TENET HEALTHCARE CORP
Form 10-Q/A
April 06, 2006

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

Form 10-Q/A

(Amendment No. 1)

ý	**Quarterly report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 for the quarterly period ended September 30, 2005**
	OR
o	**Transition report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 for the transition period from to**

Commission file number 1-7293

TENET HEALTHCARE CORPORATION

(Exact name of Registrant as specified in its charter)

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

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

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

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 ý No o

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

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

As of September 30, 2005, there were 469,406,255 shares of common stock outstanding.

Explanatory Note

We are filing this Amendment No. 1 on Form 10-Q/A to Tenet Healthcare Corporation s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, which was originally filed with the Securities and Exchange Commission (the SEC) on November 1, 2005 (the Original Form 10-Q), to reflect the restatements of our Condensed Consolidated Balance Sheet at September 30, 2005 and our Condensed Consolidated Statements of Operations, Comprehensive Income (Loss) and Cash Flows for the three and nine months ended September 30, 2005 and 2004, and the related notes.

We reported the decision to restate this information in a Current Report on Form 8-K/A, which we filed with the SEC on March 9, 2006. The decision to restate was based on the findings of an independent investigation conducted by the audit committee of our board of directors. Part I of this Form 10-Q/A contains more information about these restatements in Note 15 - Restatement of Financial Statements, which accompanies the Condensed Consolidated Financial Statements in Item 1.

Although this Form 10-Q/A contains the Original Form 10-Q in its entirety, it amends and restates only Items 1 and 2 of Part I, Item 1 of Part II and Exhibits 31(a), 31(b) and 32, referred to in Item 6 of Part II, of the Original Form 10-Q, in each case solely to update the status of the previously disclosed SEC investigation of our contractual allowances and to reflect the restatements. No other information in the Original Form 10-Q is amended hereby. This Form 10-Q/A has been repaginated and references to Form 10-Q have been revised to refer to Form 10-Q/A as applicable.

Except for the amended information referred to above, this Form 10-Q/A continues to present information as of November 1, 2005, and we have not updated or modified the disclosures herein for events that occurred after that date. Events occurring after the filing date of the Original Form 10-Q, and other disclosures necessary to reflect subsequent events, have not been addressed other than in our Annual Report on Form 10-K for the year ended December 31, 2005 (the 2005 Form 10-K), which we filed with the SEC on March 9, 2006. The 2005 Form 10-K includes our restated Consolidated Financial Statements as of December 31, 2004. All balances as of December 31, 2004 presented in this report reflect the restated amounts as presented in the 2005 Form 10-K. For further information on the restated Consolidated Balance Sheet as of December 31, 2004, refer to the audited Consolidated Financial Statements and notes in the 2005 Form 10-K.

TENET HEALTHCARE CORPORATION

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PART I.

ITEM 1. FINANCIAL STATEMENTS

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES

CONDENSED CONSOLIDATED BALANCE SHEETS

Dollars in Millions

	September 30 2005	December 31 2004
ASSETS	Restated (See Note 15 (Unaudited)	
Current assets:		
Cash and cash equivalents	$ 1,480	$ 654
Restricted cash	263	263
Investments in marketable debt securities	65	117
Accounts receivable, less allowance for doubtful accounts ($642 at September 30, 2005 and $688 at December 31, 2004)	1,523	1,692
Inventories of supplies, at cost	187	188
Income tax receivable		530
Deferred income taxes	195	118
Assets held for sale	29	114
Other current assets	284	320
Total current assets	**4,026**	**3,996**
Investments and other assets	302	296
Property and equipment, at cost, less accumulated depreciation and amortization ($2,661 at September 30, 2005 and $2,574 at December 31, 2004)	4,593	4,820
Goodwill	800	800
Other intangible assets, at cost, less accumulated amortization ($125 at September 30, 2005 and $101 at December 31, 2004)	246	169
Total assets	**$ 9,967**	**$ 10,081**
LIABILITIES AND SHAREHOLDERS EQUITY		
Current liabilities:		
Current portion of long-term debt	$ 20	$ 41
Accounts payable	806	937
Accrued compensation and benefits	391	390
Professional liability reserves	132	115
Accrued interest payable	96	96
Accrued legal settlement costs	130	40
Other current liabilities	407	495
Total current liabilities	**1,982**	**2,114**
Long-term debt, net of current portion	4,783	4,395
Professional liability reserves	606	590
Other long-term liabilities and minority interests	925	972
Deferred income taxes	347	311

Total liabilities	**8,643**	**8,382**
Commitments and contingencies		
Shareholders equity:		
Common stock, $0.05 par value; authorized 1,050,000,000 shares; 524,961,696 shares issued at September 30, 2005 and 521,132,853 shares issued at December 31, 2004	26	26
Additional paid-in capital	4,311	4,251
Accumulated other comprehensive loss	(12)	(13)
Accumulated deficit	(1,521)	(1,083)
Less common stock in treasury, at cost, 55,555,441 shares at September 30, 2005 and 53,896,498 shares at December 31, 2004	(1,480)	(1,482)
Total shareholders equity	**1,324**	**1,699**
Total liabilities and shareholders equity	**$ 9,967**	**$ 10,081**

See accompanying Notes to Condensed Consolidated Financial Statements.

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES

CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS

Dollars in Millions,

Except Per-Share Amounts

(Unaudited)

	Three Months Ended September 30		Nine Months Ended September 30	
	2005	2004	2005	2004
		Restated (See Note 15)		
Net operating revenues	**$ 2,394**	**$ 2,420**	**$ 7,315**	**$ 7,506**
Operating expenses:				
Salaries, wages and benefits	1,099	1,069	3,337	3,249
Supplies	446	421	1,350	1,280
Provision for doubtful accounts	206	251	526	1,010
Other operating expenses	554	557	1,628	1,675
Depreciation	95	92	271	272
Amortization	10	6	22	16
Impairment and restructuring charges	205	2	210	35
Loss from hurricane and related costs	40		40	
Costs of litigation and investigations	28	10	47	29
Loss from early extinguishment of debt			15	5
Operating income (loss)	**(289)**	**12**	**(131)**	**(65)**
Interest expense	(102)	(91)	(305)	(242)
Investment earnings	17	6	41	13
Minority interests		(1)	(6)	(6)
Net gain on sales of long-term investments				6
Loss from continuing operations, before income taxes	**(374)**	**(74)**	**(401)**	**(294)**
Income tax (expense) benefit	(4)	18	31	97
Loss from continuing operations, before discontinued operations	**(378)**	**(56)**	**(370)**	**(197)**
Discontinued operations:				
Income (loss) from operations of asset group	7	(37)	(52)	(238)
Impairment of long-lived assets and goodwill, and restructuring charges	(27)	(9)	(35)	(415)
Net gain (loss) on sales of asset group	(2)	4	20	33
Income tax (expense) benefit	(1)	21	(1)	198
Loss from discontinued operations	**(23)**	**(21)**	**(68)**	**(422)**
Net loss	**$ (401)**	**$ (77)**	**$ (438)**	**$ (619)**
Loss per common share and common equivalent share				
Basic				
Continuing operations	$ (0.80)	$ (0.12)	$ (0.79)	$ (0.42)
Discontinued operations	(0.05)	(0.05)	(0.15)	(0.91)
	$ (0.85)	**$ (0.17)**	**$ (0.94)**	**$ (1.33)**

Diluted				
Continuing operations	$ (0.80)	$ (0.12)	$ (0.79)	$ (0.42)
Discontinued operations	(0.05)	(0.05)	(0.15)	(0.91)
	$ (0.85)	**$ (0.17)**	**$ (0.94)**	**$ (1.33)**
Weighted average shares and dilutive securities outstanding (in thousands):				
Basic	469,179	466,646	468,663	465,956
Diluted	469,179	466,646	468,663	465,956

See accompanying Notes to Condensed Consolidated Financial Statements.

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES

CONDENSED CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME (LOSS)

Dollars in Millions

(Unaudited)

	Three Months Ended September 30		Nine Months Ended September 30	
	2005	**2004**	**2005**	**2004**
		Restated (See Note 15)		
Net loss	$ (401)	$ (77)	$ (438)	$ (619)
Other comprehensive income (loss):				
Foreign currency translation adjustments				(4)
Unrealized gains on securities held as available for sale		1		
Reclassification adjustments for realized (gains) losses included in net loss	1	1	2	(3)
Other comprehensive income (loss) before income taxes	**1**	**2**	**2**	**(7)**
Income tax (expense) benefit related to items of other comprehensive income (loss)	(1)	(1)	(1)	2
Other comprehensive income (loss)		**1**	**1**	**(5)**
Comprehensive loss	**$ (401)**	**$ (76)**	**$ (437)**	**$ (624)**

See accompanying Notes to Condensed Consolidated Financial Statements.

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

Dollars in Millions

(Unaudited)

	Nine Months Ended September 30	
	2005	2004
		Restated (See Note 15)
Net loss	**$ (438)**	**$ (619)**
Adjustments to reconcile net loss to net cash provided by operating activities:		
Depreciation and amortization	293	288
Provision for doubtful accounts	526	1,010
Deferred income tax expense (benefit)	(35)	(167)
Stock-based compensation charges	38	82
Impairment and restructuring charges	210	35
Loss from early extinguishment of debt	15	5
Pre-tax loss from discontinued operations	67	620
Other items		(14)
Increases (decreases) in cash from changes in operating assets and liabilities:		
Accounts receivable	(535)	(710)
Inventories and other current assets	14	(19)
Income taxes	537	(184)
Accounts payable, accrued expenses and other current liabilities	(19)	(19)
Other long-term liabilities	32	120
Payments against reserves for restructuring charges and litigation costs and settlements	**(73)**	**(249)**
Net cash provided by operating activities from discontinued operations, excluding income taxes	**53**	**29**
Net cash provided by operating activities	**685**	**208**
Cash flows from investing activities:		
Purchases of property and equipment:		
Continuing operations	(358)	(271)
Discontinued operations	(2)	(16)
Construction of new hospitals		(79)
Deposits on purchases of property and equipment	(7)	
Net cash released from escrow accounts to fund construction costs		88
Proceeds from sales of facilities, long-term investments and other assets	153	295
Insurance recoveries	21	
Investment in hospital authority bonds		(3)
Other items	(14)	(15)
Net cash used in investing activities	**(207)**	**(1)**
Cash flows from financing activities:		
Sale of new senior notes	773	954
Repurchases of senior notes	(413)	(450)
Payments of borrowings	(25)	(16)
Proceeds from exercise of stock options	11	

Other items	2	9
Net cash provided by financing activities	**348**	**497**
Net increase in cash and cash equivalents	826	704
Cash and cash equivalents at beginning of period	654	619
Cash and cash equivalents at end of period	**$ 1,480**	**$ 1,323**
Supplemental disclosures:		
Interest paid, net of capitalized interest	$ (292)	$ (183)
Income tax refunds received (payments made), net	$ 529	$ (53)

See accompanying Notes to Condensed Consolidated Financial Statements.

TENET HEALTHCARE CORPORATION

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1 BASIS OF PRESENTATION

This amended quarterly report for Tenet Healthcare Corporation (together with our subsidiaries, referred to as Tenet, the Company, we or us) supplements our Annual Report on Form 10-K for the year ended December 31, 2004 (Annual Report). As permitted by the Securities and Exchange Commission (SEC) for interim reporting, we have omitted certain footnotes and disclosures that substantially duplicate those in our Annual Report. For further information, refer to the audited consolidated financial statements and footnotes included in our Annual Report.

