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 June 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 x

As of July 31, 2005, there were 469,014,010 shares of common stock outstanding.

TENET HEALTHCARE CORPORATION

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 June 30, 2005, which was originally filed with the Securities and Exchange Commission (the SEC) on September 20, 2005 (the Original Form 10-Q), to reflect the restatements of our Condensed Consolidated Balance Sheet at June 30, 2005 and our Condensed Consolidated Statements of Operations, Comprehensive Income (Loss) and Cash Flows for the three and six months ended June 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 September 20, 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.

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PART I.

ITEM 1. FINANCIAL STATEMENTS

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED BALANCE SHEETS
Dollars in Millions

ASSETS	June 30 2005 Restated (See Note 15) (Unaudited)	December 31 2004
Current Assets:		
Cash and cash equivalents	$ 1,594	$ 654
Restricted cash	263	263
Investments in marketable debt securities	75	117
Accounts receivable, less allowance for doubtful accounts ($642 at June 30, 2005 and $688 at December 31, 2004)	1,499	1,692
Inventories of supplies, at cost	193	188
Income tax receivable		530
Deferred income taxes	104	118
Assets held for sale	74	114
Other current assets	321	320
Total current assets	**4,123**	**3,996**
Investments and other assets	300	296
Property and equipment, at cost, less accumulated depreciation and amortization ($2,722 at June 30, 2005 and $2,574 at December 31, 2004)	4,849	4,820
Goodwill	800	800
Other intangible assets, at cost, less accumulated amortization ($114 at June 30, 2005 and $101 at December 31, 2004)	180	169
Total assets	**$ 10,252**	**$ 10,081**
LIABILITIES AND SHAREHOLDERS EQUITY		
Current liabilities:		
Current portion of long-term debt	$ 20	$ 41
Accounts payable	744	937
Accrued compensation and benefits	412	390
Professional liability reserves	132	115
Accrued interest payable	125	96
Accrued legal settlement costs	128	40
Other current liabilities	415	495
Total current liabilities	**1,976**	**2,114**
Long-term debt, net of current portion	4,784	4,395
Professional liability reserves	600	590
Other long-term liabilities and minority interests	910	972
Deferred income taxes	273	311
Total liabilities	**8,543**	**8,382**
Commitments and contingencies		
Shareholders equity:		
Common stock, $0.05 par value; authorized 1,050,000,000 shares; 524,638,110 shares issued at June 30, 2005 and 521,132,853 shares issued at December 31, 2004	26	26
Additional paid-in capital	4,294	4,251
Accumulated other comprehensive loss	(12)	(13)
Accumulated deficit	(1,120)	(1,083)

Less common stock in treasury, at cost, 55,684,146 shares at June 30, 2005 and 53,896,498 shares at December 31, 2004		(1,479)		(1,482)
Total shareholders equity		**1,709**		**1,699**
Total liabilities and shareholders equity	**$**	**10,252**	**$**	**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 June 30		Six Months Ended June 30	
	2005	2004	2005	2004
		Restated (See Note 15)		
Net operating revenues	**$ 2,420**	**$ 2,510**	**$ 4,921**	**$ 5,086**
Operating expenses:				
Salaries, wages and benefits	1,114	1,089	2,238	2,180
Supplies	447	425	904	859
Provision for doubtful accounts	153	482	320	759
Other operating expenses	547	587	1,074	1,118
Depreciation	86	90	176	180
Amortization	6	5	12	10
Impairment and restructuring charges (credits)	(4)	24	5	33
Costs of litigation and investigations	11	9	19	19
Loss from early extinguishment of debt		5	15	5
Operating income (loss)	**60**	**(206)**	**158**	**(77)**
Interest expense	(102)	(74)	(203)	(151)
Investment earnings	15	3	24	7
Minority interests	(3)		(6)	(5)
Net gain on sales of long-term investments		6		6
Loss from continuing operations, before income taxes	**(30)**	**(271)**	**(27)**	**(220)**
Income tax benefit	18	103	35	79
Income (loss) from continuing operations, before discontinued operations	**(12)**	**(168)**	**8**	**(141)**
Discontinued operations:				
Loss from operations of asset group	(20)	(123)	(59)	(201)
Impairment of long-lived assets and goodwill, and restructuring charges	(1)	(269)	(8)	(406)
Net gain on sales of asset group		31	22	29
Income tax benefit		106		177
Loss from discontinued operations	**(21)**	**(255)**	**(45)**	**(401)**
Net loss	**$ (33)**	**$ (423)**	**$ (37)**	**$ (542)**
Earnings (loss) per common share and common equivalent share				
Basic				
Continuing operations	$ (0.03)	$ (0.36)	$ 0.02	$ (0.30)
Discontinued operations	(0.04)	(0.55)	(0.10)	(0.86)
	$ (0.07)	**$ (0.91)**	**$ (0.08)**	**$ (1.16)**
Diluted				
Continuing operations	$ (0.03)	$ (0.36)	$ 0.02	$ (0.30)
Discontinued operations	(0.04)	(0.55)	(0.10)	(0.86)
	$ (0.07)	**$ (0.91)**	**$ (0.08)**	**$ (1.16)**
Weighted average shares and dilutive securities outstanding (in thousands):				
Basic	468,758	465,922	468,403	465,609
Diluted	468,758	465,922	469,635	465,609

