion to determine whether a judgment, decree or order is a DRO, to determine whether a DRO shall be accepted for purposes of this Section 6.1 and to make interpretations under this Section 6.1, including determining who is to receive benefits, all calculations of benefits and determinations of the form of such benefits, and the amount of taxes to be withheld. The decisions of the Plan Administrator shall be binding on all parties with an interest.

(d) Any benefits payable to an Alternate Payee pursuant to the terms of a DRO shall be subject to all provisions and restrictions of the Plan and any dispute regarding such benefits shall be resolved pursuant to the Plan claims procedure in Article VIII.

6.2 **Legal Disability.** If a person entitled to any payment under this Plan shall, in the sole judgment of the Plan Administrator, be under a legal disability, or otherwise shall be unable to apply such payment to his/her own interest and advantage, the Plan Administrator, in the exercise of its discretion, may direct the Employer or payor of the benefit to make any such payment in any one or more of the following ways:

(a) Directly to such person;

(b) To his/her legal guardian or conservator; or

(c) To his/her spouse or to any person charged with the duty of his/her support, to be expended for his/her benefit and/or that of his/her dependents.

The decision of the Plan Administrator shall in each case be final and binding upon all persons in interest, unless the Plan Administrator shall reverse its decision due to changed circumstances.

6.3 **Assignment.** Except as provided in Section 6.1, no Participant or Beneficiary shall have any right to assign, pledge, transfer, convey, hypothecate, anticipate or in any way create a lien on any amounts payable hereunder. No amounts payable hereunder shall be subject to assignment or transfer or otherwise be alienable, either by voluntary or involuntary act, or by operation of law, or subject to attachment, execution, garnishment, sequestration or other seizure under any legal, equitable or other process, or be liable in any way for the debts or defaults of Participants and their Beneficiaries.

End of Article VI

ARTICLE VII
FUNDING

7.1 **Funding.** Benefits under this Plan shall be funded solely by the Employer. Benefits under this Plan shall constitute an unfunded general obligation of the Employer, but the Employer may create reserves, funds and/or provide for amounts to be held in trust to fund such benefits on its behalf. Payment of benefits may be made by the Employer, any trust established by the Employer or through a service or benefit provider to the Employer or such trust.

7.2 **Creditor Status.** Participants and their Beneficiaries shall be general unsecured creditors of their respective Employer with respect to the payment of any benefit under this Plan, unless such benefits are provided under a contract of insurance or an annuity contract that has been delivered to Participants, in which case Participants and their Beneficiaries shall look to the insurance carrier or annuity provider for payment, and not to the Employer. The Employer's obligation for such benefit shall be discharged by the purchase and delivery of such annuity or insurance contract.

End of Article VII

ARTICLE VIII
ADMINISTRATION

8.1 **The PAC.** The overall administration of the Plan will be the responsibility of the PAC.

8.2 **Powers of PAC.** The PAC shall have sole and absolute discretion regarding the exercise of its powers and duties under this Plan. In order to effectuate the purposes of the Plan, the PAC will have the following powers and duties:

(a) To appoint the Plan Administrator;

(b) To review and render decisions respecting a denial of a claim for benefits under the Plan;

(c) To construe the Plan and to make equitable adjustments for any mistakes or errors made in the administration of the Plan; and

(d) To determine and resolve, in its sole and absolute discretion, all questions relating to the administration of the Plan and the trust established to secure the assets of the Plan (i) when differences of opinion arise between the Company, an Affiliate, the Plan Administrator, the Trustee, a Participant, or any of them, and (ii) whenever it is deemed advisable to determine such questions in order to promote the uniform and nondiscriminatory administration of the Plan for the greatest benefit of all parties concerned.

The foregoing list of express powers is not intended to be either complete or conclusive, and the PAC will, in addition, have such powers as it may reasonably determine to be necessary or appropriate in the performance of its powers and duties under the Plan.

8.3 **Appointment of Plan Administrator.** The PAC will appoint the Plan Administrator, who will have the responsibility and duty to administer the Plan on a daily basis. The PAC may remove the Plan Administrator with or without cause at any time. The Plan Administrator may resign upon written notice to the PAC.

8.4 **Duties of Plan Administrator.** The Plan Administrator shall have sole and absolute discretion regarding the exercise of its powers and duties under this Plan. The Plan Administrator will have the following powers and duties:

(a) To direct the administration of the Plan in accordance with the provisions herein set forth;

(b) To adopt rules of procedure and regulations necessary for the administration of the Plan, provided such rules are not inconsistent with the terms of the Plan;

(c) To determine all questions with regard to rights of Employees, Participants, and Beneficiaries under the Plan including, but not limited to, questions involving eligibility of an Employee to participate in the Plan and the value of a Participant's Accounts;

(d) To enforce the terms of the Plan and any rules and regulations adopted by the PAC;

(e) To review and render decisions respecting a claim for a benefit under the Plan;

(f) To furnish the Employer with information that the Employer may require for tax or other purposes;

(g) To engage the service of counsel (who may, if appropriate, be counsel for the Employer), actuaries, and agents whom it may deem advisable to assist it with the performance of its duties;

(h) To prescribe procedures to be followed by distributees in obtaining benefits;

(i) To receive from the Employer and from Participants such information as is necessary for the proper administration of the Plan;

(j) To establish and maintain, or cause to be maintained, the individual Accounts described in Section 4.3;

(k) To create and maintain such records and forms as are required for the efficient administration of the Plan;

(l) To make all determinations and computations concerning the benefits, credits and debits to which any Participant, or other Beneficiary, is entitled under the Plan;

(m) To give the Trustee of the trust established to serve as a source of funds under the Plan specific directions in writing with respect to:

(i) the making of distribution payments, giving the names of the payees, the amounts to be paid and the time or times when payments will be made; and

(ii) the making of any other payments which the Trustee is not by the terms of the trust agreement authorized to make without a direction in writing by the Plan Administrator;

(n) To comply with all applicable lawful reporting and disclosure requirements of the Act;

(o) To comply (or transfer responsibility for compliance to the Trustee) with all applicable federal income tax withholding requirements for benefit distributions; and

(p) To construe the Plan, in its sole and absolute discretion, and make equitable adjustments for any mistakes and errors made in the administration of the Plan.

The foregoing list of express duties is not intended to be either complete or conclusive, and the Plan Administrator will, in addition, exercise such other powers and perform such other duties as it may deem necessary, desirable, advisable or proper for the supervision and administration of the Plan.

8.5 **Indemnification of PAC and Plan Administrator.** To the extent not covered by insurance, or if there is a failure to provide full insurance coverage for any reason, and to the extent permissible under corporate by-laws and other applicable laws and regulations, the Employer agrees to hold harmless and indemnify the PAC and Plan Administrator against any and all claims and causes of action by or on behalf of any and all parties whomsoever, and all losses therefrom, including, without limitation, costs of defense and reasonable attorneys' fees, based upon or arising out of any act or omission relating to or in connection with the Plan other than losses resulting from the PAC's, or any such person's, fraud or willful misconduct.

8.6 **Claims for Benefits.**

(a) **Initial Claim**. In the event that an Employee, Eligible Employee, Participant or his/her Beneficiary claims to be eligible for benefits, or claims any rights under this Plan, he/she must complete and submit such claim forms and supporting documentation as shall be required by the Plan Administrator, in its sole and absolute discretion. Likewise, any Participant or Beneficiary who feels unfairly treated as a result of the administration of the Plan, must file a written claim, setting forth the basis of the claim, with the Plan Administrator. In connection with the determination of a claim, or in connection with review of a denied claim, the claimant may examine this Plan, and any other pertinent documents generally available to Participants that are specifically related to the claim.

A written notice of the disposition of any such claim shall be furnished to the claimant within 90 days after the claim is filed with the Plan Administrator. Such notice shall refer, if appropriate, to pertinent provisions of this Plan, shall set forth in writing the reasons for denial of the claim if a claim is denied (including references to any pertinent provisions of this Plan) and, where appropriate, shall describe any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary. If the claim is denied, in whole or in part, the claimant shall also be notified of the Plan's claim review procedure and the time limits applicable to such procedure, including the claimant's right to arbitration following an adverse benefit determination on review as provided below. All benefits provided in this Plan as a result of the disposition of a claim will be paid as soon as practicable following receipt of proof of entitlement, if requested.

(b) **Request for Review**. Within 90 days after receiving the written notice of the Plan Administrator's disposition of the claim, the claimant may file with the PAC a written request for review of his/her claim. In connection with the request for review, the claimant shall be entitled to be represented by counsel and shall be given, upon request and free of charge, reasonable access to all pertinent documents for the preparation of his claim. If the claimant does not file a written request for review within 90 days after receiving written notice of the Plan Administrator's disposition of the claim, the claimant shall be deemed to have accepted the Plan Administrator's written disposition, unless the claimant shall have been physically or mentally incapacitated so as to be unable to request review within the 90 day period.

(c) **Decision on Review**. After receipt by the PAC of a written application for review of his claim, the PAC will review the claim taking into account all comments, documents, records and other information submitted by the claimant regarding the claim without regard to whether such information was considered in the initial benefit determination. The PAC will notify the claimant of its decision by delivery or by certified or registered mail to his last known address. A decision on review of the claim shall be made by the PAC at its next meeting following receipt of the written request for review. If no meeting of the PAC is scheduled within 45 days of receipt of the written request for review, then the PAC shall hold a special meeting to review such written request for review within such 45-day period. If special circumstances require an extension of the 45-day period, the PAC shall so notify the claimant and a decision shall be rendered within 90 days of receipt of the request for review. In any event, if a claim is not determined by the PAC within 90 days of receipt of written submission for review, it shall be deemed to be denied.

The decision of the PAC will be provided to the claimant as soon as possible but no later than 5 days after the benefit determination is made. The decision will be in writing and will include the specific reasons for the decision presented in a manner calculated to be understood by the claimant and will contain references to all relevant Plan provisions on which the decision was based. Such decision will also advise the claimant that he may receive upon request, and free of charge, reasonable access to and copies of all documents, records and other information relevant to his claim and will inform the claimant of his right to arbitration in the case of an adverse decision regarding his appeal. The decision of the PAC will be final and conclusive.

8.7 **Arbitration.** In the event the claims review procedure described in Section 8.6 of the Plan does not result in an outcome thought by the claimant to be in accordance with the Plan document, he/she may appeal to a third party neutral arbitrator. The claimant must appeal to an arbitrator within 60 days after receiving the PAC's denial or deemed denial of his/her request for review and before bringing suit in court.

The arbitrator shall be mutually selected by the Participant and the PAC from a list of arbitrators provided by the American Arbitration Association ("AAA"). If the parties are unable to agree on the selection of an arbitrator within 10 days of receiving the list from the AAA, the AAA shall appoint an arbitrator. The arbitrator's review shall be limited to interpretation of the Plan document in the context of the particular facts involved. The claimant, the PAC and the Employer agree to accept the award of the arbitrator as binding, and all exercises of power by the arbitrator hereunder shall be final, conclusive and binding on all interested parties, unless found by a court of competent jurisdiction, in a final judgment that is no longer subject to review or appeal, to be arbitrary and capricious. The costs of arbitration will be paid by the Employer; the costs of legal representation for the claimant or witness costs for the claimant will be borne by the claimant; provided, that, as part of his award, the Arbitrator may require the Employer to reimburse the claimant for all or a portion of such amounts.