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 September 30, 2005, our subsidiaries operated 73 general hospitals, including four hospitals that are part of discontinued operations not yet divested, 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; physician practices; captive insurance companies; and various other ancillary health care businesses (including outpatient surgery centers and occupational and rural health care clinics).

Certain prior-period balances in the accompanying Condensed Consolidated Financial Statements have been reclassified to conform to the current period s presentation of financial information. These reclassifications for discontinued operations as described in Note 3 have no impact on total assets, liabilities, shareholders equity, net loss or cash flows. Unless otherwise indicated, all financial and statistical information included herein relates to our continuing operations, with dollar amounts expressed in millions (except per-share amounts).

Although the Condensed Consolidated Financial Statements and related footnotes within this document are unaudited, we believe all adjustments (consisting only of normal recurring adjustments) considered necessary for fair presentation have been included. In preparing our 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 Condensed 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.

Operating results for the three and nine months ended September 30, 2005 are not necessarily indicative of the results that may be expected for the full fiscal year 2005. Reasons for this include, but are not limited to: overall revenue and cost trends, particularly trends in patient accounts receivable collectibility and associated provisions for doubtful accounts; the timing and magnitude of price changes; fluctuations in contractual allowances, including the impact of the discounting components of our *Compact with Uninsured Patients* (Compact); changes in Medicare regulations; Medicaid funding levels set by the states in which we operate; levels of malpractice expense and settlement trends; impairment of long-lived assets and goodwill; restructuring charges; losses and costs related to natural disasters; litigation and investigation costs; acquisitions and dispositions of facilities and other assets; income tax rates and valuation allowances; the timing and amounts of stock option and restricted stock unit grants to employees, directors and others; and changes in occupancy levels and patient volumes. Factors that affect 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 treated at our hospitals; (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 relating to the timing of elective procedures. These considerations apply to year-to-year comparisons as well.

TENET HEALTHCARE CORPORATION

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

NOTE 2 ACCOUNTS RECEIVABLE AND ALLOWANCE FOR DOUBTFUL ACCOUNTS

During the second quarter of 2004, we modified our process for estimating and writing down self-pay accounts, which include co-payments and deductibles to be made by patients, to their net realizable value. This change in how we estimate the net realizable value of self-pay accounts, as more fully described in the Annual Report, resulted in a pretax charge of $196 million ($0.26 per share after-tax), which was primarily attributable to the continued increase in numbers of uninsured and underinsured patients.

Also in the second quarter of 2004, we began the implementation of our Compact. 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 accounts had previously been written down as 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. In June 2005, the Texas Governor signed Senate Bill 500, which allows hospitals to discount the services they provide to self-pay patients. We implemented the discounting components of the Compact at our hospitals in Texas effective September 1, 2005. The discounts for uninsured patients were in effect at all 69 of our continuing operations hospitals by September 30, 2005.

During the three and nine months ended September 30, 2005, there were approximately $203 million and $504 million, respectively, of discounts recorded as contractual allowances on self-pay accounts under the Compact compared to $108 million and $136 million, respectively, during the three and nine months ended September 30, 2004. Prior to implementation of the discounting provisions under the Compact, the vast majority of these accounts were ultimately recognized to be uncollectible and, as a result, were then recorded in our provision for doubtful accounts.

We also provide charity care to patients who are financially unable to pay for the health care services they receive. Most patients who qualify for charity care are charged a per diem amount for services received, subject to a cap. Except for the per diem amounts, our policy is not to pursue collection of amounts determined to qualify as charity care; and, therefore, we do not report these amounts in net operating revenues or in provision for doubtful accounts. For the nine months ended September 30, 2005, $458 million in charity care gross charges were excluded from net operating revenues and provision for doubtful accounts compared to $426 million for the nine months ended September 30, 2004.

As of September 30, 2005, our total estimated collection rates on managed care accounts and self-pay accounts were approximately 93% and 23%, respectively, which included collections from point-of-service through collections by our in-house collection agency or external collection agencies or vendors. Our self-pay collection rate includes payments made by patients, including co-payments and deductibles paid by patients with insurance, prior to an account being classified and assigned to our in-house self-pay collection group. The comparable managed care and self-pay collection rates as of December 31, 2004 were approximately 95% and 22%, respectively.

Accounts that are pursued for collection through regional or hospital-based business offices are maintained on our hospitals books and reflected in patient accounts receivable with an allowance for doubtful accounts established based on their estimated net realizable value (see Management s Discussion and Analysis of Financial Condition and Results of Operations Critical Accounting Estimates in our Annual Report).

Accounts assigned to a collection agency are written off and excluded from patient accounts receivable and allowance for doubtful accounts; however, an estimate of future recoveries from all accounts in collection is determined based on historical experience and recorded as a component of accounts receivable in the Condensed Consolidated Balance Sheets.

TENET HEALTHCARE CORPORATION

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

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

	September 30 2005	December 31 2004
Continuing Operations:		
Patient accounts receivable	$ 2,065	$ 2,075
Allowance for doubtful accounts	(572)	(568)
Estimated future recovery of accounts in collection	65	100
Net cost report settlements payable and valuation allowances	(60)	(118)
	1,498	1,489
Discontinued Operations Accounts receivable, net of allowance for doubtful accounts ($70 million at September 30, 2005 and $120 million at December 31, 2004) and net cost report settlements payable and valuation allowances ($46 million at September 30, 2005 and $84 million at December 31, 2004)	25	203
Accounts receivable, less allowance for doubtful accounts	**$ 1,523**	**$ 1,692**

NOTE 3 DISCONTINUED OPERATIONS

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. As of September 30, 2005, we had completed the divestiture of 23 of the 27 facilities. In October 2005, we entered into a definitive agreement for the sale of our Community Hospital and Mission Hospital, both in Huntington Park, California, for estimated net after-tax proceeds of $3 million, which includes the liquidation of working capital. Discussions and negotiations with potential buyers for the remaining two hospitals slated for divestiture are ongoing.

In connection with our divestiture actions, as further described in the Annual Report, we have classified the results of operations of the following hospitals as discontinued operations for all periods presented in the accompanying Condensed Consolidated Statements of Operations in accordance with Statement of Financial Accounting Standards (SFAS) No. 144, Accounting for the Impairment or Disposal of Long-Lived Assets :

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 general hospitals whose intended divestiture we announced in January 2004, including Doctors Medical Center San Pablo, in San Pablo, California, a leased hospital, which was classified in discontinued operations when its lease expired in July 2004,

Our general hospital in Barcelona, Spain, which we sold in May 2004,

Redding Medical Center, in Redding, California, of which we sold certain hospital assets in July 2004,

Century City Hospital in Los Angeles, California, a previously leased hospital that we no longer operated by the end of April 2004,

Medical College of Pennsylvania Hospital, in Philadelphia, Pennsylvania, which we sold in September 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 $22 million and $101 million of assets of the hospitals included in discontinued operations as held for sale in current assets in the accompanying Condensed Consolidated Balance Sheets at September 30, 2005 and December 31, 2004, respectively. 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 and net cost report settlements payable and

TENET HEALTHCARE CORPORATION

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

valuation allowances, are included in our consolidated net accounts receivable in the accompanying Condensed Consolidated Balance Sheets. At September 30, 2005 and December 31, 2004, the accounts receivable, net of allowance for doubtful accounts and cost report settlements payable and valuation allowances, for these hospitals was $25 million and $203 million, respectively.

We recorded $35 million of impairment and restructuring charges in discontinued operations during the nine months ended September 30, 2005 consisting primarily of $28 million for the write-down of long-lived assets to their estimated fair values, less estimated costs to sell, $10 million in employee severance, retention and other costs, and a $3 million reduction in reserves recorded in prior periods.

We recorded $415 million of impairment and restructuring charges in discontinued operations during the nine months ended September 30, 2004 consisting primarily of $308 million for the write-down of long-lived assets to their net estimated fair values, less estimated costs to sell, $33 million for the write-down of goodwill, $26 million in employee severance, retention 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 Medical College of Pennsylvania Hospital on September 1, 2004, we are contractually responsible for certain university costs through December 2005.

Net operating revenues and loss before taxes reported in discontinued operations for the three and nine months ended September 30, 2005 and 2004 are as follows:

	Three Months Ended September 30		Nine Months Ended September 30	
	2005	2004	2005	2004
		Restated (See Note 15)		
Net operating revenues	$ 120	$ 620	$ 346	$ 2,112
Loss before taxes	(22)	(42)	(67)	(620)

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

NOTE 4 IMPAIRMENT AND RESTRUCTURING CHARGES

During the nine months ended September 30, 2005, we recorded impairment and restructuring charges of $210 million consisting of $206 million for the write-down of long-lived assets, primarily damaged assets of our Gulf Coast operations affected by Hurricane Katrina, net of $10 million of insurance proceeds received from our insurance carriers (see Note 14), $11 million in employee severance, benefits and relocation costs, $3 million of lease termination costs and $4 million in non-cash stock option modification costs related to terminated employees, offset by a $14 million reduction of reserves, primarily related to restructuring charges recorded in prior periods. During the nine months ended September 30, 2004, we recorded restructuring charges of $35 million consisting of $19 million in employee severance, benefits and related costs, $8 million in non-cash stock option modification costs related to terminated employees and $8 million in contract termination

and consulting costs.

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.

TENET HEALTHCARE CORPORATION

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

The table below is a reconciliation of beginning and ending liability balances in connection with restructuring charges recorded during the nine months ended September 30, 2005 in continuing and discontinued operations:

	Balances at Beginning of Period	Restructuring Charges	Cash Payments	Other Items	Balances at End of Period
Nine months ended September 30, 2005					
Continuing Operations:					
Severance and related costs in connection with general overhead-reduction plans and unfavorable lease commitments	$ 71	$ 7	$ (25)	$ (4)	$ 49
Discontinued Operations:					
Lease cancellations and estimated costs associated with the sale or closure of hospitals and other facilities	58	7	(37)	(8)	20
	$ 129	**$ 14**	**$ (62)**	**$ (12)**	**$ 69**

The above liability balances are included in other current liabilities and other long-term liabilities in the accompanying Condensed 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 September 30, 2005 are expected to be approximately $13 million in 2005 and $56 million thereafter.

NOTE 5 LONG-TERM DEBT AND LEASE OBLIGATIONS

The table below shows our long-term debt as of September 30, 2005 and December 31, 2004:

	September 30 2005	December 31 2004
Senior notes:		
$5\frac{3}{8}$%, due 2006	$	$ 215
5%, due 2007		185
$6\frac{3}{8}$%, due 2011	1,000	1,000
$6\frac{1}{2}$%, due 2012	600	600
$7\frac{3}{8}$%, due 2013	1,000	1,000
$9\frac{7}{8}$%, due 2014	1,000	1,000
$9\frac{1}{4}$%, due 2015	800	

$6\frac{7}{8}$%, due 2031	450	450
Other senior and senior subordinated notes		22
Notes payable and capital lease obligations, secured by property and equipment, payable in installments to 2013(1)	59	65
Unamortized note discounts	(106)	(101)
Total long-term debt	**4,803**	**4,436**
Less current portion	20	41
Long-term debt, net of current portion	**$ 4,783**	**$ 4,395**

(1) Includes $1 million and $5 million at September 30, 2005 and December 31, 2004, respectively, related to the general hospitals held for sale (see Note 3).