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 June 30		Six Months Ended June 30	
	2005	**2004**	**2005**	**2004**
		Restated (See Note 15)		
Net loss	$ (33)	$ (423)	$ (37)	$ (542)
Other comprehensive income (loss):				
Foreign currency translation adjustments		(2)		(4)
Unrealized gains (losses) on securities held as available for sale	1	(1)		(1)
Reclassification adjustments for realized (gains) losses included in net loss		(5)	1	(4)
Other comprehensive income (loss) before income taxes	**1**	**(8)**	**1**	**(9)**
Income tax benefit related to items of other comprehensive income (loss)		3		3
Other comprehensive income (loss)	**1**	**(5)**	**1**	**(6)**
Comprehensive loss	**$ (32)**	**$ (428)**	**$ (36)**	**$ (548)**

See accompanying Notes to Condensed Consolidated Financial Statements.

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

Dollars in Millions

(Unaudited)

	Six Months Ended June 30	
	2005	**2004**
	Restated (See Note 15)	
Net loss	**$ (37)**	**$ (542)**
Adjustments to reconcile net loss to net cash provided by operating activities:		
Depreciation and amortization	188	190
Provision for doubtful accounts	320	759
Deferred income tax expense (benefit)	(38)	(179)
Stock-based compensation charges	26	57
Impairment and restructuring charges	5	33
Loss from early extinguishment of debt	15	5
Pre-tax loss from discontinued operations	45	578
Other items	4	(10)
Increases (decreases) in cash from changes in operating assets and liabilities:		
Accounts receivable	(323)	(530)
Inventories and other current assets	(4)	23
Income taxes	541	(136)
Accounts payable, accrued expenses and other current liabilities	(92)	(85)
Other long-term liabilities	15	111
Payments against reserves for restructuring charges and litigation costs and settlements	**(42)**	**(230)**
Net cash provided by operating activities from discontinued operations, excluding income taxes	**77**	**41**
Net cash provided by operating activities	**700**	**85**
Cash flows from investing activities:		
Purchases of property and equipment:		
Continuing operations	(223)	(174)
Discontinued operations	(1)	(11)
Construction of new hospitals		(65)
Net cash released from escrow accounts to fund construction costs		76
Proceeds from sales of facilities, long-term investments and other assets	117	190
Other items	(3)	(23)
Net cash used in investing activities	**(110)**	**(7)**
Cash flows from financing activities:		
Sale of new senior notes	773	954
Repurchases of senior notes	(413)	(450)
Payments of borrowings	(22)	(13)
Proceeds from exercise of stock options	9	2
Other items	3	3
Net cash provided by financing activities	**350**	**496**
Net increase in cash and cash equivalents	940	574
Cash and cash equivalents at beginning of period	654	619
Cash and cash equivalents at end of period	**$ 1,594**	**$ 1,193**
Supplemental disclosures:		
Interest paid, net of capitalized interest	$ (161)	$ (137)
Income tax refunds received (payments made), net	$ 535	$ (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) that we filed with the Securities and Exchange Commission (SEC) on March 8, 2005. As permitted by the 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 June 30, 2005, our subsidiaries operated 74 general hospitals, including five 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; and 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 six months ended June 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; 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.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

NOTE 2 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. The discounts for uninsured patients were in effect at 57 of our hospitals by June 30, 2005. In June 2005, the Texas Governor signed Senate Bill 500, which allows hospitals to discount the services they provide to self-pay patients. We plan to implement the discounting components of the Compact at our hospitals in Texas effective September 1, 2005.

During the three and six months ended June 30, 2005, there were approximately $146 million and $301 million, respectively, of discounts recorded as contractual allowances on self-pay accounts under the Compact compared to $28 million during the three and six months ended June 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 six months ended June 30, 2005, $307 million in charity care gross charges were excluded from net operating revenues and provision for doubtful accounts compared to $287 million for the six months ended June 30, 2004.

Our current total estimated collection rates on managed care accounts and self-pay accounts are approximately 95% and 22%, respectively, which includes collections from point-of-service through collections by our in-house collection agency or external collection agencies or vendors. This self-pay collection rate now 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. Previous disclosures did not include these payments. We believe this all-inclusive payment percentage provides additional information on our self-pay collection performance. The comparable self-pay collection percentage as of December 31, 2004 was approximately 22%.

