UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(MARK ONE)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended June 30, 2015

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number 1-10765

UNIVERSAL HEALTH SERVICES, INC.
(Exact name of registrant as specified in its charter)

DELAWARE	**23-2077891**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**

UNIVERSAL CORPORATE CENTER
367 SOUTH GULPH ROAD
KING OF PRUSSIA, PENNSYLVANIA 19406
(Address of principal executive offices) (Zip Code)

Registrant's telephone number, including area code (610) 768-3300

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 (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

Indicate the number of shares outstanding of each of the issuer's classes of common stock, as of the latest practicable date. Common shares outstanding, as of July 31, 2015:

Class A	6,595,308
Class B	91,736,432
Class C	663,940
Class D	27,862

UNIVERSAL HEALTH SERVICES, INC.

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This Quarterly Report on Form 10-Q is for the quarter ended June 30, 2015. This Report modifies and supersedes documents filed prior to this Report. Information that we file with the Securities and Exchange Commission (the "SEC") in the future will automatically update and supersede information contained in this Report.

In this Quarterly Report, "we," "us," "our" "UHS" and the "Company" refer to Universal Health Services, Inc. and its subsidiaries. UHS is a registered trademark of UHS of Delaware, Inc., the management company for, and a wholly-owned subsidiary of Universal Health Services, Inc. Universal Health Services, Inc. is a holding company and operates through its subsidiaries including its management company, UHS of Delaware, Inc. All healthcare and management operations are conducted by subsidiaries of Universal Health Services, Inc. To the extent any reference to "UHS" or "UHS facilities" in this report including letters, narratives or other forms contained herein relates to our healthcare or management operations it is referring to Universal Health Services, Inc.'s subsidiaries including UHS of Delaware, Inc. Further, the terms "we," "us," "our" or the "Company" in such context similarly refer to the operations of Universal Health Services Inc.'s subsidiaries including UHS of Delaware, Inc. Any reference to employees or employment contained herein refers to employment with or employees of the subsidiaries of Universal Health Services, Inc. including UHS of Delaware, Inc.

PART I. FINANCIAL INFORMATION

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF INCOME

(amounts in thousands, except per share amounts)
(unaudited)

	Three months ended June 30,		Six months ended June 30,	
	2015	2014	2015	2014
Net revenues before provision for doubtful accounts	$2,452,680	$2,227,721	$4,832,781	$4,374,219
Less: Provision for doubtful accounts	177,476	175,955	332,224	384,139
Net revenues	2,275,204	2,051,766	4,500,557	3,990,080
Operating charges:				
Salaries, wages and benefits	1,044,064	961,920	2,075,767	1,897,285
Other operating expenses	535,711	460,665	1,041,677	860,573
Supplies expense	240,979	223,774	479,720	439,572
Depreciation and amortization	97,257	90,691	196,255	184,050
Lease and rental expense	23,196	23,458	46,087	46,796
Electronic health records incentive income	(1,395)	(2,174)	(1,395)	(2,604)
	1,939,812	1,758,334	3,838,111	3,425,672
Income from operations	335,392	293,432	662,446	564,408
Interest expense, net	27,684	35,087	57,721	70,280
Income before income taxes	307,708	258,345	604,725	494,128
Provision for income taxes	106,304	91,731	208,998	175,662
Net income	201,404	166,614	395,727	318,466
Less: Income attributable to noncontrolling interests	19,211	14,943	39,235	28,717
Net income attributable to UHS	$ 182,193	$ 151,671	$ 356,492	$ 289,749
Basic earnings per share attributable to UHS	$ 1.84	$ 1.53	$ 3.60	$ 2.93
Diluted earnings per share attributable to UHS	$ 1.80	$ 1.51	$ 3.54	$ 2.89
Weighted average number of common shares - basic	99,004	98,872	98,957	98,722
Add: Other share equivalents	1,923	1,363	1,830	1,474
Weighted average number of common shares and equivalents - diluted	100,927	100,235	100,787	100,196

The accompanying notes are an integral part of these consolidated financial statements.