The arbitrator shall have no power to add to, subtract from, or modify any of the terms of the Plan, or to change or add to any benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under the Plan. Nonetheless, the arbitrator shall have absolute discretion in the exercise of its powers in this Plan. Arbitration decisions will not establish binding precedent with respect to the administration or operation of the Plan.

8.8 **Receipt and Release of Necessary Information.** In implementing the terms of this Plan, the PAC and Plan Administrator, as applicable, may, without the consent of or notice to any person, release to or obtain from any other insuring entity or other organization or person any information, with respect to any person, which the PAC or Plan Administrator deems to be necessary for such purposes. Any Participant or Beneficiary claiming benefits under this Plan shall furnish to the PAC or Plan Administrator, as applicable, such information as may be necessary to determine eligibility for and amount of benefit, as a condition of claiming and receiving such benefit.

8.9 **Overpayment and Underpayment of Benefits.** The Plan Administrator may adopt, in its sole and absolute discretion, whatever rules, procedures and accounting practices are appropriate in providing for the collection of any overpayment of benefits. If a Participant or Beneficiary receives an underpayment of benefits, the Plan Administrator shall direct that payment be made as soon as practicable to make up for the underpayment. If an overpayment is made to a Participant or Beneficiary, for whatever reason, the Plan Administrator may, in its sole and absolute discretion, withhold payment of any further benefits under the Plan until the overpayment has been collected or may require repayment of benefits paid under this Plan without regard to further benefits to which the Participant or Beneficiary may be entitled.

End of Article VIII

ARTICLE IX
OTHER BENEFIT PLANS OF THE COMPANY

9.1 **Other Plans.** Nothing contained in this Plan shall prevent a Participant prior to his/her death, or a Participant's spouse or other Beneficiary after such Participant's death, from receiving, in addition to any payments provided for under this Plan, any payments provided for under any other plan or benefit program of the Employer, or which would otherwise be payable or distributable to him/her, his/her surviving spouse or Beneficiary under any plan or policy of the Employer or otherwise. Nothing in this Plan shall be construed as preventing the Company or any of its Affiliates from establishing any other or different plans providing for current or deferred compensation for employees and/or Directors. Unless otherwise specifically provided in any plan of the Company intended to "qualify" under section 401 of the Code, Compensation Deferrals made under this Plan shall constitute earnings or compensation for purposes of determining contributions or benefits under such qualified plan.

End of Article IX

ARTICLE X
AMENDMENT AND TERMINATION OF THE PLAN

10.1 **Amendment.** The Compensation Committee may amend this Plan by duly authorized written amendment; provided that no amendment or modification shall deprive a Participant, or person claiming benefits under this Plan through a Participant, of any benefit accrued under this Plan up to the date of amendment or modification, except as may be required by applicable law.

10.2 **Termination.** The Compensation Committee may terminate or suspend this Plan in whole or in Part at any time, provided that no such termination or suspension shall deprive a Participant, or person claiming benefits under this Plan through a Participant, of any benefit accrued under this Plan up to the date of suspension or termination, except as required by applicable law. Upon the complete termination of the Plan, the Compensation Committee, in its sole and absolute discretion, may direct the Plan Administrator to distribute each Participant's account to him/her or his/her Beneficiary, as applicable, in a lump sum and regardless of whether benefit payments have previously commenced to be made to such Participant.

An Affiliate may terminate its participation in the Plan at any time by an action of its governing body and providing written notice to the Company. Likewise, the Company may terminate an Affiliate's participation in the Plan at any time by an action of the Compensation Committee and providing written notice to the Affiliate. The effective date of any such termination shall be the later of the date specified in the notice of the termination of participation or the date on which the PAC can administratively implement such termination.

10.3 **Continuation.** The Company intends to continue this Plan indefinitely, but nevertheless assumes no contractual obligation beyond the promise to pay the benefits described in this Plan.

End of Article X

ARTICLE XI
MISCELLANEOUS

11.1 **No Reduction of Employer Rights.** Nothing contained in this Plan shall be construed as a contract of employment between the Employer and an Employee, or as a right of any Employee to continue in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its Employees, with or without cause or as a right of any Director to be renominated to serve as a Director.

11.2 **Provisions Binding.** All of the provisions of this Plan shall be binding upon all persons who shall be entitled to any benefit hereunder, their heirs and personal representatives.

End of Article XI

IN WITNESS WHEREOF, this amended and restated Plan has been executed on this 11th day of September, 2003 effective as of March 31, 2003, except as specifically provided otherwise herein.

TENET HEALTHCARE CORPORATION

By: /s/ DEBRA L. ANDONIE-WALL

Debra L. Andonie-Wall
Senior Director, Retirement Plans

EXHIBIT A[1]
LIMITS ON ELIGIBILITY AND PARTICIPATION

Section 3.1 of the Tenet 2001 Deferred Compensation Plan (the "DCP") provides the Pension Administration Committee ("PAC") with the authority to limit the classification of employees of Tenet Healthcare Corporation or its participating affiliates (collectively the "Employer") eligible to participate in the DCP at any time and states that any such limitation shall be set forth in this Exhibit A. The PAC, by the adoption of a resolution effective as of March 31, 2003, exercised this authority and declared the following limitation on eligibility under the DCP:

(i) Employees of the Employer who experience a "qualifying termination" under under the Tenet Executive Severance Protection Plan (the "TESPP")(such employees are referred to herein as "Senior Management") and are, thus, entitled to benefits under the TESPP, shall be ineligible for future participation in the DCP as active employees of the Employer;

(ii) that, for purposes of the DCP, each such Senior Management member shall be treated as having terminated employment with the Employer as of the last day on which he performs services for the Employer as an employee; and

(iii) that each such Senior Management member whose employment with the Employer and active participation in the DCP is so terminated shall continue to participate in the DCP as an inactive participant pursuant to the terms of the DCP until such Senior Management member has received payment of all amounts payable to him/her under the DCP.

[1]This Exhibit A may be updated from time to time without the need for a formal amendment to the DCP.

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Exhibit 10(s)

SECOND AMENDED AND RESTATED TENET HEALTHCARE CORPORATION
2001 STOCK INCENTIVE PLAN

1. Purpose of the Plan.

The purpose of the Second Amended and Restated Tenet Healthcare Corporation 2001 Stock Incentive Plan is to promote the interests of the Company and its shareholders by strengthening the Company's ability to attract, motivate and retain Employees, Directors, advisors and consultants of training, experience and ability, and to provide a means to encourage stock ownership and a proprietary interest in the Company to Directors, officers and valued Employees of the Company and consultants and advisors to the Company upon whose judgment, initiative, and efforts the financial success and growth of the business of the Company largely depend.

2. Definitions.

(a) "Affiliate" shall have the meaning ascribed to such term in Rule 12b-2 of the General Rules and Regulations under the Exchange Act.

(b) "Annual Retainer" means the annual retainer for Directors established by the Committee or the Board from time to time, but does not include meeting fees and committee fees.

(c) "Appreciation Right" means an award made under Section 9.

(d) "Associate" shall have the meanings ascribed to such term in Rule 12b-2 of the General Rules and Regulations under the Exchange Act.

(e) "Board" means the Board of Directors of the Company.

(f) "Business Unit" means any facility, region, division, group, subsidiary or other unit within the Company that is designated by the Committee to constitute a Business Unit.

(g) "Change in Control" of the Company means a Person, alone or together with its Affiliates and Associates, becoming the beneficial owner of 20% or more of the general voting power of the Company or any Person making a filing under Sections 13(d) or 14(d) of the Exchange Act with respect to the Company which discloses an intent to acquire control of the Company in a transaction or series of transactions not approved by the Board.

(h) "Code" means the Internal Revenue Code of 1986, as amended, and any successor statute and the regulations promulgated thereunder, as it or they may be amended from time to time.

(i) "Committee" means the Compensation Committee of the Board, unless the Board appoints another committee to administer the Plan.

(j) "Common Stock" means the $0.075 par value Common Stock of the Company.

(k) "Company" means Tenet Healthcare Corporation, a Nevada corporation.

(l) "Director" means a member of the Board of the Company who is not an Employee or a former Employee who is receiving severance or retirement benefits (other than under the Tenet Healthcare Corporation Amended and Restated Supplemental Executive Retirement Plan, as it may be amended from time to time) from the Company or any of its present or future Business Units.

(m) "Eligible Person" means an Employee, Director, advisor or consultant of the Company or any of its present or future Business Units.

(n) "Employee" means any executive officer or other employee of the Company, or of any of its present or future Business Units.

(o) "Exchange Act" means the Securities Exchange Act of 1934, as amended from time to time or any successor statute.

(p) "Fair Market Value" means the closing price of a share of Common Stock on the New York Stock Exchange on the date as of which fair market value is to be determined or the actual sale price of the shares acquired upon exercise if the shares are sold in a same day sale, or if no sales were made on such date, the closing price of such shares on the New York Stock Exchange on the next preceding date on which there were such sales.

(q) "Incentive Award" means an Option, Restricted Stock, an Appreciation Right, a Performance Unit, a Restricted Unit, a Section 162(m) Award or a cash bonus award granted under the Plan.

(r) "Incentive Stock Option" means an Option intended to qualify under Section 422 of the Code and the Treasury regulations thereunder.

(s) "Option" means an Incentive Stock Option or a nonqualified stock option.

(t) "Participant" means any Eligible Person selected to receive an Incentive Award pursuant to Section 5.

(u) "Plan" means the Second Amended and Restated Tenet Healthcare Corporation 2001 Stock Incentive Plan as set forth herein, as it has been or may be amended and/or restated from time to time.

(v) "Performance Criterion" or "Performance Criteria" means any one or more of the following performance measures, taken alone or in conjunction with each other, each of which may be adjusted by the Committee to exclude the before-tax or after-tax effects of any significant acquisitions or dispositions not included in the calculations made in connection with setting the Performance Criterion or Performance Criteria for the relevant Incentive Award:

(1) Basic or diluted earnings per share of common stock, which may be calculated as (A) income calculated in accordance with Section 2(v)(4), divided by (x) the weighted average number of shares, in the case of basic earnings per share, and (y) the weighted average number of shares and shares equivalents of common stock, in the case of diluted earnings per share, or (B) using a method as may be specified by the Committee;

(2) Cash flow, which may be calculated or measured in a manner specified by the Committee;

(3) Economic value added, which is after-tax operating profit less the annual total cost of capital, which may be calculated or measured in a manner specified by the Committee;

(4) Income, which may include, without limitation, net income and operating income and may be calculated or measured (A) before or after income taxes, including or excluding interest, depreciation and amortization, minority interests, extraordinary items and other material non-recurring items, discontinued operations, the cumulative effect of changes in accounting policies and the effects of any tax law changes; or (B) using a method as may be specified by the Committee;

(5) Quality of service and/or patient care, which may be measured by (A) the extent to which the Company achieves pre-set quality objectives including, without limitation, patient satisfaction objectives, or (B) a method as may be specified by the Committee;

(6) Return measures (including, but not limited to, return on assets, capital, equity, or sales), which may be calculated or measured in a manner specified by the Committee; or

(7) The price of the Common Stock or the Company's preferred stock. (including, but not limited to, growth measures and total shareholder return) which may be calculated or measured in a manner specified by the Committee.