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:

	June 30 2005 Restated (See Note 15)	December 31 2004
Continuing Operations:		
Patient accounts receivable	$ 2,025	$ 2,075
Allowance for doubtful accounts	(555)	(568)
Estimated future recovery of accounts in collection	74	100
Net cost report settlements payable and valuation allowances	(53)	(118)
	1,491	1,489
Discontinued Operations Accounts receivable, net of allowance for doubtful accounts ($87 at June 30, 2005 and $120 at December 31, 2004) and net cost report settlements payable and valuation allowances ($78 million at June 30, 2005 and $84 million at December 31, 2004)	8	203
Accounts receivable, less allowance for doubtful accounts	**$ 1,499**	**$ 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 June 30, 2005, we had completed the divestiture of 22 of the 27 facilities, including four hospitals in Orange County, California sold on March 8, 2005. The four hospitals are Chapman Medical Center, Coastal Communities Hospital, Western Medical Center Anaheim and Western Medical Center Santa Ana. Net after-tax proceeds, including the liquidation of working capital, for these four hospitals are estimated to be approximately $80 million. We recorded a gain of approximately $20 million in the quarter ended March 31, 2005 on the sale of these four facilities. In May 2005, we announced we had reached a definitive agreement to sell Brotman Medical Center in Culver City, California for approximately $27 million in net after-tax proceeds, including the liquidation of working capital. The sale was completed on September 1, 2005. Discussions and negotiations with potential buyers for the remaining four 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, 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.

TENET HEALTHCARE CORPORATION

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

We have classified $58 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 June 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 valuation allowances, are included in our consolidated net accounts receivable in the accompanying Condensed Consolidated Balance Sheets. At June 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 $8 million and $203 million, respectively.

We recorded $8 million of impairment and restructuring charges in discontinued operations during the six months ended June 30, 2005 consisting primarily of $2 million for the write-down of long-lived assets, $9 million in employee severance and retention costs and a $3 million reduction in reserves recorded in prior periods.

We recorded $406 million of impairment and restructuring charges in discontinued operations during the six months ended June 30, 2004 consisting primarily of $320 million for the write-down of long-lived assets, $33 million for the write-down of goodwill, $5 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 six months ended June 30, 2005 and 2004 are as follows:

	Three Months Ended June 30		Six Months Ended June 30	
	2005	2004	2005	2004
		Restated (See Note 15)		
Net operating revenues	$ 70	$ 706	$ 226	$ 1,493
Loss before taxes	(21)	(361)	(45)	(578)

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 six months ended June 30, 2005, we recorded impairment and restructuring charges of $5 million consisting of $8 million in employee severance, benefits and relocation costs, $2 million of lease termination costs, $3 million of asset impairment charges and $4 million

in non-cash stock option modification costs related to terminated employees, offset by a $12 million reduction primarily in restructuring reserves recorded in prior periods. During the six months ended June 30, 2004, we recorded restructuring charges of $33 million consisting of $17 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. (See Note 14.)

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 six months ended June 30, 2005 in continuing and discontinued operations:

	Balances at Beginning of Period	Restructuring Charges	Cash Payments	Other Items	Balances at End of Period
Six months ended June 30, 2005					
Continuing Operations:					
Severance and related costs in connection with general overhead-reduction plans and unfavorable lease commitments	$ 71	$ 5	$ (18)	$ (3)	$ 55
Discontinued Operations:					
Lease cancellations and estimated costs associated with the sale or closure of hospitals and other facilities	58	6	(26)	(8)	30
	$ 129	**$ 11**	**$ (44)**	**$ (11)**	**$ 85**

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 June 30, 2005 are expected to be approximately $32 million in 2005 and $53 million thereafter.

NOTE 5 LONG-TERM DEBT AND LEASE OBLIGATIONS

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

	June 30 2005	December 31 2004
Senior notes:		
5 3/8 %, due 2006	$	$ 215
5%, due 2007		185
6 3/8 %, due 2011	1,000	1,000
6 1/2 %, due 2012	600	600
7 3/8 %, due 2013	1,000	1,000
9 7/8 %, due 2014	1,000	1,000
9 1/4 %, due 2015	800	
6 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)	62	65
Unamortized note discounts	(108)	(101)

Total long-term debt		**4,804**		**4,436**
Less current portion		20		41
Long-term debt, net of current portion	**$**	**4,784**	**$**	**4,395**

(1) Includes $1 million and $5 million at June 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 the stock of certain of our subsidiaries and cash equal to 105% of the facility amount (approximately $263 million reflected as

TENET HEALTHCARE CORPORATION

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

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 June 30, 2005, outstanding letters of credit under the agreement totaled $214 million.

Loans under the previous credit agreement were unsecured and generally bore interest at a base rate equal to the prime rate or, if higher, the federal funds rate plus 0.5% or, at our option, an adjusted London Interbank Offered Rate plus an interest margin between 100 and 250 basis points. We paid the lenders an annual facility fee on the total loan commitment at rates between 50 and 57.5 basis points. The interest rate margins and the facility fee rates were based on our leverage covenant ratio (calculated as the ratio of consolidated total debt to operating income plus the sum of depreciation, amortization, impairment, other unusual charges, stock-based compensation expense, and losses from early extinguishment of debt). In consideration for amendments to the previous credit agreement in March 2004, we paid a one-time fee equal to 12.5 basis points. Also in connection with the amendment, we wrote off approximately $5 million in unamortized deferred loan fees in March 2004.

SENIOR NOTES AND SENIOR SUBORDINATED NOTES

In January 2005, we sold $800 million of senior notes with registration rights in a private placement. The senior notes bear interest at a rate of 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 of Tenet and rank equally in right of payment with all of our other unsecured senior indebtedness, but are effectively subordinated to any obligations under our 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, 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.