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME
(amounts in thousands, unaudited)

	Three months ended June 30,		Six months ended June 30,	
	2015	2014	2015	2014
Net income	$201,404	$166,614	$395,727	$318,466
Other comprehensive income (loss):				
Unrealized derivative gains on cash flow hedges	806	4,465	4,938	8,210
Amortization of terminated hedge	(84)	(84)	(168)	(168)
Foreign currency translation adjustment	2,626	0	2,208	0
Other comprehensive income before tax	3,348	4,381	6,978	8,042
Income tax expense related to items of other comprehensive income	715	1,620	2,212	2,974
Total other comprehensive income, net of tax	2,633	2,761	4,766	5,068
Comprehensive income	204,037	169,375	400,493	323,534
Less: Comprehensive income attributable to noncontrolling interests	19,211	14,943	39,235	28,717
Comprehensive income attributable to UHS	$184,826	$154,432	$361,258	$294,817

The accompanying notes are an integral part of these consolidated financial statements.

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED BALANCE SHEETS
(amounts in thousands, unaudited)

	June 30, 2015	December 31, 2014
Assets		
Current assets:		
Cash and cash equivalents	$ 42,464	$ 32,069
Accounts receivable, net	1,360,973	1,282,735
Supplies	109,117	108,115
Deferred income taxes	124,857	114,565
Other current assets	71,548	77,654
Total current assets	1,708,959	1,615,138
Property and equipment	6,371,767	6,212,030
Less: accumulated depreciation	(2,685,730)	(2,532,341)
	3,686,037	3,679,689
Other assets:		
Goodwill	3,316,945	3,291,213
Deferred charges	36,927	40,319
Other	329,691	348,084
	$ 9,078,559	$ 8,974,443
Liabilities and Stockholders' Equity		
Current liabilities:		
Current maturities of long-term debt	$ 73,807	$ 68,319
Accounts payable and accrued liabilities	1,096,081	1,113,062
Federal and state taxes	24,423	1,446
Total current liabilities	1,194,311	1,182,827
Other noncurrent liabilities	279,281	268,555
Long-term debt	2,961,515	3,210,215
Deferred income taxes	271,109	282,214
Redeemable noncontrolling interests	250,533	239,552
Equity:		
UHS common stockholders' equity	4,061,756	3,735,946
Noncontrolling interest	60,054	55,134
Total equity	4,121,810	3,791,080
	$ 9,078,559	$ 8,974,443

The accompanying notes are an integral part of these consolidated financial statements.

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(amounts in thousands, unaudited)

	Six months ended June 30,	
	2015	2014
Cash Flows from Operating Activities:		
Net income	$ 395,727	$ 318,466
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation & amortization	196,255	184,050
Stock-based compensation expense	20,474	14,945
Gains on sales of assets and businesses, net of losses	0	(10,134)
Changes in assets & liabilities, net of effects from acquisitions and dispositions:		
Accounts receivable	(95,013)	(61,865)
Accrued interest	(1,520)	(271)
Accrued and deferred income taxes	10,870	(9,435)
Other working capital accounts	(10,899)	17,739
Other assets and deferred charges	4,074	10,415
Other	2,163	(4,092)
Accrued insurance expense, net of commercial premiums paid	50,511	38,520
Payments made in settlement of self-insurance claims	(41,039)	(39,922)
Net cash provided by operating activities	531,603	458,416
Cash Flows from Investing Activities:		
Property and equipment additions, net of disposals	(170,580)	(186,786)
Proceeds received from sale of assets and businesses	0	11,450
Acquisition of property and businesses	(34,500)	(71,000)
Costs incurred for purchase and implementation of electronic health records application	0	(8,399)
Net cash used in investing activities	(205,080)	(254,735)
Cash Flows from Financing Activities:		
Reduction of long-term debt	(255,658)	(179,126)
Additional borrowings	5,200	0
Repurchase of common shares	(68,157)	(35,773)
Dividends paid	(19,804)	(9,884)
Issuance of common stock	4,039	3,287
Excess income tax benefits related to stock-based compensation	28,489	28,493
Profit distributions to noncontrolling interests	(23,295)	(13,184)
Proceeds received from sale/leaseback of real property	12,765	0
Net cash used in financing activities	(316,421)	(206,187)
Effect of exchange rate changes on cash and cash equivalents	293	0
Increase (decrease) in cash and cash equivalents	10,395	(2,506)
Cash and cash equivalents, beginning of period	32,069	17,238
Cash and cash equivalents, end of period	$ 42,464	$ 14,732
Supplemental Disclosures of Cash Flow Information:		
Interest paid	$ 55,718	$ 60,078
Income taxes paid, net of refunds	$ 166,637	$ 156,434
Noncash purchases of property and equipment	$ 34,488	$ 58,020