(w) "Performance Goals" means the performance objectives with respect to one Performance Criterion or two or more Performance Criteria established by the Committee for the Company, a Business Unit or an individual for the purpose of determining whether, and the extent to which, a Section 162(m) Award will be awarded or paid.

(x) "Performance Unit" means a grant made under Section 10.

(y) "Person" means an individual, firm, corporation or other entity or any successor to such entity, but "Person" shall not include the Company, any subsidiary of the Company, any employee benefit plan or employee stock plan of the Company, or any Person organized, appointed, established or holding Voting Stock by, for or pursuant to the terms of such a plan or any Person who acquires 20% or more of the general voting power of the Company in a transaction or series of transactions approved prior to such transaction or series of transactions by the Board.

(z) "Restricted Stock" means an award of shares of Common Stock made under Section 8.

(aa) "Restricted Unit" means an award made under Section 11.

(bb) "Section 162(m)" means Section 162(m) of the Code and regulations and governmental interpretations thereunder.

(cc) "Section 162(m) Award" means a grant of Options, Restricted Stock, Performance Units or Restricted Units meeting the requirements of Code Section 162(m).

(dd) "Voting Stock" means shares of the Company's capital stock having general voting power, with "voting power" meaning the power under ordinary circumstances (and not merely upon the happening of a contingency) to vote in the election of directors.

3. Shares of Common Stock Subject to the Plan.

(a) Subject to the provisions of Section 3(d) and Section 14, the aggregate number of shares of Common Stock that may be issued under the Plan is 40,000,000 shares of Common Stock.

(b) Notwithstanding anything in the Plan to the contrary, the aggregate number of shares of Common Stock that may be issued to settle grants of Restricted Stock, Appreciation Rights, Performance Units and Restricted Units under the Plan shall not exceed 4,000,000 shares.

(c) The shares of Common Stock to be delivered under the Plan will be made available, at the discretion of the Board or the Committee, either from authorized but unissued shares of Common Stock or from previously issued shares of Common Stock reacquired by the Company, including shares purchased on the open market.

(d) If any share of Common Stock that is the subject of an Incentive Award is not issued or transferred and ceases to be issuable or transferable for any reason, such share of Common Stock will no longer be charged against the limitations provided for in Section 3(a) and (b) and may again be made subject to Incentive Awards. Shares as to which an Option has been surrendered in connection with the exercise of a related Appreciation Right, however, will not again be available for the grant of any further Incentive Awards. Incentive Awards shall not be applied against the limitations provided for in Section 3(a) and 3(b) to the extent they are paid out in cash and not in Common Stock.

4. Administration of the Plan.

(a) The Plan will be administered by the Committee, which will consist of two or more persons (1) who satisfy the requirements of a "Non-Employee Director" for purposes of Rule 16b-3 under the Exchange Act, and (2) who satisfy the requirements of an "outside director" for purposes of Section 162(m).

(b) The Committee has and may exercise such powers and authority of the Board as may be necessary or appropriate for the Committee to carry out its functions as described in the Plan. The Committee has authority in its discretion to determine the Eligible Persons to whom, and the time(s) at which, Incentive Awards may be granted and the number of shares, units, or Appreciation Rights subject to each Incentive Award. The Committee has authority to interpret the Plan, to make determinations as to whether a Participant or a Director is permanently and totally disabled, and to determine the terms and provisions of Incentive Awards. The Committee has authority to make all other determinations necessary or advisable for Plan administration and to prescribe and rescind rules and regulations relating to the Plan. All interpretations, determinations, and actions by the Committee will be final, conclusive, and binding upon all parties.

(c) No member of the Board or the Committee will be liable for any action or determination made in good faith by the Board or the Committee with respect to the Plan or any Incentive Award under it.

5. Eligibility.

(a) All Employees who have been determined by the Committee to be key Employees and all consultants and advisors to the Company, or to any Business Unit, present or future, that have been determined by the Committee to be key consultants or advisors are eligible to receive Incentive Awards under the Plan; provided, however, that only Employees who have been determined by the Committee to be key Employees of the Company or any subsidiary corporation (within the meaning of Section 424(f) of the Code) shall be eligible to receive Incentive Stock Options under the Plan.

(b) All Directors are eligible to receive Options in accordance with Section 7.

(c) No person will be eligible for the grant of any Incentive Stock Option who owns or would own immediately after the grant of such Option, directly or indirectly, stock possessing more than 10 percent of the total combined voting power of all classes of stock of the Company or of any subsidiary corporation (within the meaning of Section 424(f) of the Code). This does not apply if, at the time such Incentive Stock Option is granted, the Incentive Stock Option price is at least 110% of the Fair Market Value of the Common Stock on the date of the grant. In this event, the Incentive Stock Option is not exercisable after the expiration of five years from the date of grant.

(d) The Committee has authority, in its sole discretion, to determine and designate from time to time those Eligible Persons who are to be granted Incentive Awards, and the type and amount of Incentive Award to be granted. Each Incentive Award will be evidenced by a written instrument and may include such other terms and conditions consistent with the Plan as the Committee may determine.

6. Terms and Conditions of Options.

(a) The exercise price per share for each Option, including Options granted to Directors under Section 7, will be at least equal to the Fair Market Value of the Common Stock on the date of grant. Once an Option has been granted, (i) the exercise price per share for that Option may not be reduced, and (ii) that Option may not be cancelled and reissued, without shareholder approval, except as provided in Section 14.

(b) Options shall vest and be exercised as determined by the Committee, but in no event may an Option be exercisable after 10 years from the date of grant.

(c) The exercise price of an Option, including an Option granted to a Director under Section 7, and any federal and state withholding obligation resulting from the exercise of such Option, will be payable in full (1) upon exercise, in cash, (2) by the Participant irrevocably authorizing a broker approved in writing by the Company to sell shares of Common Stock acquired through exercise of the Option and remitting to the Company a sufficient portion of the sale proceeds to pay the entire exercise price and any federal and state withholding resulting from such exercise (a "cashless exercise"); provided that, notwithstanding anything in this Plan to the contrary, (A) the Company shall issue such shares of Common Stock only at or after the time the Company receives full payment for such shares, (B) the exercise price for such shares of Common Stock will be due and payable to the Company no later than one business day following the date on which the proceeds from the sale of the underlying shares of Common Stock are received by the authorized broker, and (C) in no event will the Company directly or indirectly extend or maintain credit, arrange for the extension of credit or renew any extension of credit, in the form of a personal loan or otherwise, in connection with a cashless exercise, (3) in the discretion of the Committee, upon exercise, by the assignment and delivery to the Company of shares of Common Stock owned by the Participant, or (4) by a combination of any of the above. Any shares assigned and delivered to the Company in payment or partial payment of the exercise price will be valued at the Fair Market Value on the exercise date and shall be accompanied by an assignment separate from certificate and any other document(s) reasonably requested by the Company.

(d) With respect to Incentive Stock Options granted under the Plan, the aggregate Fair Market Value (determined as of the date the Incentive Stock Option is granted) of the number of shares with respect to which Incentive Stock Options are exercisable for the first time by an Employee during any calendar year (under the Plan or any other plan of the Company or a subsidiary corporation (within the meaning of Section 424(f) of the Code)) shall not exceed one hundred thousand dollars ($100,000) or such other limit as may be set forth in the Code.

(e) No fractional shares will be issued pursuant to the exercise of an Option, including Options granted to Directors under Section 7, nor will any cash payment be made in lieu of fractional shares.

(f) With respect to the exercise of an Option under the Plan, the Participant may, in the discretion of the Committee, receive a replacement Option under the Plan to purchase a number of shares of Common Stock equal to the number of shares of Common Stock, if any, that the Participant delivered on exercise of the Option, with a purchase price equal to the Fair Market Value on the exercise date and with a term extending to the expiration date of the original Option.

(g) All Incentive Stock Options shall be granted within 10 years from the date this Plan is adopted or is approved by the shareholders, whichever is earlier.

7. Terms and Conditions of Options Granted to Directors.

(a) The Board shall determine in its discretion the Directors to whom, and the time(s) at which, Options may be granted to Directors and the number of shares subject to such Option grants.

(b) Each Option will be evidenced by a written instrument, which shall include such terms and conditions consistent with this Plan as the Committee may determine.

(c) Options granted to Directors shall vest as determined by the Board, in its discretion, and may vest immediately upon grant.

(d) A Director may make an election (i) upon being elected to the Board, within 30 days from the date he/she is notified that he/she is eligible to make the election, and (ii) between November 1 and December 15 of each year, to convert all or a portion of his/her Annual Retainer for the following calendar year into Options; provided, however, that at the time the Director makes such an election, the Director meets the Company's stock ownership guidelines for Directors established by the Board from time to time.

(1) Unless otherwise determined by the Board, on the day that a Director who has elected to convert all or a portion of his/her Annual Retainer into Options otherwise would have received payment of a portion of the Annual Retainer, the Director shall receive a number of Options equal to (x) four times the amount of the Annual Retainer to be converted into Options on such date divided by (y) the Fair Market Value of the Common Stock on such date.

(2) Unless otherwise determined by the Board, Options granted under this Section 7(d) shall vest immediately and shall have a term of ten years.

(3) A Director shall not transfer or otherwise dispose of the shares acquired upon exercising an Option granted under this Section 7(d) earlier than one year following the date of the exercise (except that a Director may dispose of a number of shares sufficient to pay the exercise price and any taxes withheld in connection with such exercise).

(e) If a non-executive Director is removed from office by the Company's shareholders, is not nominated for reelection by the Board or is nominated by the Board but is not reelected by the Company's shareholders, then the Options granted hereunder will expire one year after the date of removal or failure to be elected unless by their terms they expire sooner.

(f) If the Director retires at or after age 65, or retires prior to age 65 with the consent of the Committee, the Options granted hereunder will continue to vest, be exercisable and expire in accordance with their terms.

(g) If the Director dies or becomes permanently and totally disabled while serving in such capacity, the Options granted hereunder will expire five years after the date of death or permanent and total disability unless by their terms they expire sooner.

(h) If the Director dies or becomes permanently and totally disabled within the one-year period referred to in Section 7(e), the Options granted hereunder will expire one year after the date of death or permanent and total disability unless by their terms they expire sooner. If the Director dies or becomes permanently and totally disabled within the five-year period referred to in Section 7(g), the Options granted hereunder will expire upon the later of the end of such five-year period or one year after the date of death or permanent and total disability unless by their terms they expire sooner.

8. Terms and Conditions of Restricted Stock.

(a) The Committee shall determine in its discretion the vesting period and any additional restrictions and conditions for Restricted Stock.

(b) Restricted Stock shall consist of Common Stock and shall be represented by stock certificates registered in the name of the Participant. The Participant shall have all rights of a shareholder prior to the vesting of a grant of Restricted Stock, including the right to vote the shares and receive all dividends and other distributions paid or made with respect thereto.

(c) Unless otherwise determined by the Committee, Restricted Stock may not be transferred, assigned or made subject to any encumbrance, pledge or charge until such Restricted Stock has vested and any other restrictions or conditions on such Restricted Stock are removed, have been satisfied or expire.