Also among those covenants are requirements to timely file and provide our quarterly and annual reports and officer certificates to our lenders and the indenture trustee. We will have cured any event of default resulting from not timely filing this quarterly report, pursuant to our various debt covenants, by filing this quarterly report within the cure period specified in our debt agreements.

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 June 30, 2005, there were approximately 26 million shares of common stock available under the 2001 Stock Incentive Plan for stock option grants and other incentive awards, including restricted stock units. Options generally have an exercise price equal to the fair market value of the shares on the date of

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grant and generally expire 10 years from the date of grant. A restricted stock unit is a contractual right to receive one share of our common stock in the future. Restricted stock units cannot exceed 10% of the total grants under the plan.

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

On February 16, 2005, we granted employee stock options for approximately 5 million shares of common stock at an exercise price of $10.52 per share, the closing price of our common stock on that date, and we also granted approximately 1.8 million restricted stock units. The estimated fair value of the options granted was $3.81 per share, and the fair value of the restricted stock units issued was $10.52 per share. Both the options and the restricted stock units vest one-third on each of the first three anniversary dates of the grant.

The following table summarizes information about our outstanding stock options at June 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	129,466	2.3 years	$ 7.83	129,433	$ 7.83
$ 10.17 to $20.34	30,059,812	6.6 years	16.15	18,484,335	14.86
$ 20.35 to $30.50	9,968,231	5.7 years	28.34	9,918,231	28.33
$ 30.51 to $40.67	8,123,855	6.4 years	40.37	8,123,855	40.37
$ 40.68 to $50.84	137,850	6.9 years	44.30	132,850	44.53
	49,841,165	6.3 years	$ 24.74	38,110,688	$ 21.98

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 92% of eligible vested and unvested options were exchanged on July 1, 2005, resulting in incremental non-cash compensation expense of approximately $17 million, together with approximately $6 million of future non-cash compensation expense for unvested eligible options exchanged, which will both be recognized as compensation expense over the three year vesting period of the restricted stock units.

NOTE 7 SHAREHOLDERS EQUITY

The following table shows the changes in consolidated shareholders equity during the six months ended June 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					(37)		(37)
Other comprehensive income				1			1
Issuance of common stock	703		3			3	6
Stock options exercised, including tax benefit	1,015		10				10
Stock-based compensation expense			30				30
Restated balances at June 30, 2005	**468,954**	**$ 26**	**$ 4,294**	**$ (12)**	**$ (1,120)**	**$ (1,479)**	**$ 1,709**

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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 June 30, 2005 and 2004 and six months ended June 30, 2005 and 2004:

	Before-Tax Amount	Tax (Expense) Benefit	Net-of-Tax Amount
Three Months Ended June 30, 2005:			
Unrealized gains on securities held as available-for-sale	$ 1	$	$ 1
	$ 1	**$**	**$ 1**
Three Months Ended June 30, 2004:			
Foreign currency translation adjustment	$ (2)	$ 1	$ (1)
Unrealized losses on securities held as available-for-sale	(1)		(1)
Reclassification adjustment for realized gains included in net loss	(5)	2	(3)
	$ (8)	**$ 3**	**$ (5)**
Six Months Ended June 30, 2005:			
Reclassification adjustment for realized losses included in net loss	$ 1	$	$ 1
	$ 1	**$**	**$ 1**
Six Months Ended June 30, 2004:			
Foreign currency translation adjustment	$ (4)	$ 1	$ (3)
Unrealized losses on securities held as available-for-sale	(1)		(1)
Reclassification adjustment for realized gains included in net loss	(4)	2	(2)
	$ (9)	**$ 3**	**$ (6)**

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 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 June 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 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

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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 June 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 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 June 30, 2005 and 3.8% at June 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 June 30, 2005, the current and long-term professional and general liability reserves on our Condensed Consolidated Balance Sheet were approximately $732 million.

Included in other operating expenses in the accompanying Condensed Consolidated Statements of Operations is malpractice expense of $66 million for the three months ended June 30, 2005, $100 million for the three months ended June 30, 2004, $118 million for the six months ended June 30, 2005 and $162 million for the six months ended June 30, 2004.

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.

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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, El Paso, Texas, New Orleans, Louisiana, St. Louis, Missouri and Memphis, Tennessee are the subject of ongoing federal investigations. Also, we are cooperating with a federal investigation into agreements with the Women s Cancer Center, a physician s group not owned by us practicing in the field of gynecologic oncology, and certain physicians affiliated with that group. An administrative subpoena for documents from us and several of our hospital subsidiaries relating to that investigation was issued in April 2003. Further, in June 2003, the Florida Medicaid Fraud Control Unit issued an investigative subpoena to us seeking the production of employee personnel records and contracts with physicians, physician assistants, therapists and management companies from the Florida hospitals 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. We are vigorously defending the Company in these matters.