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 at that time. The new facility was initially collateralized by

TENET HEALTHCARE CORPORATION

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

the stock of certain of our subsidiaries and cash equal to 105% of the facility amount (approximately $263 million reflected as restricted cash on the Condensed Consolidated Balance Sheets). In March 2005, the facility was amended to provide for the release of the liens on the stock of our subsidiaries, and on April 19, 2005, the stock certificates were returned to us. All liens were subsequently terminated. In accordance with the amendment, the termination date of the letter of credit facility was extended from December 31, 2005 to June 30, 2006. The letter of credit facility was further amended in August 2005 to extend the termination date to June 30, 2008. 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 September 30, 2005, outstanding letters of credit under the agreement totaled $196 million.

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 9¼% per year and mature on February 1, 2015. 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 senior notes are general unsecured senior obligations and rank equally in right of payment with all of our other unsecured senior indebtedness, but are effectively subordinated to any obligations under our letter of credit facility. On April 8, 2005, we filed with the SEC a Form S-4 registration statement to register the $800 million principal amount of 9¼% Senior Notes due 2015 to be issued and offered in exchange for the unregistered senior notes sold in January 2005. The registration statement has not yet been declared effective. The terms of the senior notes to be registered on the Form S-4 filed with the SEC are substantially similar to the terms of the unregistered senior notes we sold in January 2005. 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 a portion of the proceeds in February 2005 for the early redemption of our remaining outstanding senior notes due in 2006 and 2007 of $400 million, resulting in a $15 million loss from early extinguishment of debt, and the balance of the proceeds for general corporate purposes.

COVENANTS

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 10, 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.

NOTE 6 STOCK BENEFIT PLANS

At September 30, 2005, there were approximately 35 million shares of common stock available under the 2001 Stock Incentive Plan for future 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.

At the annual meeting of shareholders on May 26, 2005, our shareholders approved a one-time exchange of certain outstanding employee stock options for a lesser number of restricted stock units to be issued on July 1, 2005. The exchange was offered only to certain current employees. Our outside directors, four most senior executives and all former employees were not eligible to participate. Approximately 9 million vested and unvested options were exchanged on July 1, 2005 for approximately 2 million restricted stock units. These exchanges will result in incremental non-cash compensation expense of approximately $17 million, together with approximately $6 million of future non-cash compensation expense for the unvested eligible options exchanged, which will both be recognized as compensation expense over the three-year vesting period of the restricted stock units. As of September 30, 2005, there were approximately 5.4 million unvested restricted stock units outstanding.

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The following table summarizes information about our outstanding stock options at September 30, 2005:

	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	115,816	2.1 years	$ 7.63	115,816	$ 7.63
$10.17 to $20.34	26,187,927	5.8 years	14.48	16,627,412	15.96
$20.35 to $30.50	9,354,547	4.8 years	27.73	9,204,547	27.73
$30.51 to $40.67	5,169,110	4.9 years	40.35	5,169,110	40.35
$40.68 to $50.84	85,350	5.7 years	46.79	80,350	46.54
	40,912,750		$ 20.83	31,197,235	$ 23.52

NOTE 7 SHAREHOLDERS EQUITY

The following table shows the changes in consolidated shareholders equity during the nine months ended September 30, 2005 (dollars in millions, shares in thousands):

	Shares Outstanding	Issued Par Amount	Additional Paid-in Capital	Other Comprehensive Income (Loss)	Accumulated Deficit	Treasury Stock	Total Shareholders Equity
Balances at December 31, 2004	**467,236**	**$ 26**	**$ 4,251**	**$ (13)**	**$ (1,083)**	**$ (1,482)**	**$ 1,699**
Restated net loss					(438)		(438)
Other comprehensive income				1			1
Issuance of common stock	970		6			2	8
Stock options exercised, including tax benefit	1,200		12				12
Stock-based compensation expense			42				42
Restated balances at September 30, 2005	**469,406**	**$ 26**	**$ 4,311**	**$ (12)**	**$ (1,521)**	**$ (1,480)**	**$ 1,324**

NOTE 8 OTHER COMPREHENSIVE INCOME (LOSS)

The table below shows the tax effect allocated to each component of other comprehensive income (loss) for the three months ended September 30, 2005 and 2004 and nine months ended September 30, 2005 and 2004:

	Before-Tax Amount	Tax (Expense) Benefit	Net-of-Tax Amount
Three Months Ended September 30, 2005:			
Reclassification adjustment for realized losses included in net loss	$ 1	$ (1)	$
	$ 1	**$ (1)**	**$**
Three Months Ended September 30, 2004:			
Unrealized gains on securities held as available for sale	$ 1	$	$ 1
Reclassification adjustment for realized losses included in net loss	1	(1)	
	$ 2	$ (1)	$ 1

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	Before-Tax Amount	Tax (Expense) Benefit	Net-of-Tax Amount
Nine Months Ended September 30, 2005:			
Reclassification adjustment for realized losses included in net loss	$ 2	$ (1)	$ 1
	$ 2	**$ (1)**	**$ 1**
Nine Months Ended September 30, 2004:			
Foreign currency translation adjustment	$ (4)	$ 1	$ (3)
Reclassification adjustment for realized gains included in net loss	(3)	1	(2)
	$ (7)	$ 2	$ (5)

NOTE 9 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 (THINC), was formed to insure substantially all of our professional and general liability risks in excess of our hospitals $2 million self-insured retention. 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 combined retentions of $5 million and $15 million, respectively, are reinsured with major independent insurance companies. For the policy period June 1, 2004 through May 31, 2005, THINC retains 17.5% of the first $10 million layer for reinsurance claims in excess of the $15 million combined retention, resulting in a maximum retention per occurrence of $14.75 million by THINC. For the policy period June 1, 2005 through May 31, 2006, THINC retains 2.5% of the first $10 million layer for reinsurance claims in excess of the $15 million combined retention, resulting in a maximum retention per occurrence of $13.25 million by THINC.

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 wholly owned insurance subsidiary, under a mature claims-made policy with a 10-year extended reporting period. 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 the $3 million combined retention 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 September 30, 2005, HUG s retained reserves for losses during 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 and the amounts paid, plus amounts committed to settlements, had 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 yet reached the limits; therefore, the policies are not yet exhausted. 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 provided by major independent insurance companies would apply. Based on an actuarial review, we have provided for estimated losses that exceed our self-insured retention that will not be covered by the HUG policies.

As of September 30, 2005, 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 THINC and any excess professional and general liability insurance we purchase are subject to policy aggregate limitations. We have sought recovery under our excess professional and general liability insurance policies for up to $275 million of our $395 million settlement, in December 2004, of the patient litigation related to Redding Medical Center, 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 are single aggregate policies with each carrier. Any limits paid, in whole or in part, could deplete or reduce the excess limits available to pay any

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other claims applicable to this policy period. 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 4.0% at September 30, 2005 and 3.8% at September 30, 2004 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 September 30, 2005, the current and long-term professional and general liability reserves on our Condensed Consolidated Balance Sheet were approximately $738 million.

Included in other operating expenses in the accompanying Condensed Consolidated Statements of Operations is malpractice expense of $60 million and $178 million for the three and nine months ended September 30, 2005 and $55 million and $217 million for the three and nine months ended September 30, 2004, respectively.

NOTE 10 CLAIMS AND LAWSUITS

During the past several years, we have been subject to a significant number of claims and lawsuits. Some of these matters have recently been resolved, as described below and in our Annual Report. During the past several years, we also became the subject of federal and state agencies civil and criminal investigations and enforcement efforts, and received subpoenas and other requests from those agencies for information relating to a variety of subjects. While we cannot predict the likelihood of future claims or inquiries, we expect that new matters may be initiated against us from time to time.

The results of claims, lawsuits and investigations cannot be predicted, and it is possible that the ultimate resolution of these matters, individually or in the aggregate, may have a material adverse effect on our business (both in the near and long term), financial 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. The trial judge declared a mistrial in the case after the members of the jury indicated that they were unable to reach a verdict, and he subsequently scheduled a second trial, which commenced on May 3, 2005 and is ongoing. 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 currently or formerly 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,

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El Paso, Texas, New Orleans, Louisiana, St. Louis, Missouri and Memphis, Tennessee are the subject of ongoing federal investigations. Also, 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 currently or formerly 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, health care 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.

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 currently or formerly operated by our subsidiaries. In connection with the California action, on August 8, 2005, we received final court approval of a settlement that is nationwide in effect. As part of the settlement, we have made no admission of wrongdoing and we continue to vigorously deny the allegations made by plaintiffs in these actions. The settlement has two primary components: (1) injunctive relief governing our conduct prospectively for a period of four years, and (2) retrospective relief, including restitution and discounting of outstanding unpaid bills, for covered patients who were treated at our hospitals during the settlement class period (June 15, 1999 to December 31, 2004). We have also agreed to make a $4 million charitable contribution to a health-care-related charity specified by plaintiffs counsel. A notice of appeal of the judgment approving the settlement has been filed in the California Court of Appeal by one of the objectors to the settlement. The settlement will become effective upon the resolution of this appeal and the expiration of the period to make any further appeals. If the nationwide settlement becomes effective, we expect the similar actions in the other states to be dismissed to the extent that the claims in those cases fall within the scope of the release provided in the settlement. At September 30, 2005, we had an accrual of $30 million, recorded in prior periods, as a minimum liability to address the potential resolution of these cases.

3. Securities and Shareholder Matters A consolidated class action lawsuit is pending in federal court in Los Angeles, California against Tenet, certain of our former officers and our independent registered public accounting firm 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. At September 30, 2005, we had an accrual of $45 million, recorded in the quarter ended June 30, 2005, as an estimated minimum liability to address the potential resolution of the consolidated securities class action lawsuit and the shareholder derivative actions. This accrual has been offset by a corresponding amount that is expected to be recovered from our insurance carriers under our insurance policies.

In addition, the SEC is conducting a formal investigation of 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 served a series of document requests and subpoenas for testimony on the Company, certain of our current and former employees, officers and directors, and our independent registered public accounting firm. On April 27, 2005, we announced that we had received a Wells Notice from the staff of the SEC in connection with this investigation, and that we had been informed that Wells Notices had also been issued to certain former senior executives of the Company who left their positions in 2002 and 2003. A Wells Notice indicates that the SEC s staff intends to recommend that the agency bring a civil enforcement action against the recipients for possible violations

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of federal securities laws. Recipients of Wells Notices have the opportunity to respond before the SEC s staff makes its formal recommendation on whether any action should be brought. We submitted a response on May 13, 2005.

As previously disclosed, the SEC is also investigating allegations made by a former employee that inappropriate contractual allowances for managed care contracts may have been established at three California hospitals through at least fiscal year 2001. At the request of the audit committee of our board of directors, the board s independent outside counsel, Debevoise & Plimpton LLP (Debevoise), conducted an investigation of these allegations utilizing the forensic accounting services of Huron Consulting Group (Huron). This investigation was expanded and included determining whether similar issues might have affected other Tenet hospitals during the periods mentioned in the allegations and any other pertinent periods. Debevoise and Huron have completed their investigation and presented the results of their findings to the audit committee.Based on these findings, the audit committee determined that it would be necessary to restate our previously reported financial statements as described in Note 15. We are continuing to cooperate with the SEC with respect to its investigation, including responding to subsequent requests for voluntary production of documents, as well as a subpoena request for documents dated October 6, 2005, and have provided regular updates to the SEC as to the progress of the investigation.

4. Redding Medical Center, Inc. We are 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 action was unsealed in October 2004 and, subsequently, was served on the defendants. Both the California Department of Insurance and the District Attorney of Shasta County, California have declined to intervene in this action. Plaintiff s second amended complaint, which was filed on May 18, 2005, generally alleges that false claims for payments were made to private insurers for allegedly medically unnecessary procedures performed at Redding Medical Center (of which we sold certain hospital assets in July 2004), and also includes a cause of action for aiding and conspiring. We have denied all material allegations and set forth numerous affirmative defenses. On September 21, 2005, the court ordered a bifurcated trial in this matter. A bench trial on two issues of law in the case is set to begin on December 13, 2005. Discovery on all other issues has been stayed.