(d) The certificates representing a grant of Restricted Stock will remain in the physical custody of the Company until such Restricted Stock has vested and any other restrictions or conditions on such Restricted Stock are removed, have been satisfied or expire.

(e) The Committee may impose such other conditions on any Restricted Stock granted pursuant to the Plan as it may deem advisable, including, without limitation, restrictions under the Securities Act of 1933, as amended, under the requirements of any stock exchange on which the Common Stock is then listed and under any blue sky or other securities laws applicable to such Restricted Stock.

(f) Restricted Stock with vesting tied to a Performance Criterion or Performance Criteria shall have a minimum vesting period of at least one year. All other Restricted Stock shall have a minimum vesting period of at least three years.

9. Terms and Conditions of Appreciation Rights.

(a) The Committee may grant an Appreciation Right in connection with or without relationship to an Option. An Appreciation Right granted with relationship to an Option may be granted at the time the Option is granted or at any time thereafter during the term of the Option.

(b) An Appreciation Right granted in connection with an Option will entitle the holder, upon exercise, to surrender such Option or any portion thereof, to the extent unexercised, with respect to the number of shares as to which such Appreciation Right is exercised, and to receive payment of an amount computed pursuant to Section 9(d). Such Option will cease to be exercisable to the extent and when surrendered.

(c) Subject to Section 9(h), an Appreciation Right granted in connection with an Option hereunder will be exercisable at such time or times, and only to the extent, that a related Option is exercisable, will expire no later than the related Option expires and will not be transferable except to the extent that such related Option may be transferable.

(d) Upon the exercise of an Appreciation Right granted in connection with an Option, the holder will be entitled to receive, at the Committee's discretion, (1) a cash payment determined by multiplying (A) the difference obtained by subtracting (i) the exercise price of the related Option from (ii) the Fair Market Value of a share of Common Stock on the date of exercise of such Appreciation Right, by (B) the number of shares as to which such Appreciation Right is being exercised, or (2) a number of whole shares of Common Stock determined by dividing (A) the dollar amount calculated in (1) above by (B) the Fair Market Value of a share of Common Stock on the date of exercise of such Appreciation Right.

(e) An Appreciation Right granted without relationship to an Option will be exercisable for the period of time determined by the Committee, which shall not exceed 10 years from the date of grant.

(f) An Appreciation Right granted without relationship to an Option will specify the number of shares to which it relates and will entitle the holder, upon exercise of the Appreciation Right, to receive, at the Committee's discretion, (1) a cash payment of an amount determined by multiplying (A) the difference obtained by subtracting (i) the amount assigned to the Appreciation Right by the Committee on the date of grant (which shall not be less than the Fair Market Value of a share of Common Stock on the date of grant) from (ii) the Fair Market Value of a share of Common Stock on the date of exercise of such Appreciation Right, by (B) the number of shares as to which such Appreciation Right will have been exercised, or (2) a number of whole shares of Common Stock determined by dividing (A) the dollar amount calculated in (1) above by (B) the Fair Market Value of a share of Common Stock on the date of exercise of such Appreciation Right.

(g) At the time an Appreciation Right is granted, the Committee may determine the maximum amount payable with respect to such Appreciation Right; provided, however, that such maximum amount shall in no event be greater than the amount determined in accordance with Section 9(d) or 9(f), as the case may be.

(h) An Appreciation Right granted in connection with an Incentive Stock Option may be exercised only when the market price of the Common Stock subject to the Incentive Stock Option exceeds the exercise price set forth in the Incentive Stock Option.

10. Terms and Conditions of Performance Units.

(a) The value of Performance Units may be measured in whole or in part by the value of shares of Common Stock, the performance of the Participant, the performance of the Company or any Business Unit or any combination thereof. Such Performance Unit shall be payable in cash and/or shares of Common Stock as determined by the Committee.

(b) At the time of a Performance Unit grant, the Committee shall determine a performance period applicable to the Performance Unit, one or more Performance Goals to be achieved during the applicable performance period and a schedule indicating the value of a Performance Unit at various levels of performance relative to the Performance Goal(s). No performance period shall be less than one year nor shall it exceed 10 years from the date of the grant. At the end of the applicable performance period, the Committee shall determine the extent to which a Performance Goal(s) have been attained in order to establish the amount of cash payment to be made, or the number of shares of Common Stock to be issued, if any. The number of shares of Common Stock issued upon attainment of a Performance Goal(s) shall be determined by dividing the value of the Performance Unit by the Fair Market Value of a share of Common Stock on the date such payment is to be made.

(c) The Performance Goals applicable to a Performance Unit grant may be subject to such later revisions as the Committee shall deem appropriate to reflect significant unforeseen events such as changes in laws, regulations or accounting practices, or unusual or nonrecurring items or occurrences.

(d) Performance Units shall be subject to such other restrictions and conditions as the Committee shall determine.

11. Terms and Conditions of Restricted Units.

(a) Restricted Units may be granted under the Plan based on a Participant's continued employment with the Company. Such Restricted Unit shall be payable in cash and/or shares of Common Stock as determined by the Committee.

(b) At the time a Restricted Unit is granted, the Committee shall determine the vesting period. No vesting period shall be less than three years nor greater than 10 years from the date of the grant. The Committee may establish a maximum value for a Restricted Unit at the time of grant.

(c) If the Restricted Unit is payable in cash, a cash amount equivalent in value to the Fair Market Value of one share of Common Stock on the last day of the vesting period, subject to any maximum value determined by the Committee at the time of grant, shall be paid with respect to each such Restricted Unit granted to a Participant. If the Restricted Unit is payable in shares of Common Stock, one share of Common Stock, subject to any maximum value determined by the Committee at the time of grant, shall be issued with respect to each such Restricted Unit granted to the Participant.

(d) A Restricted Unit grant may be made subject to such later revisions as the Committee shall deem appropriate to reflect significant unforeseen events such as changes in laws, regulations or accounting practices, or unusual or nonrecurring items or occurrences.

(e) Restricted Units shall be subject to such other restrictions and conditions as the Committee shall determine.

12. Section 162(m) Awards.

Without limiting the generality of the foregoing, Restricted Stock, Performance Units and Restricted Units referred to in Sections 8, 10 and 11, respectively, may be granted as awards that satisfy the additional requirements of this Section 12 so as to qualify for exemption as "performance-based compensation" within the meaning of Section 162(m). Any such award shall be designated as a Section 162(m) Award at the time of grant.

(a) *Eligible Class*. The eligible class of persons for Section 162(m) Awards shall be all Eligible Persons.

(b) *Performance Goals*. A Participant's right to receive any payment with respect to an Incentive Award designated as a Section 162(m) Award shall be determined by the degree Performance Goal(s) is/are achieved. The specific Performance Goal(s) with respect to a Section 162(m) Award must be established by the Committee in accordance with Section 162(m). Notwithstanding anything in the Plan to the contrary (other than Section 14(d)), as and to the extent required by Section 162(m), the Performance Goal(s) must state, in terms of an objective formula or standard, the method of computing the amount of compensation payable to the Participant if the Performance Goal(s) is attained, and must not allow the Committee nor the Board to use its discretion to increase the amount of compensation payable that otherwise would be due upon attainment of the Performance Goal(s).

(c) *Committee Certification*. Before any Section 162(m) Award is paid to a Participant, the Committee must certify in writing (by resolution or otherwise) that the applicable Performance Goal(s) and any other material terms of the Section 162(m) Award were satisfied; provided, however, that a Section 162(m) Award may be paid without regard to the satisfaction of the applicable Performance Goal(s) (and the requirements of Section 162(m)) in the event of a Change in Control as provided in Section 14(d).

(d) *Terms And Conditions of Awards; Committee Discretion to Reduce Awards*. The Committee shall have discretion to determine the conditions, restrictions or other limitations, in accordance with the terms of this Plan and Section 162(m), on the payment of individual Section 162(m) Awards. Unless otherwise provided in a Section 162(m) Award agreement, the Committee reserves the right to reduce the amount otherwise payable under a Section 162(m) Award on any basis (including the Committee's discretion).

(e) *Adjustments For Material Changes*. As and to the extent permitted by Section 162(m), in the event of (1) a change in corporate capitalization, a corporate transaction or a complete or partial corporate liquidation, or (2) any extraordinary gain or loss or other event that is treated for accounting purposes as an extraordinary item under generally accepted accounting principles, or (3) any material change in accounting policies or practices affecting the Company and/or the Performance Goal(s), then, to the extent any of the foregoing events was not anticipated at the time the Performance Goal(s) was established, the Committee may make adjustments to the Performance Goal(s), based solely on objective criteria, so as to neutralize the effect of the event on the applicable Section 162(m) Award.

(f) *Interpretation*. It is the intent of the Company that the Section 162(m) Awards satisfy, and be interpreted in a manner that satisfy, the applicable requirements of Section 162(m), including the requirements for performance-based compensation under Section 162(m)(4)(C), so that the Company's tax deduction for remuneration in respect of such an award for services performed by employees of the Company who are subject to Section 162(m) is not disallowed in whole or in part by the operation of such Code section. If any provision of this Plan otherwise would frustrate or conflict with the intent expressed in this Section 12, that provision, to the extent possible, shall be interpreted and deemed amended so as to avoid such conflict. To the extent of any remaining irreconcilable conflict with such intent, such provision shall be deemed void as applicable to such employees with respect to whom such conflict exists. Nothing herein shall be interpreted so as to preclude any Eligible Person from receiving an award that is not a Section 162(m) Award.

13. Limits on Awards.

The maximum number of shares of Common Stock or stock units underlying Incentive Awards that may be granted to any Eligible Person during any period of five consecutive fiscal years of the Company, beginning with fiscal year 2002, shall not exceed an average of 1,000,000 shares per year, either individually or in the aggregate, with respect to all such types of awards, with such number of shares subject to adjustment on the same basis as provided in Section 14. To the extent required by Section 162(m), awards subject to the foregoing limit that are cancelled shall not again be available for grant under this limit. The maximum dollar amount of cash compensation in respect of Performance Units that may be paid to any Eligible Person during any period of five consecutive fiscal years of the Company, beginning with fiscal year 2002, shall not exceed an annual average of $5,000,000.

14. Adjustment Provisions.

(a) Subject to Section 14(b), if the outstanding shares of Common Stock of the Company are increased, decreased, or exchanged for a different number or kind of shares or other securities, or if additional shares or new or different shares or other securities are distributed with respect to such shares of Common Stock, through merger, consolidation, spin off, sale of all or substantially all the property of the Company, reorganization, recapitalization, reclassification, stock dividend, stock split, reverse stock split or other distribution with respect to such shares of Common Stock, or other securities, the Committee may make an appropriate and proportionate adjustment in (1) the maximum number and kind of shares provided in Section 3, (2) the maximum number and kind of shares provided in Section 13, (3) the number and kind of shares, units, or other securities subject to then-outstanding Incentive Awards, and (4) the exercise or other price for each share or unit subject to then-outstanding Incentive Awards without change in the aggregate purchase price or value as to which such Incentive Awards remain exercisable or subject to restrictions.