In addition, plaintiffs in California, Tennessee, Louisiana, Florida, South Carolina, Pennsylvania, Texas, Missouri and Alabama have brought class action lawsuits against us and certain of our subsidiaries in courts in those states alleging that they paid unlawful or unfair prices for

prescription drugs or medical products or procedures at hospitals or other medical facilities 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. The settlement will become effective upon the expiration of the appeals period if no appeals are filed by any objectors to the settlement or, if any appeal is filed, upon the resolution of any such appeal. 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 June 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

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certain current and former members of our board of directors and former members of senior management by shareholders. These actions purport to allege various causes of action on behalf of Tenet and for our benefit, including breach of fiduciary duty, insider trading and other causes of action. The shareholder derivative actions are pending in federal court in Los Angeles, and in state court in Santa Barbara, California. In the quarter ended June 30, 2005, we recorded an accrual of $45 million 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 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. In July 2005, we filed demurrers and a motion to strike, and a hearing on the matters addressed in those filings was held on August 22, 2005. On August 24, 2005, the court denied our demurrers and motion to strike. On September 15, 2005, we filed our answer to plaintiff s second amended complaint, which denied all material allegations and set forth numerous affirmative defenses. Limited discovery has commenced. No trial date has been set.

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 June 30, 2005, we had an accrual of $34 million, recorded in prior years, for this matter.

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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 September 26, 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.

(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 cooperating with an investigation by the United States Senate Committee on Finance concerning Redding Medical Center, Medicare outlier payments, patient care and other matters. In addition, we are one of 20 large health care systems in the United States that has received requests for documents and information as part of an

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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. 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 plus interest of approximately $146 million through June 30, 2005, before any federal or state tax benefit. As of June 30, 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 $64 million through June 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 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) We recently resolved our disputes with several managed care plans regarding charges at facilities owned by our subsidiaries and the impact of those charges on stop-loss and other payments. We and our subsidiaries continue to be engaged in disputes with managed care plans, although our charges and their influence on contract provisions are less frequently the focus of these disputes.

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 Condensed Consolidated Financial Statements all potential liabilities that may result. If adversely determined, the outcome of some of these matters could have a material adverse effect on our business, liquidity, financial position or results of operations.

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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 six months ended June 30, 2005 and 2004:

	Balances at Beginning of Period	Additions charged to: Costs of Litigation and Investigations	Additions charged to: Other(1)	Cash Payments	Other(2)	Balances at End of Period
Six Months Ended June 30, 2005						
Continuing operations	$ 40	$ 19	$	$ (19)	$ 83	$ 123
Discontinued operations			5			5
	$ 40	$ 19	$ 5	$ (19)	$ 83	$ 128
Six Months Ended June 30, 2004						
Continuing operations	$ 203	$ 19	$ 2	$ (209)	$ (4)	$ 11
Discontinued operations			8			8
	$ 203	$ 19	$ 10	$ (209)	$ (4)	$ 19

(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) Other items 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 June 30, 2005.

For the six months ended June 30, 2005 and 2004, we recorded total costs of $24 million and $29 million, respectively, in connection with significant legal proceedings and investigations, including $5 million in 2005 and $8 million in 2004 that was reflected in discontinued operations. 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.

NOTE 11 INCOME TAXES

Income taxes in the six months ended June 30, 2005 included the following: (1) a $9 million income tax benefit in continuing operations to reduce the valuation allowance for our deferred tax assets and (2) income tax expense of $17 million in discontinued operations to increase the valuation allowance. 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 completed the preparation of our federal tax return for 2004, which reflects 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 plus interest of approximately $146 million through June 30, 2005, before any federal or state tax benefit. As of June 30, 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

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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. We expect the tax liability with respect to the issues that are no longer disputed (approximately $23 million) to be assessed in the third quarter of 2005. After adding accrued interest thereon (approximately $15 million through June 30, 2005) and after taking into account prior payments and credits of $30 million, we expect to pay approximately $8 million of tax and interest during the third quarter of 2005 to settle the issues that are no longer 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 $64 million through June 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 EARNINGS PER COMMON SHARE

The table below is a reconciliation of the numerators and denominators of our basic and diluted earnings per common share calculations for continuing operations for the three and six months ended June 30, 2005 and 2004. Income (loss) is expressed in millions and weighted average shares are expressed in thousands.

	Income (Loss) (Numerator)	Weighted Average Shares (Denominator)	Per-Share Amount
Restated Three Months Ended June 30, 2005:			
Loss to common shareholders for basic earnings per share	$ (12)	468,758	$ (0.03)
Effect of dilutive stock options, restricted stock units and other plans			
Loss to common shareholders for diluted earnings per share	$ (12)	468,758	$ (0.03)
Restated Three Months Ended June 30, 2004:			
Loss to common shareholders for basic earnings per share	$ (168)	465,922	$ (0.36)
Effect of dilutive stock options, restricted stock units and other plans			
Loss to common shareholders for diluted earnings per share	$ (168)	465,922	$ (0.36)
Restated Six Months Ended June 30, 2005:			
Income available to common shareholders for basic earnings per share	$ 8	468,403	$ 0.02

Effect of dilutive stock options, restricted stock units and other plans			1,232		
Income available to common shareholders for diluted earnings per share	$	8	469,635	$	0.02
Restated Six Months Ended June 30, 2004:					
Loss to common shareholders for basic earnings per share	$	(141)	465,609	$	(0.30)
Effect of dilutive stock options, restricted stock units and other plans					
Loss to common shareholders for diluted earnings per share	$	(141)	465,609	$	(0.30)

All potentially dilutive securities were excluded from the calculation of diluted loss per share for the three months ended June 30, 2005 and 2004 and the six months ended June 30, 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.