The accompanying notes are an integral part of these consolidated financial statements.

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(1) General

This Quarterly Report on Form 10-Q is for the quarterly period ended June 30, 2015. In this Quarterly Report, "we," "us," "our" "UHS" and the "Company" refer to Universal Health Services, Inc. and its subsidiaries.

The condensed consolidated financial statements include the accounts of our majority-owned subsidiaries and partnerships and limited liability companies controlled by us, or our subsidiaries, as managing general partner or managing member. The condensed consolidated financial statements included herein have been prepared by us, without audit, pursuant to the rules and regulations of the Securities and Exchange Commission ("SEC") and reflect all adjustments (consisting only of normal recurring adjustments) which, in our opinion, are necessary to fairly state results for the interim periods. Certain information and footnote disclosures normally included in financial statements prepared in accordance with accounting principles generally accepted in the United States of America have been condensed or omitted pursuant to such rules and regulations, although we believe that the accompanying disclosures are adequate to make the information presented not misleading. These condensed consolidated financial statements should be read in conjunction with the consolidated financial statements, significant accounting policies and the notes thereto included in our Annual Report on Form 10-K for the year ended December 31, 2014.

Provider Taxes: We incur health-care related taxes ("Provider Taxes") imposed by states in the form of a licensing fee, assessment or other mandatory payment which are related to: (i) healthcare items or services; (ii) the provision of, or the authority to provide, the health care items or services, or; (iii) the payment for the health care items or services. Such Provider Taxes are subject to various federal regulations that limit the scope and amount of the taxes that can be levied by states in order to secure federal matching funds as part of their respective state Medicaid programs. We derive a related Medicaid reimbursement benefit from assessed Provider Taxes in the form of Medicaid claims based payment increases and/or lump sum Medicaid supplemental payments.

Under these programs, including the impact of Uncompensated Care and Upper Payment Limit programs, and the Texas Delivery System Reform Incentive program, we earned revenues (before Provider Taxes) of approximately $92 million and $75 million during the three-month periods ended June 30, 2015 and 2014, respectively, and approximately $159 million and $124 million during the six-month periods ended June 30, 2015 and 2014, respectively. These revenues were offset by Provider Taxes of approximately $39 million and $32 million during the three-month periods ended June 30, 2015 and 2014, respectively, and approximately $67 million and $50 million during the six-month periods ended June 30, 2015 and 2014, respectively, which are recorded in other operating expenses on the Condensed Consolidated Statements of Income as included herein. Prior to 2015, these Provider Taxes were recorded as a reduction to our net revenues. Accordingly, the unaudited Condensed Consolidated Statements of Income for the three and six-month periods ended June 30, 2014 have been revised to reflect the current period classification, resulting in an increase in net revenue and an increase in other operating expenses of $32 million and $50 million, respectively. We assessed this adjustment to the classification and concluded that it was not material to our previously issued annual and quarterly Consolidated Statements of Income, which will be revised in future filings.