(b) Notwithstanding the provisions of Section 14(a), upon dissolution or liquidation of the Company or upon a reorganization, merger, or consolidation of the Company with one or more corporations as a result of which the Company is not the surviving corporation or survives as a subsidiary of another corporation, or upon the sale of all or substantially all the property of the Company, all Incentive Awards then outstanding under the Plan will be fully vested and exercisable and all restrictions will immediately cease, unless provisions are made in connection with such transaction for the continuance of the Plan or the assumption or the substitution for such Incentive Awards of new incentive awards covering the stock of a successor corporation, or a parent or subsidiary thereof, with appropriate adjustments as to the number and kind of shares and prices.

(c) Adjustments under Sections 14(a) and (b) will be made by the Committee, whose determination as to what adjustments will be made and the extent thereof will be final, binding and conclusive. No fractional interest will be issued under the Plan on account of any such adjustments.

(d) Notwithstanding any provision herein to the contrary, in the event a Change of Control occurs, (1) all Options held by Directors will be fully vested and any restrictions upon exercise in Section 7 will immediately cease, and (2) the Committee may, in its sole discretion, without obtaining shareholder approval, take any one or more of the following actions with respect to all Participants other than Directors:

(A) Accelerate the vesting and/or performance periods of, or where applicable make fully payable, any outstanding Incentive Awards;

(B) Determine that all or any portion of conditions and/or restrictions associated with any Incentive Award have been met;

(C) Grant a cash bonus award to any of the holders of outstanding Options, except the holders of outstanding Options that meet the requirements of Section 162(m);

(D) Grant Appreciation Rights to holders of outstanding Options;

(E) Pay cash to any or all Option holders in exchange for the cancellation of their outstanding Options;

(F) Make any other adjustments or amendments to the Plan and outstanding Incentive Awards and substitute new Incentive Awards.

15. General Provisions.

(a) Nothing in the Plan or in any instrument executed pursuant to the Plan will confer upon any Participant who is an Employee, Director, consultant or advisor any right to continue in the employ or service of the Company or any of its subsidiaries or affect the right of the Company to terminate the employment of any Employee, terminate the consulting or advisory services of any Participant at any time with or without cause, or the right of the Company's shareholders to remove any Director from office in accordance with the Company's Bylaws.

(b) No shares of Common Stock will be issued or transferred pursuant to an Incentive Award unless and until all then-applicable requirements imposed by federal and state securities and other laws, rules and regulations and by any regulatory agencies having jurisdiction, and by any stock exchanges upon which the Common Stock may be listed, have been fully met. As a condition precedent to the issuance of shares pursuant to the grant or exercise of an Incentive Award, the Company may require the Participant to take any reasonable action to meet such requirements.

(c) No Participant and no beneficiary or other person claiming under or through such Participant will have any right, title or interest in or to any shares of Common Stock allocated or reserved under the Plan or subject to any Incentive Award except as to such shares of Common Stock, if any, that have been issued or transferred to such Participant.

(d) The Company shall have the right to deduct from any settlement, including the delivery or vesting of Incentive Awards, made under the Plan any federal, state or local taxes of any kind required by law to be withheld with respect to such payments or take such other action as may be necessary in the opinion of the Company to satisfy all obligations for the payment of such taxes. With respect to an Incentive Award, the Committee may, in its discretion, permit the Participant to satisfy, in whole or in part, any tax withholding obligation which may arise in connection with the exercise of the Incentive Award by electing to have the Company withhold shares of Common Stock having a Fair Market Value equal to the amount of the tax withholding.

(e) Except with the prior written consent of the Committee, Incentive Awards granted under the Plan, shall not be transferable other than (1) by will or the laws of descent and distribution, (2) pursuant to a qualified domestic relations order as defined by the Code or Title I of the Employee Retirement Income Security Act, or the rules thereunder, or (3) by gift, and not for value, during the Participant's lifetime to a revocable trust that has the same taxpayer identification number as the Participant and of which the Participant is the trustee, but only if such gift (A) would not result in the Company losing all or any part of the tax deduction to which it would be entitled, (B) does not otherwise adversely affect the interests of the Company as determined by the Committee, and (C) complies with all rules and regulations regarding such gifts established by the Company from time to time. The Committee in its own discretion may permit other transfers of Incentive Awards and may establish guidelines pursuant to which other transfers will be permissible.

(f) The forms of Incentive Awards granted under the Plan may contain such other provisions as the Committee may deem advisable.

16. Termination of Incentive Awards

(a) Unless otherwise determined by the Committee, an Appreciation Right or an Option held by a person who was an Employee at the time such Appreciation Right or Option was granted will expire immediately if and when such person ceases to be an Employee, except as follows:

(1) If the employment of an Employee is terminated by the Company other than for cause, for which the Company will be the sole judge, then the Appreciation Rights and Options will expire three months thereafter unless by their terms they expire sooner. During said period, the Appreciation Rights and Options may be exercised in accordance with their terms, but only to the extent exercisable on the date of termination of employment.

(2) If the Employee retires at normal retirement age as determined by the Company from time to time, retires with the consent of the Company at an earlier date or becomes permanently and totally disabled, as determined by the Committee, while employed by the Company, the Appreciation Rights and Options of the Employee will continue to vest, be exercisable and expire in accordance with their terms.

(3) If an Employee dies while employed by the Company, the Appreciation Rights and Options of the Employee will become fully exercisable as of the date of death and will expire three years after the date of death unless by their terms they expire sooner. If the Employee dies or becomes permanently and totally disabled as determined by the Committee within the three months referred to in subparagraph (1) above, the Appreciation Rights and Options will become fully exercisable as of the date of death or such permanent disability and will expire, in the case of death, one year after the date of such death. In the case of permanent and total disability such Options and Appreciation Rights will expire in accordance with their terms. If the Employee dies or becomes permanently and totally disabled as determined by the Committee subsequent to the time the Employee retires at normal retirement age or retires with the consent of the Company at an earlier date, the Appreciation Rights and Options will fully vest as of the date of death or permanent and total disability and will expire, in the case of death, one year after the date of death. In the case of permanent and total disability, such Appreciation Rights and Options will expire in accordance with their terms.

(b) Unless otherwise determined by the Committee, in the event an Employee who holds Restricted Stock, Performance Units or Restricted Units (including any such award designated as a Section 162(m) Award) ceases to be an Employee, all such Restricted Stock, Performance Units or Restricted Units subject to restrictions at the time his/her employment terminates will expire, terminate and be cancelled except as follows:

(1) In the event the holder of Restricted Stock or Restricted Units ceases to be an Employee due to death, all such Restricted Stock or Restricted Units subject to restrictions at the time his/her employment terminates will no longer be subject to said restrictions.

(2) If an Employee retires at normal retirement age as determined by the Company from time to time or retires with the consent of the Company at an earlier date or becomes permanently and totally disabled as determined by the Committee, all such Restricted Stock, Performance Units or Restricted Units will continue to vest over the applicable vesting or performance period provided that during these periods such Employee does not engage in or assist any business that the Company, in its sole discretion, determines to be in competition with any business conducted by the Company or any of its Business Units.

(3) In the event a holder of Performance Units ceases to be an Employee prior to the end of a performance period applicable thereto, the Committee in its sole discretion shall determine whether to make any payment to the Participant in respect of such Performance Unit and the timing of such payment, if any.

(c) Unless otherwise determined by the Committee, in the event the engagement by the Company of a Participant who is an advisor or consultant, but not an Employee or Director, ceases for any reason (whether terminated by the Company or the Participant), the Participant's unvested Appreciation Rights or Options shall not vest and the Participant's unexercised but vested Appreciation Rights or Options will expire and become unexercisable 90 days after termination. The Participant's Restricted Stock, Performance Units or Restricted Units subject to restrictions at the time the engagement ceases will expire, terminate and be cancelled

(d) The Committee in its sole discretion may determine that any Participant who is on leave of absence for any reason will be considered as still in the employ or service of the Company with respect to any Incentive Award; provided, however, that such Participant's rights to such Incentive Award during a leave of absence will be limited to the extent to which such Incentive Aware was earned or vested at the commencement of such leave of absence.

17. Amendment and Termination

(a) The Committee shall have the power, in its discretion, to amend, suspend or terminate the Plan at any time. The Committee may not make amendments to the Plan that increase the benefits available under the Plan in any material respect, including, without limitation, (1) amending the provisions of Section 6(a), (2) increasing the number of shares of Common Stock that may be issued, transferred or exercised pursuant to Incentive Awards under the Plan, or (3) changing the types or terms of Incentive Awards that may be made under the Plan, without the approval of the shareholders of the Company.

(b) Subject to Section 6(a), the Committee, with the consent of a Participant, may make such modifications in the terms and conditions of an Incentive Award as it deems advisable. Notwithstanding the foregoing, only the Board, with the consent of a Director, may make modifications in the terms and conditions of an Option granted to a Director.

(c) No amendment, suspension or termination of the Plan will, without the consent of the Participant, alter, terminate, impair or adversely affect any right or obligation under any Incentive Award previously granted under the Plan.

18. Effective Date of the Plan and Duration of the Plan .

This Plan will become effective upon adoption by the Board subject to approval by the holders of a majority of the shares which are represented in person or by proxy and entitled to vote on the subject at the Annual Meeting of Shareholders of the Company to be held on October 10, 2001 (or on such other date as may be determined by the Board). Unless previously terminated, the Plan will terminate on October 10, 2011, except with respect to Incentive Awards then outstanding.

QuickLinks

SECOND AMENDED AND RESTATED TENET HEALTHCARE CORPORATION 2001 STOCK INCENTIVE PLAN

Exhibit 21

Subsidiaries of Tenet Healthcare Corporation

All of the following subsidiaries are 100% owned by Tenet Healthcare Corporation unless otherwise indicated.

Assured Investors Life Company

H.F.I.C. Management Company, Inc.

Tenet HealthSystem International, Inc.

(a) N.M.E. International (Cayman) Limited (Cayman Islands, B.W.I.)

(b) HUG Services, Inc. *(owned 21.85% by Tenet Healthcare Corporation, 3.23% by Tenet Healthsystem Medical, Inc., 67.42% by NME International (Cayman) Limited and 7.5% by non-Tenet shareholders)*

(a) Tenet UK Properties Limited

(a) The Healthcare Insurance Corporation

NME Headquarters, Inc.

NME Management Services, Inc.

NME Properties Corp.

(a) NME Properties, Inc.

(b) Lake Health Care Facilities, Inc.

(b) NME Properties West, Inc.

(a) NME Property Holding Co., Inc.

NME Psychiatric Hospitals, Inc.

(a) The Huron Corporation

NME Psychiatric Properties, Inc.

(a) Brawner Hospital, Inc.

(a) Leesburg Institute, Inc.

(a) Nashua Brookside Hospital, Inc.

(a) Northeast Behavioral Health, Inc.

(a) Northeast Psychiatric Associates -2, Inc.

(a) P.D. at New Baltimore, Inc.

(a) P.I.A. Central Jersey, Inc.

(a) P.I.A. Detroit, Inc.

(b) Psychiatric Facility at Michigan

(a) P.I.A. Educational Institute, Inc.

(a) P.I.A. Green Bay, Inc.

(a) P.I.A. Indianapolis, Inc.

(a) P.I.A. Lincoln, Inc.

(a) P.I.A. Michigan City, Inc.

(a) P.I.A. Milwaukee, Inc.

(a) P.I.A. New Jersey, Inc.

(a) P.I.A. North Jersey, Inc.