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Stock options (in thousands) that were not included in the computation of diluted earnings per share from continuing operations because their exercise price exceeded the average market price of our common stock were 37,407 and 46,556 for the three months ended June 30, 2005 and 2004, and 41,408 and 43,813 for the six months ended June 30, 2005 and 2004, respectively.

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 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 SUBSEQUENT EVENTS

Five of our hospitals 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. Our NorthShore Regional Medical Center in Slidell, Louisiana was one of the few hospitals in the area to remain open. Gulf Coast Medical Center in Biloxi, Mississippi is not fully operational but is receiving inpatients on a limited basis. Two of our hospitals were surrounded by water, and the other two are being used by government officials for relief efforts. The timing of recovery for these hospitals to resume full operations is unknown. Although we do not yet know the full extent of the damage or other financial impact caused by the hurricane on our Louisiana and Mississippi operations, we anticipate that the cost will be significant even after taking into account our existing insurance coverage for property damage, business interruption and related coverages, and we will likely incur significant asset 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 completely inspect all impacted locations to determine the nature and cause of the losses or establish accurate loss estimates. If all the losses or 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 exhausted.

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In order to minimize the financial consequences if our flood limits are exhausted, we are pursuing purchasing a reinstatement of flood limits with our current insurance carriers or possibly purchasing replacement insurance coverage. At this time, due to the widespread impact of Hurricane Katrina, insurance carriers have not established terms and conditions for policyholders who may have exhausted policy limits and are seeking reinstatements. We cannot provide assurances as to whether such reinstatement coverage will be available or whether we will be able to obtain such coverage on acceptable terms. If such flood policy limits should be 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 reinstatement or replacement coverage, our financial position, results of operations or cash flows could be materially adversely affected.

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 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 increased by $12 million ($0.03 per share) and $13 million ($0.03 per share) for the quarter and six months ended June 30, 2005, respectively, and was decreased by $3 million ($0.00 per share) and $6 million ($0.02 per share) for the quarter and six months ended June 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.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(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.

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 June 30				Six Months Ended June 30			
	2005		2004		2005		2004	
	Amount	EPS	Amount	EPS	Amount	EPS	Amount	EPS
Net loss, as originally reported	**$ (21)**	**$ (0.04)**	**$ (426)**	**$ (0.91)**	**$ (24)**	**$ (0.05)**	**$ (548)**	**$ (1.18)**
Adjustments resulting from the investigation, before tax:								
Unsupported or inappropriate contractual allowances(1)								
Net operating revenues			4	0.01	2		7	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)			(3)	(0.01)
	(1)		2		(1)		4	0.01
Audit differences recorded, before tax:								
Decrease in professional and general liability reserves(4)								
Other operating expenses	(8)	(0.03)			(8)	(0.02)		
	(8)	(0.03)			(8)	(0.02)		
Total adjustments to loss from continuing operations, before income taxes	(9)	(0.03)	2		(9)	(0.02)	4	0.01
Income tax effect of the above adjustments	3				3	(0.01)	(1)	
Change in valuation allowance due to adjustments recorded(5)	(3)				(3)	0.01		
							(1)	
Total impact on net loss from continuing operations	**(9)**	**(0.03)**	**2**		**(9)**	**(0.02)**	**3**	**0.01**

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

	Three Months Ended June 30				Six Months Ended June 30			
	2005		2004		2005		2004	
	Amount	EPS	Amount	EPS	Amount	EPS	Amount	EPS
Unsupported or inappropriate contractual allowances(1)								
Net operating revenues							3	0.01
Timing of revenue recognition(2)								
Net operating revenues	(1)		1		(1)		2	
Decrease in professional and general liability reserves(4)								
Other operating expenses	(2)				(2)			
Unsupported allowance for doubtful accounts(1)								
Provision for doubtful accounts					(1)			
Total adjustments to loss from discontinued operations, before income taxes	(3)		1		(4)	(0.01)	5	0.01
Income tax effect of discontinued operations adjustments	1				1		(2)	
Change in valuation allowance due to adjustments recorded(5)	(1)				(1)			
							(2)	
Total impact on net loss from discontinued operations	**(3)**		**1**		**(4)**	**(0.01)**	**3**	**0.01**
Net loss, as restated	**$ (33)**	**$ (0.07)**	**$ (423)**	**$ (0.91)**	**$ (37)**	**$ (0.08)**	**$ (542)**	**$ (1.16)**

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

Consolidated Statements of Operations

	Three Months Ended June 30		Six Months Ended June 30	
	2005	2004	2005	2004
Net operating revenues	**$ (1)**	**$ 5**	**$ 1**	**$ 7**
Operating expenses:				
Provision for doubtful accounts			9	
Other operating expenses	8		1	
Impairment of long-lived assets and goodwill, and restructuring charges		3		3
Income (loss) from continuing operations, before income taxes	**(9)**	**2**	**(9)**	**4**
Income tax (expense) benefit				(1)
Income (loss) from continuing operations, before discontinued operations	**(9)**	**2**	**(9)**	**3**
Discontinued operations:				
Income (loss) from operations of asset group	(3)	1	(4)	5
Income tax (expense) benefit				(2)
Income (loss) from discontinued operations	**(3)**	**1**	**(4)**	**3**