(2) Relationship with Universal Health Realty Income Trust and Related Party Transactions

Relationship with Universal Health Realty Income Trust:

Universal Health Realty Income Trust (the "Trust") commenced operations in 1986 by purchasing certain properties from us and immediately leasing the properties back to our respective subsidiaries. Most of the leases were entered into at the time the Trust commenced operations and provided for initial terms of 13 to 15 years with up to six additional 5-year renewal terms. Each lease also provided for additional or bonus rental, as discussed below. The base rents are paid monthly and the bonus rents are computed and paid on a quarterly basis, based upon a computation that compares current quarter revenue to a corresponding quarter in the base year. The leases with our subsidiaries are unconditionally guaranteed by us and are cross-defaulted with one another.

At June 30, 2015, we held approximately 5.9% of the outstanding shares of the Trust. We serve as Advisor to the Trust under an annually renewable advisory agreement pursuant to the terms of which we conduct the Trust's day-to-day affairs, provide administrative services and present investment opportunities. In addition, certain of our officers and directors are also officers and/or directors of the Trust. Management believes that it has the ability to exercise significant influence over the Trust, therefore we account for our investment in the Trust using the equity method of accounting.

We earned an advisory fee from the Trust, which is included in net revenues in the accompanying consolidated statements of income, of approximately $700,000 and $600,000 during the three-month periods ended June 30, 2015 and 2014, respectively, and approximately $1.4 million and $1.2 million during the six-month periods ended June 30, 2015 and 2014, respectively. Our pre-tax share of income from the Trust was approximately $800,000 and $100,000 during the three-month periods ended June 30, 2015 and 2014, respectively, and approximately $1.0 million and $400,000 for the six-month periods ended June 30, 2015 and 2014,

respectively. Included in our share of the Trust's income for the three and six months ended June 30, 2015, is our share of a gain realized by the Trust in connection with a property exchange transaction completed during the second quarter of 2015. The carrying value of this investment was approximately $9.3 million at each of June 30, 2015 and December 31, 2014, and is included in other assets in the accompanying consolidated balance sheets. The market value of our investment in the Trust was $36.6 million at June 30, 2015 and $37.9 million at December 31, 2014, based on the closing price of the Trust's stock on the respective dates.

During the first quarter of 2015, wholly-owned subsidiaries of ours sold to and leased back from the Trust, two recently constructed free-standing emergency departments ("FEDs") located in Texas which were completed and opened during the first quarter of 2015. In conjunction with these transactions, ten-year lease agreements with six, five-year renewal options have been executed with the Trust. We have the option to purchase the properties upon the expiration of the fixed terms and each five-year renewal terms at the fair market value of the property. The aggregate construction cost/sales proceeds of these facilities was approximately $13 million, and the aggregate rent expense paid to the Trust at the commencement of the leases will approximate $900,000 annually.

In December, 2014, upon the expiration of the lease term, we elected to purchase from the Trust for $17.3 million, the real property of The Bridgeway, a 103-bed behavioral health care facility located in North Little Rock, Arkansas. Pursuant to the terms of the lease, we and the Trust were both required to obtain appraisals of the property to determine its fair market value/purchase price. The rent expense paid by us to the Trust, prior to our purchase of The Bridgeway's real property in December, 2014, was approximately $1.1 million annually.

The table below details the renewal options and terms for each of our three acute care hospital facilities leased from the Trust as of June 30, 2015:

Hospital Name	Annual Minimum Rent	End of Lease Term	Renewal Term (years)
McAllen Medical Center	$5,485,000	December, 2016	15(a)
Wellington Regional Medical Center	$3,030,000	December, 2016	15(b)
Southwest Healthcare System, Inland Valley Campus	$2,648,000	December, 2016	15(b)

(a) We have three 5-year renewal options at existing lease rates (through 2031).
(b) We have one 5-year renewal option at existing lease rates (through 2021) and two 5-year renewal options at fair market value lease rates (2022 through 2031).