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. Discovery has commenced, and trials relating to the original complaint and two additional related complaints are set to begin March 6, 2007. At September 30, 2005, we had an accrual of $34 million, recorded in prior years, for this matter.

In addition, we are cooperating with an investigation by the U.S. Attorney s Office for the Central District of California into coding, billing and cost reporting relating to 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. We contend that the severance benefit plan does not apply to Mr. Dennis, who resigned in November 2002. The arbitration is scheduled to commence on December 13, 2005.

(b) On June 24, 2005, Thomas B. Mackey, our former chief operating officer, filed a demand for arbitration with the American Arbitration Association alleging that he is entitled to a lump sum payment under Tenet s Supplemental Executive Retirement Plan (SERP). The arbitration demand was brought against Tenet Healthcare Corporation Pension Administration Committee, Tenet Healthcare Corporation Supplemental Executive Retirement Plan, and Tenet Healthcare Corporation. We contend that the Pension Administration Committee properly denied Mr. Mackey s claim for a lump sum payment. Mr. Mackey is seeking approximately $7.8 million, less monthly payments made to date under the SERP, and attorneys fees. The arbitration is in its early stages.

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(c) 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 contend that certification of a class in the action is not appropriate because our uniform policies comply with the applicable Labor Code and Wage Orders. In addition, we contend that each of these claims must be addressed individually based on its particular facts and, therefore, should not be subject to class certification.

(d) We are cooperating with an investigation by the U.S. Attorney s Office in New Orleans, Louisiana of Peoples Health Network (PHN), 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 to PHN in 2003 seek various PHN-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 concerning physicians and others, third-party reviews of denials of services and certain medical staff committees and other medical staff entities. A subpoena issued to PHN in September 2004 seeks various documents, including medical policies and practice guidelines, and an additional subpoena issued to PHN in April 2005 seeks documents related to PHN s appeal and grievance policies and member disenrollment, as well as information on PHN members who were admitted to a long-term acute care facility. We continue to provide certain information as requested by the government.

(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 voluntary requests 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. The voluntary requests also seek additional information regarding certain admissions and medical procedures at Twin Rivers.

(f) 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 received the most recent request on April 25, 2005, and have provided the Committee with written responses. We continue to cooperate with this investigation.

(g) In May 2003, the Internal Revenue Service completed an examination of our federal income tax returns for fiscal years ended May 31, 1995, 1996 and 1997 and issued a Revenue Agent s Report in which it proposed to assess an aggregate tax deficiency for the three-year audit period of $157 million. In the second quarter of 2005, we recorded an adjustment of $26 million ($23 million in continuing operations and $3 million in discontinued operations) to reduce our estimated liability for audit contingencies as a result of the resolution of several disputed issues. Among these issues was a disputed adjustment with respect to the timing of the recognition of income for tax purposes pertaining to Medicare and Medicaid net revenues, which we resolved by agreeing to spread the impact of the disputed adjustment over fiscal years ended May 31, 1995 through May 31, 2002. As a result of resolving these disputed issues, our tax liability for fiscal years May 31, 1995, 1996 and 1997 has been reduced to approximately $90 million, approximately $23 million of which is attributable to the issues that are no longer in dispute and approximately $67 million of which is still in dispute.

After the settlement, the tax liability that remains in dispute for fiscal years ended May 31, 1995, 1996 and 1997 is approximately $67 million plus interest of approximately $66 million through September 30, 2005, before any federal or state tax benefit. The principal issues that remain in dispute include the deductibility of a portion of the civil settlement we paid to the federal government in 1994 related to our discontinued psychiatric hospital business and the computation of depreciation expense with respect to certain capital expenditures incurred during the

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foregoing fiscal years. We expect to resolve the remaining disputed issues through formal litigation in Tax Court. We presently cannot determine the ultimate resolution of the remaining disputed issues.

The Internal Revenue Service has commenced an examination of our tax returns for 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 fiscal years ended May 31, 1998 through the seven-month transition period ended December 31, 2002, including the impact on these years of the partial settlement of the audit for fiscal years ended May 31, 1995, 1996 and 1997.

(h) On March 24, 2005, the Florida Department of Children and Families (DCF) notified our Florida Medical Center hospital in Ft. Lauderdale that DCF had reinstated the hospital s authority to receive patients under the Baker Act, a Florida state law that governs the involuntary admission of psychiatric patients to a hospital. On February 14, 2005, DCF had suspended the hospital s authority to receive Baker Act patients. On March 1, 2005, we received a voluntary request for documents from the Florida Attorney General s Medicaid Fraud Control Unit (MFCU) office in Ft. Lauderdale seeking medical records and billing information for certain Medicaid patients admitted to Florida Medical Center s psychiatric unit from January 2004 through February 2005, as well as certain information concerning patients admitted to the hospital under the Baker Act. We are cooperating with the Florida MFCU in connection with its review.

(i) On October 1, 2005, representatives of the Louisiana Attorney General s Office conducted a search of the campus of Memorial Medical Center in New Orleans, Louisiana. Included on Memorial s campus is a 317-bed Tenet hospital that has been closed since September 2, 2005 because of damage from Hurricane Katrina. The Attorney General s Office removed certain records and other materials, most of which came from an independently owned long-term acute care facility on Memorial s campus, which is managed and operated under separate license by LifeCare Holdings Inc., which is not affiliated with us. The Attorney General s Office conducted its search in connection with a search warrant issued by an Orleans Parish state judge on September 30, 2005. We were informed by representatives of the Attorney General s Office that this was one of several searches the Attorney General intends to make of hospitals and nursing homes where deaths occurred during and after Hurricane Katrina. The Attorney General has publicly stated that he is investigating all deaths that occurred at all nursing homes and hospitals immediately following the hurricane. On October 24, 2005, the Attorney General s Office issued a subpoena to Tenet and Memorial Medical Center requesting documents pertaining to the matters under investigation and events occurring at the hospital during and after the hurricane. The Attorney General s Office has also subpoenaed certain individuals it wishes to question on these matters, including a number of Tenet employees. We are cooperating with the Attorney General s Office with respect to this investigation.

(j) On September 27, 2005, a political subdivision of Jefferson Parish, Louisiana attempted to initiate an expropriation action against our Meadowcrest Hospital by making an unsolicited written offer to purchase the hospital

for $15.7 million. On October 7, 2005, Meadowcrest Hospital responded to the unsolicited offer and expropriation attempt by filing a civil action in the U.S. District Court for the Eastern District of Louisiana, seeking a declaratory judgment and injunctive relief prohibiting the expropriation on the grounds that it is anticompetitive in nature and, if allowed, would violate federal antitrust laws and both the United States and Louisiana state constitutions. On October 21, 2005, the defendant answered the complaint and counterclaimed for expropriation, claiming the need to acquire Meadowcrest Hospital in order to ensure that the future health care needs of the residents of Jefferson Parish are met. No trial date has yet been set for this matter.

(k) We and our subsidiaries continue to be engaged in disputes with managed care plans. For the most part, we believe the issues raised in these contract interpretation and rate disputes are commonly encountered by other providers in the health care industry.

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.

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

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The table below presents reconciliations of the beginning and ending liability balances in connection with legal settlements and related costs recorded during the nine months ended September 30, 2005 and 2004:

	Balances at Beginning of Period	Additions charged to: Costs of Litigation and Investigations	Additions charged to: Other(1)	Cash Payments(2)	Other(3)	Balances at End of Period
Nine Months Ended September 30, 2005						
Continuing operations	$ 40	$ 47	$	$ (44)	$ 82	$ 125
Discontinued operations			5			5
	$ 40	$ 47	$ 5	$ (44)	$ 82	$ 130
Nine Months Ended September 30, 2004						
Continuing operations	$ 203	$ 29	$ 2	$ (216)	$ (7)	$ 11
Discontinued operations			8	(8)		
	$ 203	$ 29	$ 10	$ (224)	$ (7)	$ 11

(1) Charges are included in other operating expenses in the Condensed Consolidated Statements of Operations. The discontinued operations charges were recorded as adjustments to net operating revenues within loss from operations of asset group.
(2) The 2004 cash payments included a March 2004 payment of an award of $163 million for contract damages to a former executive of the Company.
(3) Other items primarily include the reclassification of reserves established in prior years, including $34 million related to the Medicare coding matter, and the accrual of $45 million as an estimated minimum liability for securities and shareholder matters, which charge has been offset by a corresponding amount expected to be recovered from our insurance carriers that has been classified as a receivable in Other Current Assets in the Condensed Consolidated Balance Sheet as of September 30, 2005.

NOTE 11 INCOME TAXES

Income taxes in the nine months ended September 30, 2005 included the following: (1) income tax expense of $130 million in continuing operations to increase the valuation allowance for our deferred tax assets; (2) income tax expense of $23 million in discontinued operations to increase the valuation allowance; and (3) a $26 million income tax benefit in continuing operations to reduce our estimated liability for audit contingencies. A $789 million valuation allowance for our deferred tax assets was initially recorded in the fourth quarter of 2004. We assess the realization of our deferred tax assets quarterly to determine whether an adjustment to the 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. Based on our assessment of the realization of our deferred tax assets and the balance of those deferred tax assets, which are adjusted each quarter for changes in temporary differences, an adjustment of the valuation allowance is recorded each quarter. Given the magnitude of our valuation allowance, our future income/losses could result in a significant adjustment to this valuation allowance.

We have filed our federal tax return for 2004, which reflected a net operating loss (NOL) of approximately $1.9 billion. After taking into account the portion of the 2004 NOL that was absorbed against taxable income in prior years and for which income tax refunds totaling $537 million were received in the first quarter of 2005, the NOL carryforward available to offset taxable income in years 2005 through 2024 is approximately $394 million.

In May 2003, the Internal Revenue Service completed an examination of our federal income tax returns for fiscal years ended May 31, 1995, 1996 and 1997 and issued a Revenue Agent s Report in which it proposed to assess an aggregate tax deficiency for the three-year audit period of $157 million. In the second quarter of 2005, we recorded an adjustment of $26 million ($23 million in continuing operations and $3 million in discontinued operations) to reduce our estimated liability for audit contingencies as a result of the resolution of several disputed issues. Among these issues was a disputed adjustment with respect to the timing of the recognition of income for tax purposes pertaining to Medicare and Medicaid net revenues, which we resolved by agreeing to spread the impact of the disputed adjustment over fiscal years ended May 31, 1995 through May 31, 2002. As a result of resolving these disputed issues, our tax liability for fiscal years May 31, 1995, 1996 and 1997 has been reduced to approximately $90 million, approximately $23 million of which is attributable to the issues that are no longer in dispute and approximately $67 million of which is still in dispute. During the third quarter of 2005, we paid

TENET HEALTHCARE CORPORATION

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approximately $8 million of tax and interest to settle the issues that are no longer in dispute, which was comprised of tax of approximately $23 million plus accrued interest of approximately $15 million less prior payments of $30 million.

After the settlement, the tax liability that remains in dispute for fiscal years ended May 31, 1995, 1996 and 1997 is approximately $67 million plus interest of approximately $66 million through September 30, 2005, before any federal or state tax benefit. The principal issues that remain in dispute include the deductibility of a portion of the civil settlement we paid to the federal government in 1994 related to our discontinued psychiatric hospital business and the computation of depreciation expense with respect to certain capital expenditures incurred during the foregoing fiscal years. We expect to resolve the remaining disputed issues through formal litigation in Tax Court. We presently cannot determine the ultimate resolution of the remaining disputed issues.