(a) P.I.A. Northern New Mexico, Inc.

(a) P.I.A. Salt Lake City, Inc.

(a) P.I.A. Seattle, Inc.

(a) P.I.A. Slidell, Inc.

(a) P.I.A. Tacoma, Inc.

(a) P.I.A. Tidewater Realty, Inc.

(a) Psychiatric Facility at Evansville, Inc.

(a) Psychiatric Facility at Lawton, Inc.

(a) Psychiatric Institute of Bucks County, Inc.

(a) Psychiatric Institute of Chester County, Inc.

(a) Psychiatric Institute of Columbus, Inc.

(a) Psychiatric Institute of Northern New Jersey, Inc.

(a) Psychiatric Institute of Richmond, Inc.

(a) Regent Hospital, Inc.

(a) Residential Treatment Center of Memphis, Inc.

(a) Riverwood Center, Inc.

(a) Sandpiper Company, Inc.

(a) Southern Crescent Psychiatric Institute, Inc.

(a) Springwood Residential Treatment Centers, Inc.

(a) Tidewater Psychiatric Institute, Inc.

(a) Tucson Psychiatric Institute, Inc.

NME Rehabilitation Hospitals, Inc.

NME Rehabilitation Properties, Inc.

(a) Pinecrest Rehabilitation Hospital, Inc.

(a) R.H.S.C. El Paso, Inc.

(a) R.H.S.C. Modesto, Inc.

(a) R.H.S.C. Prosthetics, Inc.

(a) Tenet HealthSystem Pinecrest Rehab, Inc.

NorthShore Hospital Management Corporation

Syndicated Office Systems

TH AR, Inc.

TenetCare, Inc.

(a) TenetCare California, Inc.

(b) TenetCare La Quinta, Inc.

(b) TenetCare La Quinta ASC, L.P. *(50% TenetCare California, Inc. and 50% TenetCare La Quinta, Inc.*

(b) TenetCare Red Bluff, Inc.

(b) Red Bluff ASC, L.P. *(50% TenetCare California, Inc. and 50% TenetCare Red Bluff, Inc.*

(a) TenetCare Frisco, Inc.

(b) Centennial ASC, L.P. *(1% GP TenetCare Frisco, Inc. and 99% LP Tenet Hospitals, Ltd.)*

(a) TenetCare Missouri, Inc.

(b) Sunset Hills ASC, L.P. *(50% TenetCare Missouri, Inc. and 50% TenetCare Sunset Hills, Inc.)*

(b) TenetCare Sunset Hills, Inc.

(a) TenetCare Tennessee, Inc.

Tenet Healthcare Foundation

Tenet HealthSystem Holdings, Inc.

(a) Tenet HealthSystem Medical, Inc.

(b) American Medical (Central), Inc.

(c) Amisub (Twelve Oaks), Inc.

(c) Amisub (Heights), Inc.

(c) Lifemark Hospitals, Inc.

(d) Amisub of Texas, Inc.

(d) Houston Network, Inc.

(d) Houston Specialty Hospital, Inc.

(d) Lifemark Hospitals of Florida, Inc.

(e) Florida Care Connect, Inc.

(e) Hospital Constructors, Ltd.—*ownership—GP: Lifemark Hospitals of Florida, Inc. (88%) LP: Eastern Professional Properties, Inc. 12%)*

(d) Lifemark Hospitals of Louisiana, Inc.

(e) Kenner Regional Clinical Services, Inc.

(d) Lifemark Hospitals of Missouri, Inc.

(e) Lifemark RMP Joint Venture—*ownership—Lifemark Hospitals of Missouri, Inc. (50%), RMP, L.L.C. (50%)*

(d) Tenet Investments-Kenner, Inc.

(d) Tenet Healthcare, Ltd.—*ownership—GP: Lifemark Hospitals (1%)*
LP: Amisub of Texas, Inc. (70.1%);
LP: Amisub (Heights), Inc. (10.3%)
LP: Amisub (Twelve Oaks), Inc. (18.6%)

(e) NMC Lessor, L.P. *(99% LP-Tenet Healthcare, Ltd; 1% GP-Tenet Healthsystem) Nacogdoches ASC LP, Inc.*

(e) NMC Investors, Ltd. *(49% LP-Tenet Healthcare Ltd; 51% non-Tenet)*

(c) Tenet Employment, Inc.

(b) American Medical Home Care, Inc.

(b) AMI Ambulatory Centres, Inc.

(c) Ambulatory Care—Broward Development Corp.

(c) Concentra New Orleans, L.L.C.—*ownership—AMI Ambulatory Centers, Inc. (49%)*
Concentra Health Services, Inc. (51%)

(b) AMI Arkansas, Inc.

(b) AMI Diagnostic Services, Inc.

(c) UCSD, Medical Center-AMI Magnetic Resonance Diagnostic Center, LP *(50% GP)*

(b) AMI Information Systems Group, Inc.

(c) American Medical International N.V.

(b) AMI/HTI Tarzana Encino Joint Venture—*ownership—Tenet HealthSystem Medical, Inc. (30%)*
Amisub of California, Inc. (26%); New H Acute, Inc. (12%)
AMI Information Systems Group, Inc. (7%)
Encino Hospital Corporation (25%)

(b) Amisub (Florida Ventures), Inc.

(c) Lauderdale Clinical Services, Inc.

(b) Tenet Home Care Tampa/St. Pete, Inc.

(b) Amisub (Hilton Head), Inc.

(c) Hilton Head Health System, L.P.—*ownership—Amisub (Hilton Head), Inc. (79%)*
Tenet Physician Services—Hilton Head, Inc. (21%)

(b) Amisub (Irvine Medical Center), Inc.

(b) Amisub (North Ridge Hospital), Inc.

(c) FL Health Complex, Inc.

(c) North Ridge Partners, Inc.

(b) Amisub (Saint Joseph Hospital), Inc.

(c) Creighton Saint Joseph Regional HealthCare System, L.L.C.— *ownership—Amisub (Saint Joseph Hospital), Inc. (74.06%)*
Creighton Healthcare, Inc. (25.94%)

(b) Amisub (SFH), Inc.

(c) Saint Francis Surgery Center, L.L.C.

(c) TenetCare Memphis, L.L.C.

(c) Tenet HealthSystem SF-SNF, Inc.

(b) Amisub of California, Inc.

(b) Amisub of North Carolina, Inc.

(c) American Homepatient of Sanford, LLC *(50% member interest)*

(c) Central Carolina Ambulatory Surgery Center, LLC

(c) CENCARE, Inc.—*ownership—Physicians (50%); Amisub of North Carolina, Inc. (50%)*

(b) Amisub of South Carolina, Inc.

(c) Piedmont Medical Equipment, G.P.—*ownership—Amisub of South Carolina, Inc. (50%)*
America Home Patient, Inc. (50%)

(c) Rock Hill Surgery Center, L.P.—*ownership—Amisub of South Carolina, Inc. (72%)*
Surgical Center of Rock Hill (28%)

(c) Tenet Rehab Piedmont, Inc.

(d) Piedmont Healthsouth Rehabilitation, LLC *(2.5% member interest)*

(c) Piedmont/Carolina's Radiation Therapy, LLC *(50% member interest)*

(b) Brookwood Center Development Corporation

(c) BWP Associates, Ltd.—*ownership—Brookwood Center Development Corporation (80%)*
Brookwood Development, Inc. (20%)

(c) Concentra Birmingham, L.L.C.—*ownership—Brookwood Center Development Corporation (49%)*
Concentra Health Services, Inc. (51%)

(c) Hoover Doctors Group, Inc.

(c) Medplex Land Associates—*ownership—Brookwood Center Development Corporation (49%)*
Hoover Doctors' Group II (51%)

(c) Medplex Outpatient Medical Centers, Inc.

(c) Medplex Outpatient Surgery Center, Ltd.—*ownership—Others (15%)*
Brookwood Center Development Corporation (8% GP, 73.765 LP);
Hoover Doctor's Group, Inc. (1% LP);
Medplex Outpatient Medical Centers, Inc. (1%LP)

(c) NSC Phase 31, LLC *(49% member interest)*

(b) Brookwood Development, Inc.

(c) Alabama Health Services (St. Clair), L.L.C.—*ownership—(50%)*

(b) Brookwood Health Services, Inc.

(b) Brookwood Parking Associates, Ltd.—*ownership—(99%)*

(b) Columbia Land Development, Inc.

(b) Cumming Medical Ventures, Inc.

(b) East Cooper Community Hospital, Inc.

(b) Eastern Professional Properties, Inc.

(b) Florida Health Network, Inc.

(b) Frye Regional Medical Center, Inc.

(c) Catawba Valley Heart Management Services, LLC *(50% member interest)*

(c) Catawba Valley Radiation Oncology Management, LLC *(50% member interest)*

(c) Catawba Valley Imaging Services, LLC *(50% member interest)*

(c) Frye Home Infusion, Inc.

(c) Guardian Health Services, L.L.C.

(c) Piedmont Health Alliance, Inc.—*ownership—(50%)*

(c) Shared Medical Ventures, L.L.C.—*ownership—(33 1/3%)*

(d) Mobile Imaging Services, L.L.C.

(c) Tate Surgery Center, LLC

(c) Viewmont Surgery Center, L.L.C.

(b) Heartland Corporation

(c) Heartland Physicians, Inc.

(b) Hot Springs NPMC, Inc.

(c) Hot Springs Outpatient Surgery, G.P.—*ownership—Hot Springs NPMC, Inc. (50%) Hot Springs Outpatient Surgery (50%)*

(c) NPMC Healthcenter—Family Healthcare Clinic, Inc.

(c) NPMC Healthcenter—Gastroenterology Center of Hot Springs, Inc.

(c) NPMC Healthcenter—Hot Springs Village, Inc.

(c) NPMC Healthcenter—Malvern, Inc.

(c) NPMC Healthcenter—National Park Surgery Clinic, Inc.

(c) NPMC Healthcenter—Physician Services, Inc.

(b) Kenner Regional Medical Center, Inc.

(b) Medical Center of Garden Grove, Inc.

(c) Orange County Kidney Stone Center, L.P.—*ownership—Medical Center of Garden Grove, Inc. (42.5805%) OCKSC Assoc., Inc. & 11 others (57.4195%)*

(c) Orange County Kidney Stone Center Assoc., G. P.—*ownership—Physicians (67.9%) Medical Center of Garden Grove, Inc. (32.1%)*

(b) National Medical Services III, Inc.

(b) National Medical Services IV, Inc.

(b) New H Acute, Inc.

(b) North Fulton Imaging Ventures, Inc.

(b) North Fulton Medical Center, Inc.

(c) Coalition for Hospital Choice, Inc.

(c) Northwoods Surgery Center, LLC

(c) NorthPoint Health System, Inc.

(c) Northwoods Ambulatory Surgery, Inc.

(b) North Fulton MOB Ventures, Inc.

(c) North Fulton Professional Building I, L.P.—*ownership—(16.407%- LP)*

(b) Occupational Health Medical Services of Florida, Inc.

(b) Palm Beach Gardens Community Hospital, Inc.

(c) Diagnostic Associates of Palm Beach Gardens, Ltd.—*ownership—(80% GP)*

(c) Gardens Surgery Center of Palm Beach County, Ltd.—*ownership—.5% GP; 49.5% LP*

(b) Physicians Development, Inc.