Total rent expense under the operating leases on these three hospital facilities was approximately $4 million during each of the three months ended June 30, 2015 and 2014, and approximately $8 million for each of the six-month periods ended June 30, 2015 and 2014. In addition, certain of our subsidiaries are tenants in several medical office buildings and two FEDs (as discussed above) owned by the Trust or by limited liability companies in which the Trust holds 100% of the ownership interest.

Pursuant to the terms of the three hospital leases with the Trust, we have the option to renew the leases at the lease terms described above by providing notice to the Trust at least 90 days prior to the termination of the then current term. We also have the right to purchase the respective leased hospitals at the end of the lease terms or any renewal terms at their appraised fair market value as well as purchase any or all of the three leased hospital properties at their appraised fair market value upon one month's notice should a change of control of the Trust occur. In addition, we have rights of first refusal to: (i) purchase the respective leased facilities during and for 180 days after the lease terms at the same price, terms and conditions of any third-party offer, or; (ii) renew the lease on the respective leased facility at the end of, and for 180 days after, the lease term at the same terms and conditions pursuant to any third-party offer.

Other Related Party Transactions:

In December, 2010, our Board of Directors approved the Company's entering into supplemental life insurance plans and agreements on the lives of our chief executive officer ("CEO") and his wife. As a result of these agreements, based on actuarial tables and other assumptions, during the life expectancies of the insureds, we would pay approximately $25 million in premiums, and certain trusts owned by our chief executive officer, would pay approximately $8 million in premiums. Based on the projected premiums mentioned above, and assuming the policies remain in effect until the death of the insureds, we will be entitled to receive death benefit proceeds of no less than $33 million representing the $25 million of aggregate premiums paid by us as well as the $8 million of aggregate premiums paid by the trusts. During 2014 we paid approximately $1.3 million in premium payments and expect to pay similar amounts during 2015.

A member of our Board of Directors and member of the Executive Committee is Of Counsel to the law firm used by us as our principal outside counsel. This Board member is also the trustee of certain trusts for the benefit of our CEO and his family. This law firm also provides personal legal services to our CEO.

(3) Other Noncurrent liabilities and Redeemable/Noncontrolling Interests

Other noncurrent liabilities include the long-term portion of our professional and general liability, workers' compensation reserves, pension and deferred compensation liabilities, and a liability incurred in connection with split-dollar life insurance agreements on the lives of our chief executive officer and his wife.

Outside owners hold noncontrolling, minority ownership interests of: (i) approximately 28% in our five acute care facilities (and one additional facility currently under construction) located in Las Vegas, Nevada; (ii) 20% in an acute care facility located in Washington, D.C.; (iii) approximately 11% in an acute care facility located in Laredo, Texas, and; (iv) 20% in a behavioral health care facility located in Philadelphia, Pennsylvania. The redeemable noncontrolling interest balances of $251 million as of June 30, 2015 and $240 million as of December 31, 2014, and the noncontrolling interest balances of $60 million as of June 30, 2015 and $55 million as of December 31, 2014, consist primarily of the third-party ownership interests in these hospitals.

In connection with five acute care facilities (and an additional facility currently under construction) located in Las Vegas, Nevada, the minority ownership interests of which are reflected as redeemable noncontrolling interests on our Consolidated Balance Sheet, the outside owners have certain "put rights" that, if exercisable, and if exercised, require us to purchase the minority member's interests at fair market value. The put rights are exercisable upon the occurrence of: (i) certain specified financial conditions falling below established thresholds; (ii) breach of the management contract by the managing member (a subsidiary of ours), or; (iii) if the minority member's ownership percentage is reduced to less than certain thresholds. In connection with a behavioral health care facility located in Philadelphia, Pennsylvania and acquired by us as part of the PSI acquisition, the minority ownership interest of which is also reflected as redeemable noncontrolling interests on our Consolidated Balance Sheet, the outside owner has a "put option" to put its entire ownership interest to us at any time. If exercised, the put option requires us to purchase the minority member's interest at fair market value.