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, including the impact on these years of the partial settlement of the audit for fiscal years ended May 31, 1995, 1996 and 1997.

NOTE 12 LOSS PER COMMON SHARE

All potentially dilutive securities were excluded from the calculation of diluted loss per share for the three and nine months ended September 30, 2005 and 2004 because we reported a loss from continuing operations in each of those periods. In circumstances where we have a loss from continuing operations, the effect of stock options and other potentially dilutive securities is anti-dilutive, that is, losses have the effect of making the diluted loss per share from 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, restricted stock units and deferred compensation units on the diluted shares calculation would have been an increase in shares of 1,824 and 479 for the three months ended September 30, 2005 and 2004, and 1,376 and 357 for the nine months ended September 30, 2005 and 2004, respectively.

Stock options (in thousands) whose exercise price exceeded the average market price of our common stock, and therefore, would not have been included in the computation of diluted shares if we had generated net income from continuing operations were 28,630 and 48,633 for the three months ended September 30, 2005 and 2004, and 32,631 and 45,420 for the nine months ended September 30, 2005 and 2004, respectively. The decrease in options whose exercise price exceeded the average market price is due primarily to the exchange of stock options for restricted stock units as described in Note 6.

NOTE 13 RECENTLY ISSUED ACCOUNTING STANDARDS

The following summarizes noteworthy recently issued accounting standards:

SFAS No. 123R (Revised 2004), Share-Based Payment (SFAS 123R), was issued in December 2004, and replaces SFAS 123, Accounting for Stock-Based Compensation and supersedes APB 25, Accounting for Stock Issued to Employees. In April 2005, the SEC adopted a final rule amending the compliance date. The accounting provisions of SFAS 123R will be effective for the first interim reporting period of the first fiscal year beginning on or after June 15, 2005, which for us will be January 1, 2006.

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. 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 were used.

In March 2005, the Financial Accounting Standards Board (FASB) issued FASB Interpretation No. 47, Accounting for Conditional Asset Retirement Obligations, an interpretation of FASB Statement No. 143. This Interpretation clarifies that an entity is required to recognize a liability for the fair value of a conditional asset retirement obligation if the fair value of the liability can be reasonably estimated. Uncertainty about the timing and (or) method of settlement of a conditional asset retirement obligation should be factored into the measurement of the liability when sufficient information exists. The types of asset retirement obligations that are covered by this Interpretation are those for which an entity has a legal obligation to perform an asset retirement

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activity, however, the timing and (or) method of settling the obligation are conditional on a future event that may or may not be within the control of the entity. We believe that future removal or containment costs associated with asbestos that may exist in certain of our properties may be subject to the accounting and disclosure requirements of this Interpretation. This Interpretation is effective for us no later than December 31, 2005. We are in the process of evaluating the estimated impact of this Interpretation on our consolidated financial statements.

NOTE 14 IMPACT OF HURRICANES

Katrina

Five of our hospitals and certain imaging centers in the New Orleans area and one hospital in Mississippi suffered considerable damage from Hurricane Katrina in late August 2005. All but one of the hospitals required complete evacuation. The timing of recovery for these hospitals to resume full operations is unknown. Although we are still evaluating the full extent of the damage and other financial impact caused by the hurricane on our Louisiana and Mississippi operations, we have recorded approximately $40 million in costs in the three months ended September 30, 2005, comprised of $27 million of relief pay and other employee-related expenses, $11 million in inventory and other working capital write-offs, and approximately $2 million in evacuation and other costs. We also recorded an impairment charge of $201 million for the write-down of damaged long-lived assets at these hospitals and imaging centers, net of $10 million of insurance proceeds for property damage from our insurance carriers received prior to September 30, 2005. Any future insurance proceeds from insurance claims related to property damage will also be recorded as a reduction to these impairment charges.

We have property, business interruption and related insurance coverage to mitigate the financial impact of these types of catastrophic events that is subject to deductible provisions based on the terms of the policies. These policies, which are on an occurrence basis and cover the period April 1, 2005 through March 31, 2006, provide up to $1 billion in coverage per occurrence and are subject to deductible provisions, exclusions and limits. One such limit, totaling $250 million per occurrence and in the aggregate, relates to flood losses as defined in the insurance policies. Due to the nature and extent of the overall damage to the area, neither the Company nor our insurance adjusters have been able to complete a full assessment of all impacted locations to determine the exact nature and cause of the losses. If significant portions of the losses at our facilities are determined to be caused by flood, flood damage limits under our insurance policies for any future damages to any of our hospitals during the remainder of the policy period may be partially or fully exhausted. In order to minimize the financial consequences if our flood limits are exhausted, we continue to monitor and evaluate options to purchase additional flood insurance coverage. We cannot provide assurances as to whether such coverage will be available or whether we will be able to obtain such coverage on acceptable terms. If existing flood policy limits should be partially or fully exhausted as a result of Hurricane Katrina and ensuing events, and we were to sustain a subsequent flood loss, and if we cannot or do not obtain additional coverage, our financial position, results of operations or cash flows could be materially adversely affected.

Wilma

All fourteen of our general hospitals in Florida sustained varying degrees of damage from Hurricane Wilma in late October 2005, including roof damage, damaged windows and water intrusion. All of the hospitals remained open and operational on regular power or emergency generators during the storm. At this point in time, all of our Florida hospitals have had their regular power restored. We are still in the process of assessing

the damages and financial impact from this hurricane.

NOTE 15 RESTATEMENT OF FINANCIAL STATEMENTS

As previously disclosed, the SEC is investigating allegations made by a former Tenet employee that inappropriate contractual allowances for managed care contracts may have been established at three California hospitals through at least fiscal year 2001. At the request of the audit committee of our board of directors, the board s independent outside counsel, Debevoise & Plimpton LLP (Debevoise), conducted an independent accounting investigation of these allegations utilizing the forensic accounting services of Huron Consulting Group (Huron). Based on the investigation findings, on January 17, 2006, the audit committee determined that it was necessary to restate our previously reported financial statements for the years ended December 31, 2004 and 2003.

In addition, during the 2005 year-end close, we determined that components of our deferred tax valuation allowance were incorrectly recorded in 2004. As a result, on February 15, 2006, the audit committee also determined that it was

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

necessary to restate our previously reported 2004 financial statements for this error.

On March 1, 2006, the audit committee determined that due to additional adjustments (see category 3 below) resulting from the final independent accounting investigation report, it was necessary to further restate our financial statements for 2004 and periods back to and including the fiscal year ended May 31, 1999. Since the financial statements for these periods were already being restated, we also recorded audit differences that were previously considered immaterial. On March 1, 2006, the audit committee also determined that the impact of the 2004 audit differences on our 2005 quarterly periods necessitated a restatement of our previously reported financial statements for the 2005 quarterly periods.

As a result of the restatement, originally reported net loss was decreased by $7 million ($0.02 per share) and increased by $6 million ($0.02 per share) for the three and nine months ended September 30, 2005, respectively, and was increased by $7 million ($0.02 per share) and $1 million ($0.00 per share) for the three and nine months ended September 30, 2004, respectively. The cumulative impact of errors related to periods prior to 2005 of $153 million has been reflected as a prior period adjustment to retained earnings as of December 31, 2004. For further information on the effect of these restatement adjustments on the December 31, 2004 Consolidated Balance Sheet, refer to the audited Consolidated Financial Statements and notes in our Annual Report on Form 10-K for the year ended December 31, 2005. All of the amounts included in this report reflect these restated financial results.

The restatement adjustments specifically impacting the periods in this Form 10-Q/A are summarized into the following categories:

(1) Certain contractual allowances and related other reserves, primarily for managed care accounts receivable, lacked adequate supporting documentation or were otherwise inappropriate.

(2) Certain revenues related to managed care payers in bankruptcy should have been recognized in earlier periods.

(3) Certain prior period reserves released during 2005 and 2004 should have been released as of 2002 or earlier. Such prior period reserves related primarily to reserves for bad debt, litigation costs, restructuring charges and other reserves related to business combinations and acquisitions and sales of assets and facilities, and previously capitalized start-up costs.

(4) Our estimated professional and general liability reserves were not adequately decreased in 2004 as a result of a management decision that the effect of this audit difference was considered immaterial.

(5) Certain of the prior period restatement adjustments increased taxable income reported in years that are currently under audit by the Internal Revenue Service. Other long-term liabilities have been increased by $52 million as of December 31, 2004 to reflect increased income taxes payable for those prior taxable years. Certain of the restatement adjustments reduced taxable income and our net operating loss carryforward was increased. The corresponding deferred tax valuation allowance that was established in 2004 was increased by the same amount.

(6) A component of the deferred tax valuation allowance established in 2004 was incorrectly charged against additional paid-in capital rather than income tax expense.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

The following table reconciles the net loss and loss per share as originally reported to amounts as reported for applicable periods with reference to the above adjustment categories:

	Three Months Ended September 30				**Nine Months Ended September 30**			
	2005		**2004**		**2005**		**2004**	
	Amount	**EPS**	**Amount**	**EPS**	**Amount**	**EPS**	**Amount**	**EPS**
Net loss, as originally reported	**$ (408)**	**$ (0.87)**	**$ (70)**	**$ (0.15)**	**$ (432)**	**$ (0.92)**	**$ (618)**	**$ (1.33)**
Adjustments resulting from the investigation, before tax:								
Unsupported or inappropriate contractual allowances(1)								
Net operating revenues	7	0.02	(7)	(0.02)	9	0.02		
Timing of revenue recognition(2)								
Net operating revenues			(1)		(1)		(1)	
Release of prior period reserves(3)								
Provision for doubtful accounts					(9)	(0.02)		
Other operating expenses					7	0.02		
Restructuring charges							(3)	(0.01)
	7	0.02	(8)	(0.02)	6	0.02	(4)	(0.01)
Audit differences recorded, before tax:								
Decrease in professional and general liability reserves(4)								
Other operating expenses					(8)	(0.02)		
					(8)	(0.02)		
Total adjustments to loss from continuing operations, before income taxes	7	0.02	(8)	(0.02)	(2)	(0.01)	(4)	(0.01)
Income tax effect of the above adjustments	(2)		3	0.01	1		2	
Change in valuation allowance due to adjustments recorded(5)	2				(1)			
			3	0.01			2	
Total impact on net loss from continuing operations	**7**	**0.02**	**(5)**	**(0.01)**	**(2)**	**(0.01)**	**(2)**	

TENET HEALTHCARE CORPORATION

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

	Three Months Ended September 30				Nine Months Ended September 30			
	2005		2004		2005		2004	
	Amount	EPS	Amount	EPS	Amount	EPS	Amount	EPS
Unsupported or inappropriate contractual allowances(1)								
Net operating revenues			(4)	(0.01)			(1)	(0.01)
Timing of revenue recognition(2)								
Net operating revenues			1		(1)		3	0.01
Decrease in professional and general liability reserves(4)								
Other operating expenses					(2)	(0.01)		
Unsupported allowance for doubtful accounts(1)								
Provision for doubtful accounts					(1)			
Total adjustments to loss from discontinued operations, before income taxes			(3)	(0.01)	(4)	(0.01)	2	
Income tax effect of discontinued operations adjustments			1		1		(1)	
Change in valuation allowance due to adjustments recorded(5)					(1)			
			1				(1)	
Total impact on net loss from discontinued operations			**(2)**	**(0.01)**	**(4)**	**(0.01)**	**1**	
Net loss, as restated	**$ (401)**	**$ (0.85)**	**$ (77)**	**$ (0.17)**	**$ (438)**	**$ (0.94)**	**$ (619)**	**$ (1.33)**