Net income (loss)	**$ (12)**	**$ 3**	**$ (13)**	**$ 6**
Basic and diluted earnings (loss) per common share				
Continuing operations	$ (0.03)	$	$ (0.02)	$ 0.01
Discontinued operations			(0.01)	0.01
	$ (0.03)	**$**	**$ (0.03)**	**$ 0.02**

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

Consolidated Balance Sheet

		June 30 2005
ASSETS		
Accounts receivable, less allowance for doubtful accounts(1)	$	(7)
Total current assets		(7)
Total assets	**$**	**(7)**
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)		(166)
Total shareholders equity		**(46)**
Total liabilities and shareholders equity	**$**	**(7)**

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

TENET HEALTHCARE CORPORATION
MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

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:

Effect of Hurricane Katrina Five of our hospitals in the New Orleans area and one hospital in Mississippi suffered considerable damage from Hurricane Katrina in late August 2005. As more fully described in Note 14 to the Condensed Consolidated Financial Statements, all but one of the hospitals required complete evacuation. Although we do not yet know the full extent of the damage or other financial impact caused by the hurricane on our Louisiana and Mississippi operations, we anticipate that the cost will be significant even after taking into account our existing insurance coverage for property, business interruption and other related coverage, and we will likely incur significant asset impairment charges.

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.

Appointment of New Chief Compliance Officer On July 7, 2005, we announced that Steven W. Ortquist was named senior vice president, ethics and compliance/chief compliance officer, a newly combined position, effective August 1, 2005. Prior to joining the Company, Steven was vice president, ethics and compliance/chief compliance officer at Banner Health in Phoenix and, before that, director of corporate compliance and assistant chief

compliance officer at Rush-Presbyterian-St. Luke s Medical Center in Chicago. He is certified in health care compliance by the Healthcare Compliance Certification Board.

Construction of New El Paso Hospital On August 18, 2005, we announced our plan to construct a new 100-bed acute care hospital in El Paso, Texas. Construction is expected to begin early next year at a cost of approximately $130 million, and the hospital is targeted to open in December 2007.

Approval of Stock Incentive Plan Amendment On May 26, 2005, our shareholders approved an amendment to our 2001 Stock Incentive Plan to allow a one-time exchange of certain outstanding employee stock options for a lesser number of restricted stock units. Directors, our four most senior executives and all former employees were not eligible to participate. Approximately 92% of the eligible stock options were exchanged for restricted stock units on July 1, 2005.

Sale of Brotman Medical Center On May 20, 2005, we entered into a definitive agreement for the previously announced sale of Brotman Medical Center in Culver City, California. The sale was completed on September 1, 2005. This hospital is one of the 27 hospitals whose intended divestiture we announced in January 2004. Net after-tax proceeds, including the liquidation of working capital, are estimated to be approximately $27 million.

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 Admissions and outpatient visits decreased from the prior year s second quarter on a total-hospital and 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 volumes will be negatively impacted in the third quarter and future

quarters as a result of the closures of our hospitals that were damaged by Hurricane Katrina in late August 2005.

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.

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.

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

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. Our future profitability depends on volume growth, reimbursement levels and cost control. Below are some of the financial highlights for the three months ended June 30, 2005 compared to the three months ended June 30, 2004:

Net inpatient revenue per patient day and per admission decreased by 2.2% and 2.6%, respectively, primarily due to the implementation of our discounting of self-pay charges under the Compact, phased in beginning in the second quarter of 2004, which had the effect of reducing net patient revenues, and changes in our payer mix from commercial managed care patients to Medicaid and Medicare managed care patients, which resulted in lower levels of reimbursement.

Outpatient visits and net outpatient revenue decreased by 8.6% and 4.3%, respectively, primarily due to the implementation of our discounting of self-pay charges under the Compact and the sale or closure of certain home health agencies, hospices and clinics beginning in the second quarter of 2004.

Cash provided by operating activities was $184 million during the three months ended June 30, 2005 compared to $144 million during the three months ended June 30, 2004.

Loss per diluted share from continuing operations decreased to $0.03 for the three months ended June 30, 2005 from a loss of $0.36 per diluted share for the three months ended June 30, 2004.