(4) Long-term debt and cash flow hedges

Debt:

During the third quarter of 2014, we completed the following financing transactions:

- In August, 2014, we entered into a fourth amendment to our credit agreement dated as of November 15, 2010, as amended ("Credit Agreement"). The Credit Agreement, which is scheduled to mature in August, 2019, consists of: (i) an $800 million revolving credit facility (no borrowings outstanding as of June 30, 2015), and; (ii) a $1.775 billion term loan A facility ($1.742 billion of borrowings outstanding as of June 30, 2015) which combined our previously outstanding term loan A and term loan A2 facilities which were scheduled to mature in 2016;
- Repaid $550 million of outstanding borrowings pursuant to our previously outstanding term loan B facility which was scheduled to mature in 2016;
- Increased the borrowing capacity on our existing accounts receivable securitization program ("Securitization") to $360 million from $275 million, effective August 1, 2014. The Securitization, the terms of which remain the same as the previous agreement, as discussed below, is scheduled to mature in October, 2016;
- Issued $300 million aggregate principal amount of 3.750% senior secured notes due in 2019 (see below for additional disclosure);
- Issued $300 million aggregate principal amount of 4.750% senior secured notes due in 2022 (see below for additional disclosure);
- Redeemed our previously outstanding $250 million, 7.00% senior unsecured notes due in 2018 on July 31, 2014 for an aggregate price equal to 104.56% of the principal amount.

Borrowings under the Credit Agreement bear interest at either (1) the ABR rate which is defined as the rate per annum equal to, at our election: the greatest of (a) the lender's prime rate, (b) the weighted average of the federal funds rate, plus 0.5% and (c) one month LIBOR rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.50% to 1.25% for revolving credit and term loan-A borrowings, or (2) the one, two, three or six month LIBOR rate (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.50% to 2.25% for revolving credit and term loan-A borrowings. As of June 30, 2015, the applicable margins were 0.50% for ABR-based loans, 1.50% for LIBOR-based loans under the revolving credit and term loan-A facilities.

As of June 30, 2015, we had no borrowings outstanding pursuant to the terms of our $800 million revolving credit facility and we had $755 million of available borrowing capacity, net of $6 million of outstanding borrowings pursuant to a short-term, on-demand credit facility and $39 million of outstanding letters of credit. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Credit Agreement is secured by certain assets of the Company and our material subsidiaries and guaranteed by our material subsidiaries.

Pursuant to the terms of the Credit Agreement, term loan-A quarterly installment payments of approximately: (i) $11 million commenced during the fourth quarter of 2014 and are scheduled to continue through September, 2016, and; (ii) $22 million are scheduled from the fourth quarter of 2016 through June, 2019.

As discussed above, on August 1, 2014, our accounts receivable securitization program ("Securitization"), with a group of conduit lenders and liquidity banks which is scheduled to mature in October, 2016, was amended to increase the borrowing capacity to $360 million from $275 million. Substantially all of the patient-related accounts receivable of our acute care hospitals ("Receivables") serve as collateral for the outstanding borrowings. We have accounted for this Securitization as borrowings. We maintain effective control over the Receivables since, pursuant to the terms of the Securitization, the Receivables are sold from certain of our subsidiaries to special purpose entities that are wholly-owned by us. The Receivables, however, are owned by the special purpose entities, can be used only to satisfy the debts of the wholly-owned special purpose entities, and thus are not available to us except through our ownership interest in the special purpose entities. The wholly-owned special purpose entities use the Receivables to collateralize the loans obtained from the group of third-party conduit lenders and liquidity banks. The group of third-party conduit lenders and liquidity banks do not have recourse to us beyond the assets of the wholly-owned special purpose entities that securitize the loans. At June 30, 2015, we had $240 million of outstanding borrowings and $120 million of additional capacity pursuant to the terms of our accounts receivable securitization program.