The following tables set forth the net effects of these restatement adjustments on our Consolidated Financial Statements:

Consolidated Statements of Operations

	Three Months Ended September 30		Nine Months Ended September 30	
	2005	2004	2005	2004
Net operating revenues	**$ 7**	**$ (8)**	**$ 8**	**$ (1)**
Operating expenses:				
Provision for doubtful accounts			9	

Other operating expenses			1	
Impairment of long-lived assets and goodwill, and restructuring charges				3
Income (loss) from continuing operations, before income taxes	**7**	**(8)**	**(2)**	**(4)**
Income tax (expense) benefit		3		2
Income (loss) from continuing operations, before discontinued operations	**7**	**(5)**	**(2)**	**(2)**
Discontinued operations:				
Income (loss) from operations of asset group		(3)	(4)	2
Income tax (expense) benefit		1		(1)
Income (loss) from discontinued operations		**(2)**	**(4)**	**1**
Net income (loss)	**$ 7**	**$ (7)**	**$ (6)**	**$ (1)**
Basic and diluted earnings (loss) per common share				
Continuing operations	$ 0.02	$ (0.01)	$ (0.01)	$
Discontinued operations		(0.01)	(0.01)	
	$ 0.02	**$ (0.02)**	**$ (0.02)**	**$**

TENET HEALTHCARE CORPORATION

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

Consolidated Balance Sheet

	September 30, 2005
LIABILITIES AND SHAREHOLDERS EQUITY	
Professional liability reserves(4)	$ (13)
Total current liabilities	**(13)**
Other long-term liabilities and minority interests(5)	52
Total liabilities	**39**
Additional paid-in capital(6)	120
Retained earnings (deficit)	(159)
Total shareholders equity	**(39)**
Total liabilities and shareholders equity	**$**

Net cash flows from operating, investing and financing activities did not change as a result of the restatement adjustments.

TENET HEALTHCARE CORPORATION

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

INTRODUCTION TO MANAGEMENT S DISCUSSION AND ANALYSIS

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

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

EXECUTIVE OVERVIEW

KEY DEVELOPMENTS

Recent key developments include:

Impact of Hurricane Wilma All fourteen of our general hospitals in Florida sustained varying degrees of damage from Hurricane Wilma in late October 2005, including roof damage, damaged windows and water intrusion. All of the hospitals remained open and operational on regular power or emergency generators during the storm. At this point in time, all of our Florida hospitals have had their regular power restored. We are still in the process of assessing the damages and financial impact from this hurricane.

Impact of Hurricane Katrina Five of our hospitals and certain imaging centers in the New Orleans area and one hospital in Mississippi suffered considerable damage from Hurricane Katrina in late August 2005. The hospitals affected are Kenner Regional Medical Center, Lindy Boggs Medical Center, Meadowcrest Hospital, Memorial Medical Center, NorthShore Regional Medical Center, and Gulf Coast Medical Center. As more fully described in Note 14 to the Condensed Consolidated Financial Statements, all but one of the hospitals required complete evacuation. Although we are still evaluating the full extent of the damage and other financial impact caused by the hurricane on our Louisiana and Mississippi operations, we have recorded approximately $40 million in costs in the three months ended September 30, 2005, comprised of $27 million of relief pay and other employee-related expenses, $11 million in inventory and other working capital write-offs, and approximately $2 million in evacuation and other costs. We also recorded an impairment charge of $201 million for the write-down of damaged long-lived assets at these hospitals and imaging centers, net of $10 million of insurance proceeds for property damage from our insurance carriers received prior to September 30, 2005.

New Health Network in New Orleans In October 2005, we announced the creation of a new, locally focused health network for restored and enhanced patient services in New Orleans. At this time, we plan on repairing our existing facilities or constructing new facilities if needed. We are still assessing whether to repair our existing Memorial and Lindy Boggs hospital buildings or construct new facilities. To help design the repair and construction of facilities in the new network, we have engaged an architectural firm with particular expertise in health care facilities. The cost of creating the new network has not yet been fully determined, but we believe a significant portion of the cost may be covered by insurance proceeds rather than borrowings.

TENET HEALTHCARE CORPORATION

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Progress in Existing Securities and Exchange Commission (SEC) Investigation As previously disclosed, the SEC is investigating allegations made by a former employee that inappropriate contractual allowances for managed care contracts may have been established at three California hospitals through at least fiscal year 2001. At the request of the audit committee of our board of directors, the board s independent outside counsel, Debevoise & Plimpton LLP (Debevoise), conducted an investigation of these allegations utilizing the forensic accounting services of Huron Consulting Group (Huron). This investigation was expanded and included determining whether similar issues might have affected other Tenet hospitals during the periods mentioned in the allegations and any other pertinent periods. Debevoise and Huron have completed their investigation and presented the results of their findings to the audit committee. Based on these findings, the audit committee determined that it would be necessary to restate our previously reported financial statements as described in Note 15 to the Condensed Consolidated Financial Statements.

Upcoming Departure of our Chief Financial Officer In October 2005, we announced that Robert S. Shapard, our chief financial officer since March 2005, has decided to depart the Company and rejoin his former employer in early November 2005, after our financial reporting for the third quarter is complete. Timothy L. Pullen, executive vice president and chief accounting officer, will serve as interim chief financial officer while we conduct a nationwide search for Mr. Shapard s successor.

SIGNIFICANT CHALLENGES

Our performance this quarter 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 Our total-hospital volumes were negatively impacted by the effects of Hurricane Katrina in late August 2005 on our Gulf Coast operations and surrounding communities and will likely continue to be negatively impacted in future quarters. As a result, we have excluded our six Gulf Coast hospitals and our imaging centers in New Orleans from our same-hospital statistics in order to provide a comparable basis for assessing our operating results. Our admissions and outpatient visits decreased from the prior year s third quarter on this same-hospital basis. We believe the reasons for the volume declines include, but are not limited to, the impact of our litigation and government investigations, physician attrition, increased competition and managed care contract negotiations or terminations. We are taking a number of steps to address the problem of volume decline. The most important of these is centered around building stronger relationships with the physicians who admit patients both to our hospitals and to our competitors hospitals.

Our *Commitment to Quality* (C2Q) initiative, which we launched in 2003, is directed at improving volumes by increasing both physician and patient satisfaction. We plan to complete the full 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. We believe that these improvements will have the effect of increasing physician and patient satisfaction, potentially improving volumes as a result.

Litigation and investigations We continue to defend ourselves against a significant amount of litigation, and we are cooperating with a number of governmental investigations; however, we are also seeking to resolve certain matters without litigation where appropriate and cost-effective. See Note 10 to the Condensed Consolidated Financial Statements for a summary of material litigation and investigations and Part II, Item 1, Legal Proceedings, in this report for more detailed information.

TENET HEALTHCARE CORPORATION

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Significant Industry Trends

Provision for doubtful accounts Like others in the health care industry, we continue to provide services to a high volume of uninsured patients. Although the discounting components of our *Compact with Uninsured Patients* (Compact) has and is expected to continue to reduce our provision for doubtful accounts recorded in our Condensed Consolidated Financial Statements, it is not expected to mitigate the net economic effects of treating uninsured patients. We continue to experience a high level of uncollectible accounts, and until a sustained level of lower unemployment in the areas our hospitals serve is achieved or our business mix improves, we anticipate this trend to continue.

Cost pressures Labor and supply costs remain a significant cost pressure facing us as well as the industry in general. In particular, the national nursing shortage continues and remains more serious in key specialties and in certain geographic areas than others, including several areas in which we operate hospitals. This has increased labor costs for nursing personnel. In addition, state-mandated nurse-staffing ratios in California affect not only our labor costs, but if we are unable to hire the necessary number of nurses to meet the required ratios, they may also cause us to limit patient admissions with a corresponding adverse effect on net operating revenues. Supply costs also continue to increase as new products and technology are used to improve the quality of care, as well as due to general inflation of supply costs.

RESULTS OF OPERATIONS OVERVIEW

Our results of operations for this quarter compared to the same quarter of the prior year reflect the challenges we have faced in restructuring our operations to focus on a smaller group of general hospitals. Our turnaround timeframe is influenced by industry trends and company-specific challenges that continue to negatively affect our patient volumes, revenue growth and operating expenses. In addition, our turnaround timeframe has now been influenced by the impact of Hurricane Katrina. Our future profitability depends on volume growth, reimbursement levels and cost control. Below are some of the financial highlights for the three months ended September 30, 2005 compared to the three months ended September 30, 2004:

Same-hospital net inpatient revenue per patient day and per admission increased by 4.5% and 3.8%, respectively, primarily due to the effect of newly negotiated levels of reimbursement on our managed care contracts.

Same-hospital net outpatient revenue per visit increased 1.4%, while same-hospital outpatient visits declined 4.3%. The increase in revenue per visit is due primarily to higher emergency room volume, a positive shift in payer mix and the sale or closure of certain home health agencies, hospices and clinics, which businesses typically generate

lower revenue per visit amounts than other outpatient services.

Cash used by operating activities was $15 million during the three months ended September 30, 2005 compared to cash provided by operating activities of $123 million during the three months ended September 30, 2004. Interest payments were $78 million higher in the current year due to debt issuances in June 2004 and January 2005.

Loss per diluted share from continuing operations was $0.80 in the current quarter compared to a loss per diluted share of $0.12 in the prior year quarter. Approximately $0.32 of the current quarter loss per share is directly attributable to Hurricane Katrina.

TENET HEALTHCARE CORPORATION

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The table below shows the pretax and after-tax impact on continuing operations of (1) an additional provision for doubtful accounts related to the change in how we estimated the net realizable value of self-pay accounts recorded in the second quarter of 2004, (2) impairment and restructuring charges, (3) hurricane costs, (4) costs of litigation and investigations, (5) net gains on sales of long-term investments, (6) loss from early extinguishment of debt, (7) adjustments to the valuation allowance for deferred tax assets and (8) reduction in our estimated income tax exposures for the three and nine months ended September 30, 2005:

	Three Months Ended September 30		Nine Months Ended September 30	
	2005	2004	2005	2004
	Restated (See Note 15) (Expense) Income			
Additional provision for doubtful accounts	$	$	$	$ (196)
Impairment and restructuring charges	(205)	(2)	(210)	(35)
Loss from hurricanes and related costs	(40)	(12)	(40)	(12)
Costs of litigation and investigations	(28)	(10)	(47)	(29)
Net gains on sales of long-term investments				6
Loss from early extinguishment of debt			(15)	(5)
Pretax impact	$ (273)	$ (24)	$ (312)	$ (271)
Deferred tax asset valuation allowance	$ (139)	$	$ (130)	$
Reduction in estimated tax exposures	$ 3	$	$ 26	$
Total after-tax impact	$ (308)	$ (17)	$ (301)	$ (168)
Diluted per-share impact of above items	$ (0.66)	$ (0.04)	$ (0.64)	$ (0.36)
Diluted loss per share, including above items	$ (0.80)	$ (0.12)	$ (0.79)	$ (0.42)

LIQUIDITY AND CAPITAL RESOURCES OVERVIEW

Net cash provided by operating activities was $685 million in the nine months ended September 30, 2005 compared to $208 million in the nine months ended September 30, 2004. The principal reasons for the change were an income tax refund of $537 million received in March 2005, additional interest payments of $109 million in 2005 and a $163 million payment of a litigation settlement to a former executive of the Company in the first quarter of 2004.

Proceeds from the sales of facilities, long-term investments and other assets during the nine months ended September 30, 2005 and 2004 aggregated $153 million and $295 million, respectively.