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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) costs of litigation and investigations, (4) net gains on sales of long-term investments, (5) loss from early extinguishment of debt, (6) adjustments to the valuation allowance for deferred tax assets and (7) reduction in our estimated income tax exposures for the three and six months ended June 30, 2005 and/or 2004:

	Three Months Ended June 30		Six Months Ended June 30	
	2005	2004	2005	2004
		Restated (See Note 15)		
		(Expense) Income		
Additional provision for doubtful accounts	$	$ (196)	$	$ (196)
Impairment and restructuring (charges) credits	4	(24)	(5)	(33)
Costs of litigation and investigations	(11)	(9)	(19)	(19)
Net gains on sales of long-term investments		6		6
Loss from early extinguishment of debt		(5)	(15)	(5)
Pretax impact	$ (7)	$ (228)	$ (39)	$ (247)
Deferred tax asset valuation allowance	$ (13)	$	$ 9	$
Reduction in estimated tax exposures	$ 23	$	$ 23	$
Total after-tax impact	$ 5	$ (140)	$ 7	$ (152)
Diluted per-share impact of above items	$ 0.01	$ (0.30)	$ 0.02	$ (0.33)
Diluted earnings per share, including above items	$ (0.03)	$ (0.36)	$ 0.02	$ (0.30)

LIQUIDITY AND CAPITAL RESOURCES OVERVIEW

Net cash provided by operating activities was $700 million in the six months ended June 30, 2005 compared to $85 million in the six months ended June 30, 2004. The principal reasons for the change were an income tax refund of $537 million received in March 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 six months ended June 30, 2005 and 2004 aggregated $117 million and $190 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 June 30, 2005, we had approximately $214 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 $1.6 billion of unrestricted cash and cash equivalents on hand as of June 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 2005 because overcoming many of these challenges will require time. These challenges include, but are not limited to, ongoing issues resulting from our prior pricing strategy, 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 by not only 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 closed facilities and surrounding local economies focus on recovery. In addition, we will likely incur significant asset impairment charges in connection with these facilities. 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 reached for the policy period April 1, 2005 through March 31, 2006. In order to minimize the future financial consequences if our flood limits are exhausted, we are pursuing purchasing a reinstatement of flood limits with our current insurance carriers or possibly purchasing replacement insurance coverage. We cannot provide assurances as to whether such reinstatement coverage will be available or whether we will be able to obtain such coverage on acceptable terms. If such flood policy limits should be 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 reinstatement or replacement 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.

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.

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.

Impacts 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, you 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 net patient revenues from all sources:

	Three Months Ended June 30			Six Months Ended June 30		
	2005	2004	Increase (Decrease)(1)	2005	2004	Increase (Decrease)(1)
				Restated (See Note 15)		
Medicare	27.2%	25.9%	1.3%	27.7%	25.9%	1.8%
Medicaid	8.3%	7.0%	1.3%	8.2%	7.2%	1.0%
Managed care(2)	50.2%	49.6%	0.6%	50.4%	49.6%	0.8%
Indemnity, self-pay and other	14.3%	17.5%	(3.2)%	13.7%	17.3%	(3.6)%

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

(2) Includes Medicare Advantage and Medicaid managed care.

GOVERNMENT PROGRAMS

The Medicare program, the nation s largest health insurance program, is administered by the Centers for Medicare and Medicaid Services (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:

Legislative and Regulatory Changes

Medicare Payment Advisory Commission (MedPAC) Recommendations

On March 8, 2005, the MedPAC released its *Report to Congress on Physician Owned Specialty Hospitals* as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The report discusses and makes recommendations on certain issues concerning physician-owned heart, orthopedic and surgical specialty hospitals, including the payment inequities caused by these limited-service facilities.

MedPAC made the following recommendations in the report:

The Secretary of the U.S. Department of Health and Human Services (Secretary) should improve payment accuracy in the hospital prospective payment system by:

Refining the current diagnosis-related groups (DRG) to more fully capture differences in severity of illness among patients;

Basing the DRG relative weights on the estimated cost of providing care, rather than on charges; and

Basing the weights on the national average of hospitals relative costs in each DRG.

Congress should amend the law to give the Secretary authority to adjust the DRG relative weights to account for differences in the prevalence of high-cost outlier cases.

Congress and the Secretary should implement the case-mix measurement and outlier policies over a transitional period.

Congress should extend the existing moratorium that prohibits the development of new limited-service facilities, such as specialty hospitals in which physicians have an ownership interest until January 1, 2007. The moratorium expired on June 8, 2005.

Congress should grant the Secretary the authority to allow gainsharing arrangements between physicians and hospitals and to regulate those arrangements to protect the quality of care and minimize financial incentives that could affect physician referrals.

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

2006 Federal Budget Proposal

On February 7, 2005, the White House released its 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 MedPAC proposal to address the payment inequities between acute care hospitals and limited-service specialty facilities in which physicians have an ownership interest and (2) a number of reform measures to the Medicaid program, which could reduce federal Medicaid spending, as well as proposed new spending initiatives designed to improve access to health insurance. 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. 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 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 six months ended June 30, 2005 (annualized), 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, 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 six months ended June 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, 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 six months ended June 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 June 30, 2005, we operated two inpatient rehabilitation hospitals, and 20 of our general hospitals operated inpatient rehabilitation units. 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.

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, 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.

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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 six months ended June 30, 2005 and 2004 are set forth in the table below:

	Three Months Ended June 30		Six Months Ended June 30	
Revenue Descriptions	**2005**	**2004**	**2005**	**2004**
Diagnosis-related group operating	$ 356	$ 341	$ 749	$ 721
Diagnosis-related group capital	36	37	77	78
Outlier	19	14	39	28
Outpatient	105	107	213	217
Disproportionate share	55	52	113	106
Direct Graduate and				