(b) Piedmont Urgent Care and Industrial Health Centers, Inc.

(c) Piedmont East Urgent Care Center, L.L.C.

(c) Piedmont Urgent Care Center at Baxter Village, LLC

(c) Piedmont West Urgent Care Center LLC

(c) Walker Medical Center, LLC

(b) Professional Healthcare Systems Licensing Corporation

(b) ProMed Pharmicenter, Inc.

(b) Quality Medical Management, Inc.

(c) Sterling Healthcare Management, LLC

(b) Roswell Medical Ventures, Inc.

(c) North Fulton Parking Deck, L.P. *(79.672% GP, 10.164% LP)*

(b) Russellville St. Mary's, Inc.

(c) Dedicated Health PHO, Inc.

(c) St. Mary's Medical Group, Inc.

(b) San Dimas Community Hospital

(b) Searcy Central, Inc.

(b) SEMO Medical Management Company, Inc.

(b) Sierra Vista Hospital, Inc.

(b) South Carolina Health Services, Inc.

(b) Stonecrest Medical Center Corporation

(b) Tenet (Brookwood Development), Inc.

(b) Tenet Caldwell Family Physicians, Inc.

(b) Tenet Choices, Inc.

(b) Tenet DISC Imaging, Inc.

(b) Tenet East Cooper Spine Center, Inc.

(b) Tenet Finance Corp.

(b) Tenet Good Samaritan, Inc.

(b) Tenet Gulf Coast Imaging, Inc.

(b) Tenet Health Network, Inc.

(b) Tenet HealthSystem Bartlett, Inc.

(b) Tenet HealthSystem GB, Inc.

(c) Sheffield Educational Fund, Inc.

(b) Tenet HealthSystem Lloyd Noland Medical, Inc.

(c) Hueytown Medical Clinic, LLC *(49% member interest)*

(b) Tenet HealthSystem Lloyd Noland Properties, Inc.

(b) Tenet HealthSystem Nacogdoches ASC, G.P., Inc.

(c) NMC Lessor, L.P. *(1% G.P.-Tenet HealthSystem Nacogdoches ASC, G.P., Inc.; 99% L.P.-Tenet Healthcare Ltd.)*

(c) NMC Surgery Center, L.P.

(b) Tenet HealthSystem Nacogdoches ASC, L.P., Inc.

(b) Tenet HealthSystem North Shore, Inc.

(c) Bayshore Medical Equipment Partners *(33 1/3% GP interest)*

(c) North Shore Physician Hospital Organization *(50%)*

(c) Tenet HealthSystem North Shore (BME), Inc.

(b) Tenet HealthSystem Philadelphia, Inc.

(c) Delaware Valley Physician Alliance, Inc. *(50%)*

(c) Philadelphia Charitable Holdings Corporation

(c) Philadelphia Health & Education Corporation

(c) Tenet HealthSystem Bucks County, LLC

(c) Tenet HealthSystem City Avenue, LLC

(c) Tenet HealthSystem Elkins Park, LLC

(c) Tenet HealthSystem Graduate, LLC

(c) Tenet HealthSystem Hahnemann, LLC

(c) Tenet HealthSystem Parkview, LLC

(c) Tenet HealthSystem Roxborough, LLC

(c) Tenet HealthSystem Roxborough MOB, LLC

(c) Tenet HealthSystem St. Christopher Hospital for Children, LLC

(d) SCHC Pediatric Associates, LLC

(c) Tenet Home Services, L.L.C.

(c) Tenet Medical Equipment Services, LLC

(c) TPS of PA, L.L.C.

(d) TPS II of PA, L.L.C.

(d) TPS III of PA, L.L.C.

(d) TPS IV of PA, L.L.C.

(d) TPS V of PA, L.L.C.

(b) Tenet HealthSystem SGH, Inc.

(b) Tenet HealthSystem SL, Inc.

(c) ER Physicians Group at SLUH, LLC

(b) Tenet HealthSystem SL-HLC, Inc.

(c) Concentra St. Louis, L.L.C.—*ownership—Tenet HealthSystem SL-HLC, Inc. (49%) Concentra Health Services, Inc. (51%)*

(b) Tenet HealthSystem Spalding, Inc.

(c) Spalding Health System, L.L.C.—*ownership—(49.836%)*

(c) Spalding Medical Ventures, L.P.

(c) Tenet EMS/Spalding 911, LLC—*ownership—(64.1%)*

(b) Tenet Healthcare-Florida, Inc.

(c) TCC Partners—*ownership—MGP: Tenet Healthcare-Florida, Inc. (51%); GP: The Cleveland Clinic(49%)*

(b) Tenet Carolina Internal Medicine, Inc.

(b) Tenet Investments, Inc.

(c) T.I. Promed, Inc.

(c) T.I. MedChannel, Inc.

(c) T.I. VM, Inc.

(c) T.I. EMA, Inc.

(b) Tenet Physician Services—Hilton Head, Inc.

(b) Tenet St. Mary's, Inc.

(b) Tenet South Fulton, Inc.

(c) Tenet South Fulton Health Care Centers, Inc.

(b) Tenet West Palm Outreach Services, Inc.

(b) Tenet West Palm Real Estate, Inc.

(c) Flagler Waterview, Ltd.—*ownership—(3.4%- LP)*

(c) G.S. North, Ltd—*ownership—(1%- GP) & (93.03%- LP*)

Tenet HealthSystem Hospitals, Inc.

(a) Alvarado Hospital Medical Center, Inc.

(a) Redding Medical Center, Inc.

(a) Tenet D.C., Inc.

Tenet HealthSystem HealthCorp

(a) OrNda Hospital Corporation

(b) AHM Acquisition Co., Inc.

(c) OrNda Investments, Inc.

(d) AHM CGH, Inc.

(d) AHM GEMCH, Inc.

(d) AHM SMC, Inc.

(d) CHHP, Inc.

(d) Monterey Park Hospital

(d) NLVH, Inc.

(b) Biltmore Surgery Center, Inc.

(b) Commonwealth Continental Health Care, Inc.

(b) Commonwealth Continental Health Care III, Inc.

(b) Coral Gables Hospital, Inc.

(c) CGH Hospital, Ltd.—*ownership—GP: Coral Gables Hospital, Inc. (99.913%) LP: FMC Medical, Inc.(.087%)*

(b) CVHS Hospital Corporation

(b) Cypress Fairbanks Medical Center, Inc.

(c) New Medical Horizons II, Ltd.—*ownership—GP: Cypress Fairbanks Medical Center, Inc. (5%) LP: Tenet HealthSystem CFMC, Inc. (95%)*

(b) FMC Acquisition, Inc.

(c) FMC Hospital, Ltd.—*ownership—GP: FMC Acquisition, Inc. (36.182%)*
LP: MCF, Inc. (63.818%)

(b) FMC Medical, Inc.

(b) Fountain Valley Imaging Corporation

(b) Fountain Valley Regional Hospital and Medical Center, Inc.

(b) GCPG, Inc.

(c) Garland Community Hospital, Ltd.—*ownership—GP: GCPG, Inc. (1%)*
LP: Republic Health Corporation of Mesquite (99%)

(c) Garland MOB Properties, LLC

(b) Gulf Coast Community Hospital, Inc.

(c) Gulf Coast Community Health Care Systems, Inc.

(c) Gulf Coast Outpatient Surgery Center, LLC—*ownership-Gulf Coast Community Hospital, Inc. (50%)*
11 Physicians (50%)

(c) Gulf Coast, PHO, LLC—*ownership—Gulf Coast Community Hospital, Inc.(50%)*
Medical Center and Coastal IPA, LLC(50%)

(c) Tenet Physician Services of Mississippi, L.L.C.

(b) Harbor View Health Systems, Inc.

(c) Harbor View Health Partners, L.P.—*ownership—GP: Harbor View Health Systems, Inc. (50%)*
LP: Republic Health Corporation of San Bernardino (50%)

(b) Health Resources Corporation of America—California

(b) Houston Northwest Medical Center, Inc.

(c) Community Health Providers

(c) HNMC, Inc.

(d) Houston Northwest Radiotherapy Center, L.L.C.—*ownership—HNMC, Inc., managing member (6.79%);*
Doctors Group, member (93.21%)

(d) Houston Rehabilitation Associates—*ownership—GP: HNMC, Inc. (20%)*
LP: Doctors Group (80%)

(d) HNW GP, Inc.

(e) Houston Northwest Partners, Ltd—*ownership—GP: HNW GP, Inc. (1%)*
LP: HNW LP, Inc. (99%)

(d) HNW LP, Inc.

(c) Northwest Community Health Network

(c) Northwest Houston Providers Alliance, Inc.

(b) Indianapolis Health Systems, Inc.

(b) MCF, Inc.

(c) Bone Marrow/Stem Cell Transplant Institute of Florida, Inc.

(d) Bone Marrow/Stem Cell Transplant Institute of Florida, Ltd.—*ownership—GP: Bone Marrow/Stem Cell Transplant Institute of Florida, Inc. (51%)*
LP: Stem Cell, Inc. (49%)

(b) MHA IPA, Inc.

(b) Midway Hospital Medical Center, Inc.

(b) OrNda FMC, Inc.

(b) OrNda of South Florida Holdings, Inc.

(b) Republic Health Corporation of Indianapolis

(c) Winona Memorial Hospital Limited Partnership—*ownership—Republic Health Corporation of Indianapolis (99.9%)*
Tenet Healthsystem Healthcorp (.01%)

(b) Republic Health Corporation of Mesquite

(b) Republic Health Corporation of Rockwall County

(c) Lake Pointe GP, Inc.

(d) Lake Pointe ASC GP, Inc.

(d) Lake Pointe Partners, Ltd.—*ownership—GP: Lake Pointe GP, Inc. (1%)*
LP: Lake Pointe Investments, Inc. (99%)

(c) Lake Pointe Holdings, Inc.

(c) Lake Pointe Investments, Inc.

(d) Lake Pointe Rockwall ASC, LP—*ownership—GP: Lake Pointe Rockwall ASC GP, Inc. (1% GP)*
LP: Lake Pointe Investments, Inc. (99% LP)

(b) Republic Health Corporation of San Bernardino

(b) Republic Health Corporation of Texas

(c) GCH Interest, Ltd.—*ownership—Republic Health Corporation of Texas (51%)*
Garland Community Hospital, Ltd (49%)

(b) Republic Health Partners, Inc.

(b) RHC Parkway, Inc.

(c) Medi-Health of Florida, Inc.

(c) North Miami Medical Center, Ltd.—*ownership—RHC Parkway, Inc. (85.91%)*
Commonwealth Continental Health Care, Inc. (14.09%)

(d) Parkway Professional Plaza Condominium Association, Inc. *(56%)*

(d) Parkway Regional Medical Center Physician Hospital Organization, Inc. *(50%)*

(c) OrNda of South Florida Services Corporation

(b) RHCMS, Inc.

(b) S.C. Management, Inc.

(b) Saint Vincent Healthcare System, Inc.

(c) Clini-Tech Laboratories, Inc.

(c) OHM Health Initiatives, Inc.

(c) OHM Services, Inc.

(c) Provident Nursing Homes, Inc.

(c) Saint Vincent Hospital, Inc.