We are currently in compliance with all covenants in our letter of credit facility and the indentures governing our senior notes. (See Note 5 to the Condensed Consolidated Financial Statements.) At September 30, 2005, we had approximately $196 million of letters of credit outstanding under the letter of credit facility, which was fully collateralized by $263 million of restricted cash on our Condensed Consolidated Balance

Sheet. In addition, we had approximately $1.5 billion of unrestricted cash and cash equivalents on hand as of September 30, 2005.

OUTLOOK

We have implemented a variety of programs and initiatives, previously announced and discussed in our Annual Report on Form 10-K for the year ended December 31, 2004 (Annual Report), 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 the remainder of 2005. In 2006, we will continue to face many of the same challenges in improving our operating performance. These challenges include, but are not limited to, ongoing issues resulting from our prior pricing strategy, reduced volume levels, 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, our ongoing program to reduce costs and enhance operating performance, and our clinical quality initiatives will ultimately position us to improve our results of operations. The expected long-term benefits of these initiatives will be temporarily offset by 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 performance, and the restructuring and other initiatives we have undertaken will position us to improve our future financial performance.

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In the short term, our Louisiana and Mississippi operations, which represented approximately 6% of our net operating revenues in the first half of 2005, will be negatively affected not only by the damage caused to our facilities by Hurricane Katrina in late August 2005, but also by loss of revenues, higher bad debt expense and other incremental costs as the impacted facilities and surrounding local economies focus on recovery. As more fully described in Note 14 to the Condensed Consolidated Financial Statements, aggregate limits for flood damage under our insurance policies may have been partially or fully exhausted for the policy period April 1, 2005 through March 31, 2006. If such flood policy limits should be partially or fully exhausted as a result of Hurricane Katrina and ensuing events, and we were to sustain a subsequent flood loss, and if we cannot or do not obtain additional coverage, our financial position, results of operations or cash flows could be materially adversely affected.

FORWARD LOOKING STATEMENTS

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

Our ability to enter into managed care provider arrangements on acceptable terms.

Changes in employer-provided insurance benefits that cause shifts in our payer mix.

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.

Settlement of professional liability claims and the availability of professional liability insurance coverage at current levels and terms.

Our ability to obtain adequate property insurance to cover flood losses.

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.

Impact of natural disasters, including our ability to reopen facilities affected by such disasters.

Demographic changes.

Our 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.

Our ability to identify and execute on measures designed to save or control costs.

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The amount and terms of our indebtedness.

The timing and payment, if any, of any final determination of potential liability as a result of Internal Revenue Service examinations.

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

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

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

CRITICAL ACCOUNTING ESTIMATES

In preparing our Condensed 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 Condensed 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 are more fully described in our Annual Report and continue to 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.

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).

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

Net patient revenues from:	Three Months Ended September 30			Nine Months Ended September 30		
	2005	2004	Increase (Decrease)(1)	2005	2004	Increase (Decrease)(1)
	Restated (See Note 15)					
Medicare	26.5%	25.3%	1.2%	27.3%	25.7%	1.6%
Medicaid	8.8%	7.8%	1.0%	8.4%	7.4%	1.0%
Managed care(2)	51.1%	49.3%	1.8%	50.6%	49.5%	1.1%
Indemnity, self-pay and other	13.6%	17.6%	(4.0)%	13.7%	17.4%	(3.7)%

(1) The change is the difference between the 2005 and 2004 amounts shown.

(2) Includes Medicare Advantage and Medicaid managed care.

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

Admissions from:	Three Months Ended September 30			Nine Months Ended September 30		
	2005	2004	Increase (Decrease)(1)	2005	2004	Increase (Decrease)(1)
Medicare	32.5%	33.0%	(0.5)%	33.6%	34.0%	(0.4)%
Medicaid	14.1%	13.5%	0.6%	13.5%	13.1%	0.4%
Managed care(2)	45.0%	44.8%	0.2%	44.7%	44.8%	(0.1)%
Indemnity, self-pay and other	8.4%	8.7%	(0.3)%	8.2%	8.1%	0.1%

GOVERNMENT PROGRAMS

The Medicare program, the nation s largest health insurance program, is administered by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS). 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 our Annual Report.

There have been no material changes to the information about these programs in our Annual Report, except as follows:

Outliers

CMS Program Memorandum Transmittal A-02-126 dated December 20, 2002 *Instructions Regarding Outlier Payments* (PM) instructed Medicare fiscal intermediaries to identify hospitals that appear, through data analysis, to present the greatest risk to the program. The PM set forth requirements and criteria for audits and reviews, which include comprehensive field audits of cost reports, uniform charge reviews and medical reviews. We previously disclosed that, in

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accordance with the PM, CMS instructed our fiscal intermediary to conduct audits and reviews of 16 of our hospitals, including nine hospitals that are part of our divestiture plan. During the third quarter of 2005, our fiscal intermediary completed the cost report audits and uniform charge reviews of our hospitals required by the PM, and we have received notices of their findings for the hospitals reviewed. There were no adverse findings from the uniform charge reviews, the purpose of which was to establish that hospitals applied charges for services uniformly and consistently. The intermediary s findings from its audit of the cost reports, most of which had been previously audited and settled through routinely conducted audits, will not have a material impact on our previously recorded revenues. However, our charging practices in connection with our Medicare outlier payments received in prior years remain under investigation. (See Note 10 to the Condensed Consolidated Financial Statements.)

Legislative and Regulatory Changes

2006 Federal Budget Proposal

On February 7, 2005, the White House released its federal fiscal year (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 a previous Medicare Payment Advisory Commission 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. On April 29, 2005, Congress approved a $10 billion reduction in Medicaid funding over five years as part of a $2.6 trillion fiscal year 2006 nonbinding budget resolution. In October 2005, the Senate and the House of Representatives began legislative mark-ups of FFY 2006 budget reconciliation measures. We cannot predict the final outcome of the budget or the effect it may have on us.

Annual Update to the Medicare Inpatient Prospective Payment System

Under Medicare law, CMS is required annually to update certain rules governing the prospective payment system (PPS) for hospitals. The updates generally become effective October 1, the beginning of the FFY. On August 1, 2005, CMS issued the Changes to the Hospital Inpatient Prospective Payment Systems and FFY 2006 Rates (Final Rule). The Final Rule includes the following payment policy changes:

An inflation update for diagnosis-related group (DRG) operating payments equal to the hospital market basket percentage, currently estimated at 3.7% for hospitals reporting specified quality data.

A 0.8% inflation update for DRG capital payments.

Expanding the post-acute transfer policy that currently applies to 30 DRGs to 182 DRGs.

A decrease in the cost outlier threshold from $25,800 to $23,600.

Replacing nine cardiovascular DRGs with 12 new DRGs that, according to CMS, better recognize severity of illness.

CMS projects that the combined impact of the changes will yield an average 3.4% increase in payments for hospitals in large urban areas (populations over 1 million). Using the impact percentages in the Final Rule for hospitals in large urban areas applied to our Medicare inpatient PPS payments for the twelve months ended September 30, 2005, the annual impact for all changes in the Final Rule on our hospitals may result in an estimated increase in our Medicare revenues of approximately $55 million. This includes an estimated decrease in payments of approximately $15 million related to the expansion of the post-acute transfer policy. Because of the uncertainty regarding the outcome of the FFY 2006 budget reconciliation, and other factors that may influence our future PPS payments, including admission volumes, length of stay and case mix, we cannot provide any assurances regarding these estimates.

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Annual Update to the Medicare Outpatient Prospective Payment System

On July 18, 2005, CMS issued the Proposed Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2006 Payment Rates. Among the changes CMS is proposing are:

A 3.2 % inflation update in Medicare payment rates in 2006 for outpatient services.

To continue to lower the coinsurance rates that Medicare patients have to pay for outpatient services.

To reduce payments for some diagnostic imaging procedures to reflect their limited additional cost when they are performed with other imaging procedures in the same session with the patient.

CMS projects that the combined impact of the proposed changes will yield an average 1.9% increase in payments for all hospitals, and an average of 0.8% increase in payments for hospitals located in large urban areas (populations over one million). Using the impact percentages in the proposed rule for hospitals in large urban areas applied to our Medicare outpatient PPS payments for the nine months ended September 30, 2005 (annualized), the annual impact for all changes in the proposed rule on our hospitals may result in an estimated increase in our Medicare revenues of approximately $3 million. Because of the uncertainty regarding the outcome of the FFY 2006 budget reconciliation, modifications to the payment policies contained in the proposed rule, and other factors that may influence our future outpatient PPS payments including volumes and case mix, we cannot provide any assurances regarding these estimates.

Inpatient Rehabilitation Reimbursement

On August 1, 2005, CMS issued the Final Rule for the Inpatient Rehabilitation Facility (IRF) Prospective Payment System for FFY 2006 (IRF-PPS Final Rule). CMS projects that the impact of the payment policy changes will yield an average 5.3% increase in payments for hospital units in urban areas. For hospitals in urban areas, CMS projects that the proposed changes will yield an average 0.0% change in payments. Applying these impact percentages to our Medicare IRF-PPS payments for the nine months ended September 30, 2005 (annualized), the annual impact for all changes on our IRF hospitals and hospital units may result in an estimated increase in our Medicare revenues of approximately $4 million. Because of the uncertainty of the factors that may influence our future IRF-PPS payments, including admission volumes, length of stay and case mix, and the impact of compliance with IRF admission criteria rules discussed below, we cannot provide any assurances regarding these estimates.

On June 21, 2005, CMS issued a notice announcing it will proceed with implementing the revised and expanded classification criteria for IRFs it adopted in a May 7, 2004 final rule. In January 2005, CMS suspended enforcement of the classification criteria in response to a provision of the Consolidated Appropriations Act, 2005, that directed CMS not to change the status of certain IRFs for their failure to comply with the classification criteria in the May 7, 2004 rule until it had reviewed recommendations from a then-pending study by the United States Government Accountability Office (GAO) of clinically appropriate IRF classification criteria. The GAO issued its report and recommendations in April 2005. The GAO recommended that CMS further identify subgroups of patients within a condition that would better identify patients that appear to need an IRF level of care, based upon research and review of IRF cases. Significantly, the GAO did not recommend the CMS delay implementing the revised criteria specified in the May 7 final rule pending further refinement. Accordingly, the June 2005 CMS notice lifts the suspension of enforcement of the criteria in the final rule.

At September 30, 2005, we operated two inpatient rehabilitation hospitals, and 20 of our general hospitals operated inpatient rehabilitation units (two of these units suspended services as a result of Hurricane Katrina). Based on the most recent data available, approximately 30% of those 20 hospital units and one inpatient rehabilitation hospital do not meet the compliance threshold. Compliance thresholds for subsequent years are scheduled to be 60%, 65% and finally 75%. If our rehabilitation hospital and units fail to continue to qualify as inpatient facilities, our business, financial position, results of operations or cash flows could be materially adversely affected.

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Medicare contractors (fiscal intermediaries and carriers) are authorized to issue local coverage determinations (LCD). An LCD is a decision by a fiscal intermediary or carrier whether to cover a particular service on an intermediary-wide or carrier-wide basis resulting from a determination as to whether the service is reasonable and necessary. During the second quarter of 2005, our fiscal intermediary issued a controversial LCD regarding inpatient rehabilitation services. This LCD establishes comparatively restrictive admission criteria to the clinical conditions required for Medicare payment for inpatient rehabilitation services. Our rehabilitation hospitals and units may experience a decline in admissions and greater difficulty meeting the aforementioned IRF classification compliance thresholds as a result of this LCD.