(d) Saint Vincent Hospital, L.L.C.

(b) Santa Ana Hospital Medical Center, Inc.

(b) SHL/O Corp.

(b) Tenet HealthSystem CFMC, Inc.

(b) Tenet HealthSystem CM, Inc.

(b) Tenet HealthSystem QA, Inc.

(c) Commercial Healthcare of California, Inc.

(b) Tenet HealthSystem Metro GP, Inc.

(b) TriLink Provider Services Organization, Inc.

(b) UWMC Hospital Corporation

(c) Santa Ana Radiology General Partnership *(40% GP interest)*

(b) West Los Angeles Health Systems, Inc.

(c) Brotman Partners, L.P.—*ownership—GP: West Los Angeles Health Systems, Inc. (44.25%) LP: OrNda Investments. (55.75%)*

(d) Western Imaging Medical Group *(40% LP interest)*

(b) Whittier Hospital Medical Center, Inc.

(a) Tenet HealthSystem MW, Inc.

(b) MW Hospitals, LP, Inc.

(b) Tenet MetroWest Healthcare System, Limited Partnership *(GP 79.9%; MW Hospitals, LP, Inc. 20.01%)*

Tenet Hospitals, Inc.

(a) Tenet California, Inc.

(b) Airmed, II, Inc.

(b) Century City Hospital, Inc.

(b) Community Hospital of Los Gatos, Inc.

(b) Doctors Hospital of Manteca, Inc.

(b) Doctors Medical Center-San Pablo/Pinole, Inc.

(b) Doctors Medical Center of Modesto, Inc.

(c) Yosemite Medical Clinic, Inc.

(b) Garfield Medical Center, Inc.

(b) JFK Memorial Hospital, Inc.

(b) Lakewood Regional Medical Center, Inc.

(b) Los Alamitos Medical Center, Inc.

(b) Manteca Medical Management, Inc.

(b) National Med, Inc.

(b) National Medical Ventures, Inc.

(c) Litho I, Ltd.—*ownership-National Medical Ventures, Inc. (63.25%); Physicians (36.75%)*

(c) McHenry Surgery Center Partners, LP—*ownership—National Medical Ventures (99%); Tenet California, Inc. (1%)*

(b) Placentia-Linda Hospital, Inc.

(b) San Ramon Regional Medical Center, Inc.

(b) San Ramon ASC, Inc.

(b) San Ramon ASC, L.P.

(b) Tenet California Nurse Resources, Inc.

(b) Tenet California Medical Ventures I, Inc.

(b) Tenet El Mirador Surgical Center, Inc.

(b) Tenet HealthSystem Desert, Inc.

(b) Tenet HealthSystem DFH, Inc.

(b) Tenet HealthSystem Norris, Inc.

(b) Twin Cities Community Hospital, Inc.

(b) USC University Hospital, Inc.

(a) Tenet Florida, Inc.

(b) Delray Medical Center, Inc.

(b) Hollywood Medical Center, Inc.

(b) National Medical Services, Inc.

(c) Barron, Barron & Roth, Inc.

(b) National Medical Services II, Inc.

(b) NMV-II, Inc.

(c) Delray Outpatient Surgery & Laser Center, Ltd.—*ownership—NMV-II, Inc. (60%); Others (40%)*

(b) Tenet Dimension Holding Company, Inc.

(b) Tenet Hialeah HealthSystem, Inc.

(c) Edgewater Provider Insurance Company, Ltd.

(c) Hialeah Real Properties, Inc.

(c) Tenet Hialeah (H.H.A.) HealthSystem, Inc.

(c) Tenet Hialeah (ASC) HealthSystem, Inc.

(d) Hialeah Ambulatory Care Center J.V.—Ownership *(66.67%)*

(c) Tenet Home Care of South Florida, Inc.

(b) Tenet Network Management, Inc.

(b) West Boca Medical Center, Inc.

(b) WBMC Investors, Ltd. *(2.2766% limited partner interest)*

(b) Siemens West Boynton, Ltd. *(45.7827% limited partner interest)*

(a) Tenet Georgia, Inc.

(a) Tenet Louisiana, Inc.

(b) Diagnostic Imaging Services, Inc.

(b) Doctors Hospital of Jefferson, LLC

(b) Meadowcrest Hospital, Inc.

(b) Meadowcrest Hospital, LLC

(b) NorthShore Regional Medical Center, Inc.

(b) NorthShore Regional Medical Center, LLC

(b) Physician Network Corporation of Louisiana, Inc.

(b) St. Charles General Hospital, Inc.

(b) St. Charles General Hospital, LLC

(b) Tenet HealthSystem Surgical, LLC

(b) Tenet HealthSystem Memorial Medical Center, Inc.

(c) Tenet Mid City Medical, LLC

(b) Tenet Jefferson, Inc.

(b) Tenet Slidell of Louisiana, Inc.

(b) New Orleans Regional Physician Hospital Organization, Inc. *(11.1% member interest)*

(a) Tenet Massachusetts, Inc.

(a) Tenet Missouri, Inc.

(b) MHJ, Inc.

(b) Tenet HealthSystem DI, Inc.

(c) Alliance for Community Health, LLC *(68% member interest)*

(c) Mid County MRI, LLC *(50% member interest)*

(c) Premier Emergency Physicians, LLC

(c) St. Louis I Investors, Ltd. *(49% LP interest)*

(c) U.S. Center for Sports Medicine, LLC

(b) Tenet HealthSystem DI-TPS, Inc.

(b) Tenet St. Alexius Hospital, Inc.

(b) Tenet St. Alexius Hospital Physicians, Inc.

(a) Tenet North Carolina, Inc.

(b) Tenet Claremont Family Medicine, L.L.C.

(b) Tenet Unifour Urgent Care Center, L.L.C.

(a) Tenet South Carolina, Inc.

(b) Tenet Fort Mill, Inc.

(a) Tenet Tennessee, Inc.

(b) National Medical Hospital of Tullahoma, Inc.

(b) National Medical Hospital of Wilson County, Inc.

(c) Lebanon Diagnostic Imaging Center, LLC

(c) Tenet Lebanon Surgery Center, LLC

(c) Wilson County Management Services, Inc.

(a) Tenet Texas, Inc.

(b) Greater El Paso Healthcare Enterprises, Inc.

(b) Sierra Providence Healthcare Enterprises, Inc.

(b) Sierra Providence Health Network, Inc.

(b) Tenet HealthSystem Hospitals Dallas, Inc.

(b) Tenet Hospitals Limited—*ownership—GP:Tenet Texas, Inc. (1%); LP: Tenetsub Texas, Inc. (99%)*

(b) Tenet Patient Financial Services, Inc.

(b) Tenetsub Texas, Inc.

(c) Tenet Frisco, Ltd.—*ownership—GP:Tenet Texas, Inc. (1%); LP: Tenetsub Texas, Inc. (99%)*

Tenet I.B.A. Holdings, Inc.

T.I. Edu, Inc.

(a) DigitalMed, Inc.

T.I. GPO, Inc.

(a) Broadlane, Inc. *(46%)*

Wilshire Rental Corp.

(a) Hitchcock State Street Real Estate, Inc.

QuickLinks

Subsidiaries of Tenet Healthcare Corporation

Exhibit 23

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors
Tenet Healthcare Corporation:

We consent to the incorporation by reference in Tenet Healthcare Corporation's registration statements on Form S-3 (Nos. 33-57801, 33-55285, 33-63451, 333-24955, 333-21867, 333-26621, 333-41907 and 333-74640), registration statements on Form S-4 (Nos. 33-57485, 333-18185, 333-74158 and 333-118751) and registration statements on Form S-8 (Nos. 33-50182, 33-57375, 333-00709, 333-01183, 333-38299, 333-41903, 333-41476, 333-41478, 333-48482 and 333-74216) of our reports dated March 7, 2005 with respect to (1) the consolidated balance sheets of Tenet Healthcare Corporation and subsidiaries as December 31, 2004 and 2003, and the related consolidated statements of operations, comprehensive income (loss), changes in shareholders' equity and cash flows for each of the years in the two-year period ended December 31, 2004, the seven-month transition period ended December 31, 2002 and the fiscal year ended May 31, 2002, and related consolidated financial statement schedule, and (2) management's assessment of the effectiveness of internal control over financial reporting as of December 31, 2004 and the effectiveness of internal control over financial reporting as of December 31, 2004, which reports appear in the Company's December 31, 2004 annual report on Form 10-K.

Our report with respect to the consolidated financial statements refers to a change in the Company's accounting for goodwill and other intangible assets effective June 1, 2002.

/s/ KPMG LLP

Dallas, Texas
March 7, 2005

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CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Exhibit 31(a)

Rule 13a-14(a)/15d-14(a) Certification

I, Trevor Fetter, Chief Executive Officer of Tenet Healthcare Corporation (the "Registrant"), certify that:

1. I have reviewed this annual report on Form 10-K of the Registrant;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;

4. The Registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the Registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the Registrant's internal control over financial reporting that occurred during the Registrant's most recent fiscal quarter (the Registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant's internal control over financial reporting; and

5. The Registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant's auditors and the audit committee of the Registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant's internal control over financial reporting.

Date: March 7, 2005

/s/ TREVOR FETTER

Trevor Fetter
Chief Executive Officer

QuickLinks

Rule 13a-14(a)/15d-14(a) Certification

Exhibit 31(b)

Rule 13a-14(a)/15d-14(a) Certification

I, Stephen D. Farber, Chief Financial Officer of Tenet Healthcare Corporation (the "Registrant"), certify that:

1. I have reviewed this annual report on Form 10-K of the Registrant;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;

4. The Registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the Registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the Registrant's internal control over financial reporting that occurred during the Registrant's most recent fiscal quarter (the Registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant's internal control over financial reporting; and

5. The Registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant's auditors and the audit committee of the Registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant's internal control over financial reporting.

Date: March 7, 2005

/s/ STEPHEN D. FARBER

Stephen D. Farber
Chief Financial Officer

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Rule 13a-14(a)/15d-14(a) Certification

Exhibit 32

Certification Pursuant to Section 1350 of Chapter 63
of Title 18 of the United States Code

We, the undersigned Trevor Fetter and Stephen D. Farber, being, respectively, the President and Chief Executive Officer and the Chief Financial Officer of Tenet Healthcare Corporation (the "Registrant"), do each hereby certify that (i) the Registrant's Annual Report on Form 10-K for the year ended December 31, 2004 (the "Form 10-K"), to be filed with the Securities and Exchange Commission on March 8, 2005, fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934 and (ii) the information contained in the Form 10-K fairly presents, in all material respects, the financial condition and results of operations of the Registrant and its subsidiaries.

Date: March 7, 2005

/s/ TREVOR FETTER

Trevor Fetter
President and Chief Executive Officer

Date: March 7, 2005

/s/ STEPHEN D. FARBER

Stephen D. Farber
Chief Financial Officer

The foregoing certification is being furnished solely pursuant to 18 U.S.C. §1350; it is not being filed for purposes of Section 18 of the Securities Exchange Act, and is not to be incorporated by reference into any filing of the Registrant, whether made before or after the date hereof, regardless of any general incorporation language in such filing.

QuickLinks

Certification Pursuant to Section 1350 of Chapter 63 of Title 18 of the United States Code