Specialty Hospitals

On June 9, 2005, CMS announced the next steps it will take in connection with the end of an 18-month moratorium imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 as to new specialty hospitals, which expired on June 8, 2005. CMS has instructed Medicare fiscal intermediaries not to process new provider enrollment applications for specialty hospitals until further notice. In addition, CMS stated that it will undertake the following steps during the suspension to reform Medicare payments that may provide specialty hospitals with an unfair advantage over other types of providers, such as community hospitals or ambulatory surgical centers (ASCs): (1) reform payment rates for inpatient hospital services through changes to the DRG system; (2) reform payment rates for ASCs; (3) review procedures for approving hospitals for participation in Medicare and closely scrutinize processes for approving and starting to pay new specialty hospitals; and (4) seek public comment on the appropriate standards for specialty hospitals. According to CMS, these steps are designed to promote true and fair competition in hospital services, while improving quality and avoiding unnecessary costs for patients and for the Medicare program.

Medicare

The major components of our net patient revenues for services provided to patients enrolled in the Traditional Medicare Plan for the three and nine months ended September 30, 2005 and 2004 are set forth in the table below:

	Three Months Ended September 30		Nine Months Ended September 30	
Revenue Descriptions	**2005**	**2004**	**2005**	**2004**
Diagnosis-related group operating	$ 340	$ 333	$ 1,089	$ 1,054
Diagnosis-related group capital	36	34	113	112
Outlier	22	19	61	47
Outpatient	98	102	311	319
Disproportionate share	57	55	170	161
Direct Graduate and Indirect Medical Education	32	34	97	95
Psychiatric, rehabilitation and skilled nursing facilities inpatient and other	39	50	125	163
Adjustments for valuation allowance and prior-year cost report settlements	2	(18)	4	(38)

Total Medicare net patient revenues	**$**	**626**	**$**	**609**	**$**	**1,970**	**$**	**1,913**

Medicaid

Estimated payments under various state Medicaid programs, excluding state-funded managed care programs, constituted approximately 9% and 8% of net patient revenues at our continuing general hospitals for the three and nine months ended September 30, 2005, respectively. 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 three and nine months ended September 30, 2005, our disproportionate-share payments and other state-funded subsidies were approximately $31 million and $76 million, and for the three and nine months ended September 30, 2004, they were approximately $20 million and $63 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

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the states budget reductions, if any, on our hospitals. Also, any changes to or new Medicaid programs could materially impact Medicaid payments to our hospitals.

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 generally 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 both the three months ended September 30, 2005 and 2004 was $1.2 billion and during both the nine months ended September 30, 2005 and 2004 was $3.6 billion. It is anticipated to be approximately $5 billion for our continuing operations for the full fiscal year 2005. Approximately 37% of our managed care net patient revenues during the nine months ended September 30, 2005 related to our top five managed care payers. At September 30, 2005 and December 31, 2004, approximately 58% and 55%, respectively, of our net accounts receivable related to continuing operations are due from managed care providers.

The table below shows the managed care admissions by type for our general hospitals, expressed as percentages of total managed care admissions:

	Three Months Ended September 30			Nine Months Ended September 30		
	2005	2004	Increase (Decrease)(1)	2005	2004	Increase (Decrease)(1)
Non-governmental	65.6%	67.9%	(2.3)%	65.3%	68.1%	(2.8)%
Governmental	34.4%	32.1%	2.3%	34.7%	31.9%	2.8%

(1) The change is the difference between the 2005 and 2004 amounts shown.

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. National payers generate approximately 39% 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. Through September 30, 2005, we have successfully negotiated approximately 78% of managed care revenues anticipated on an annual basis.

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 per diem and DRG contracts with stop-loss payment components as well.

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We have been working to transition key managed care payers to contracts that use fixed, predictable market-based per diems and/or DRG methodology and 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 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, and who do not have some form of private insurance, and are, therefore, responsible for their own medical bills. A significant portion of our self-pay patients is being admitted through our hospitals emergency departments and often require 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 our level of self-pay patients has been higher in the last two years than previous periods 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 September 30, 2005 and December 31, 2004, approximately 6% and 8%, respectively, of our net accounts receivable related to continuing operations are due from self-pay patients. The decrease in this percentage is attributable to a higher number of accounts under our Compact. 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 high level of 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 in an effort to increase collections.

Over the longer term, several other initiatives we have previously announced and begun to implement should also help address this challenge. For example, our Compact, which is discussed in Note 2 to the Condensed Consolidated Financial Statements, is enabling us to offer lower rates to uninsured patients who historically have been charged standard gross charges.

We also provide charity care to patients who are financially unable to pay for the health care services they receive. Most patients who qualify for charity care are charged a per diem amount for services received, subject to a cap. Except for the per diem amounts, our policy is not to pursue collection of amounts determined to qualify as charity care; and, therefore, we do not report these amounts in net operating revenues or in provision for doubtful accounts. For the nine months ended September 30, 2005, $458 million in charity care gross charges were excluded from net operating revenues and provision for doubtful accounts compared to $426 million for the nine months ended September 30, 2004.

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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 three and nine months ended September 30, 2005 and 2004:

	Three Months Ended September 30		Nine Months Ended September 30	
	2005	2004	2005	2004
	Restated (See Note 15)			
Net operating revenues:				
General hospitals	$ 2,344	$ 2,357	$ 7,147	$ 7,327
Other operations	50	63	168	179
Net operating revenues	**2,394**	**2,420**	**7,315**	**7,506**
Operating expenses:				
Salaries, wages and benefits	1,099	1,069	3,337	3,249
Supplies	446	421	1,350	1,280
Provision for doubtful accounts	206	251	526	1,010
Other operating expenses	554	557	1,628	1,675
Depreciation	95	92	271	272
Amortization	10	6	22	16
Impairment and restructuring charges	205	2	210	35
Loss from hurricane and related costs	40		40	
Costs of litigation and investigations	28	10	47	29
Loss from early extinguishment of debt			15	5
Operating income (loss)	**$ (289)**	**$ 12**	**$ (131)**	**$ (65)**

	Three Months Ended September 30		Nine Months Ended September 30	
	2005	2004	2005	2004
	Restated (See Note 15) (% of Net Operating Revenues)			
Net operating revenues:				
General hospitals	97.9%	97.4%	97.7%	97.6%
Other operations	2.1%	2.6%	2.3%	2.4%
Net operating revenues	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Operating expenses:				
Salaries, wages and benefits	45.9%	44.2%	45.6%	43.3%
Supplies	18.6%	17.4%	18.5%	17.1%
Provision for doubtful accounts	8.6%	10.4%	7.2%	13.4%
Other operating expenses	23.1%	23.0%	22.3%	22.3%
Depreciation	4.0%	3.8%	3.7%	3.6%

Amortization	0.4%	0.2%	0.3%	0.2%
Impairment and restructuring charges	8.6%	0.1%	2.9%	0.5%
Loss from hurricane and related costs	1.7%	%	0.5%	%
Costs of litigation and investigations	1.2%	0.4%	0.6%	0.4%
Loss from early extinguishment of debt	%	%	0.2%	0.1%
Operating income (loss)	**(12.1)%**	**0.5%**	**(1.8)%**	**(0.9)%**

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 cafeterias, 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.

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Net operating revenues from our other operations were $50 million and $63 million for the three months ended September 30, 2005 and 2004, respectively, and were $168 million and $179 million for the nine months ended September 30, 2005 and 2004, respectively, including equity earnings of unconsolidated affiliates of $5 million and $4 million for the three months ended September 30, 2005 and 2004, respectively, and $16 million and $14 million for the nine months ended September 30, 2005 and 2004, respectively. As we continue to focus on our general hospital operations, the revenue attributable to our other operations may decrease.

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

	Three Months Ended September 30			Nine Months Ended September 30		
	2005	**2004**	**Increase (Decrease)**	**2005**	**2004**	**Increase (Decrease)**
	Restated (See Note 15) (Dollars in Millions, Except Per Patient Day, Per Admission and Per Visit Amounts)					
Net inpatient revenues(2)	$ 1,603	$ 1,579	1.5%	$ 4,902	$ 4,939	(0.7)%
Net outpatient revenues(2)	$ 708	$ 746	(5.1)%	$ 2,144	$ 2,285	(6.2)%
Number of general hospitals (at end of period)	69	69	(1)	69	69	(1)
Licensed beds (at end of period)	17,859	17,933	(0.4)%	17,859	17,933	(0.4)%
Average licensed beds	17,859	17,932	(0.4)%	18,023	17,847	1.0%
Utilization of licensed beds(5)	50.8%	52.7%	(1.9)%(1)	53.5%	55.0%	(1.5)%(1)
Patient days	834,601	868,975	(4.0)%	2,634,200	2,688,413	(2.0)%
Equivalent patient days(4)	1,179,032	1,219,423	(3.3)%	3,692,519	3,744,508	(1.4)%
Net inpatient revenue per patient day	$ 1,921	$ 1,817	5.7%	$ 1,861	$ 1,837	1.3%
Admissions(3)	163,707	169,211	(3.3)%	510,691	518,514	(1.5)%
Equivalent admissions(4)	233,272	239,723	(2.7)%	721,244	728,189	(1.0)%
Net inpatient revenue per admission	$ 9,792	$ 9,332	5.0%	$ 9,599	$ 9,525	0.8%
Average length of stay (days)	5.1	5.1	(1)	5.2	5.2	(1)
Surgeries	120,871	122,401	(1.3)%	369,879	371,541	(0.4)%
Net outpatient revenue per visit	$ 568	$ 561	1.2%	$ 541	$ 530	2.1%
Outpatient visits	1,246,170	1,328,946	(6.2)%	3,964,119	4,314,374	(8.1)%

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(1) The change is the difference between 2005 and 2004 amounts shown.

(2) Net inpatient revenues and net outpatient revenues are components of net operating revenues.

(3) Self-pay admissions represented 3.8% of total admissions for both the three months ended September 30, 2005 and 2004, and 3.7% and 3.5% for the nine months ended September 30, 2005 and 2004, 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.

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The table below shows certain selected operating statistics for our continuing general hospitals on a same-hospital basis. Our hospitals and imaging centers in the Gulf Coast area that were operationally impacted by Hurricane Katrina (see *Key Developments* above) are excluded from same-hospital statistics for all periods presented. Centennial Medical Center and St. Francis Hospital Bartlett, which both opened in June 2004, are excluded from same-hospital statistics for the six months ended June 30, 2005 and 2004, but are included for the three months ended September 30, 2005 and 2004 in the periods presented below.

	Three Months Ended September 30			Nine Months Ended September 30		
	2005	**2004**	**Increase (Decrease)**	**2005**	**2004**	**Increase (Decrease)**
	Restated (See Note 15) (Dollars in Millions, Except Per Patient Day, Per Admission and Per Visit Amounts)					
Net inpatient revenues	$ 1,533	$ 1,498	2.3 %	$ 4,616	$ 4,653	(0.8)%
Net outpatient revenues	$ 678	$ 698	(2.9)%	$ 2,010	$ 2,133	(5.8)%
Number of general hospitals (at end of period)	63	63	(1)	63	63	(1)
Average licensed beds	16,582	16,640	(0.3)%	16,603	16,534	0.4 %
Patient days	793,309	810,595	(2.1)%	2,455,135	2,504,951	(2.0)%
Net inpatient revenue per patient day	$ 1,932	$ 1,848	4.5 %	$ 1,880	$ 1,858	1.2 %
Admissions	156,682	158,908	(1.4)%	479,401	486,302	(1.4)%
Net inpatient revenue per admission	$ 9,784	$ 9,427	3.8 %	$		