On August 7, 2014, we issued $300 million aggregate principal amount of 3.750% Senior Secured Notes due 2019 (the "2019 Notes") and $300 million aggregate principal amount of 4.750% Senior Secured Notes due 2022 (the "2022 Notes", and together with the 2019 Notes, the "New Senior Secured Notes"). The New Senior Secured Notes were offered only to qualified institutional buyers under Rule 144A and to non-U.S. persons outside the United States in reliance on Regulation S under the Securities Act of 1933, as amended (the "Securities Act"). The New Senior Secured Notes have not been registered under the Securities Act and may not be offered or sold in the United States absent registration or an applicable exemption from registration requirements. Interest is payable on the New Senior Secured Notes on February 1 and August 1 of each year to the holders of record at the close of business on the January 15 and July 15 immediately preceding the related interest payment dates, commencing on February 1, 2015 until the maturity date of August 1, 2019 for the 2019 Notes and August 1, 2022 for the 2022 Notes.

On June 30, 2006, we issued $250 million of senior secured notes which have a 7.125% coupon rate and mature on June 30, 2016 (the "7.125% Notes"). Interest on the 7.125% Notes is payable semiannually in arrears on June 30th and December 30th of each year. In June, 2008, we issued an additional $150 million of 7.125% Notes which formed a single series with the original 7.125% Notes issued in June, 2006. Other than their date of issuance and initial price to the public, the terms of the 7.125% Notes issued in June, 2008 are identical to and trade interchangeably with, the 7.125% Notes which were originally issued in June, 2006.

On July 31, 2014, we redeemed the $250 million, 7.00% senior unsecured notes (the "Unsecured Notes"), which were scheduled to mature on October 1, 2018, at a redemption price equal to 104.56% of the principal amount of the Unsecured Notes resulting in a make-whole premium payment of approximately $11 million. The Unsecured Notes were issued on September 29, 2010 and registered in April, 2011. Interest on the Unsecured Note was payable semiannually in arrears on April 1st and October 1st of each year.

In connection with entering into the previous Credit Agreement on November 15, 2010, and in accordance with the Indenture dated January 20, 2000 governing the rights of our existing notes, we entered into a supplemental indenture pursuant to which our 7.125% Notes (due in 2016) were equally and ratably secured with the lenders under the Credit Agreement with respect to the collateral for so long as the lenders under the Credit Agreement are so secured.

Our Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens and indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage and minimum interest coverage ratios. We are in compliance with all required covenants as of June 30, 2015.

As of June 30, 2015, the carrying value of our debt was $3.0 billion and the fair-value of our debt was $3.1 billion. The fair value of our debt was computed based upon quotes received from financial institutions. We consider these to be "level 2" in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with debt instruments.

Cash Flow Hedges:

We manage our ratio of fixed and floating rate debt with the objective of achieving a mix that management believes is appropriate. To manage this risk in a cost-effective manner, we, from time to time, enter into interest rate swap agreements in which we agree to exchange various combinations of fixed and/or variable interest rates based on agreed upon notional amounts. We account for our derivative and hedging activities using the Financial Accounting Standard Board's ("FASB") guidance which requires all derivative instruments, including certain derivative instruments embedded in other contracts, to be carried at fair value on the balance sheet. For derivative transactions designated as hedges, we formally document all relationships between the hedging instrument and the related hedged item, as well as its risk-management objective and strategy for undertaking each hedge transaction.

Derivative instruments designated in a hedge relationship to mitigate exposure to variability in expected future cash flows, or other types of forecasted transactions, are considered cash flow hedges. Cash flow hedges are accounted for by recording the fair value of the derivative instrument on the balance sheet as either an asset or liability, with a corresponding amount recorded in accumulated other comprehensive income ("AOCI") within shareholders' equity. Amounts are reclassified from AOCI to the income statement in the period or periods the hedged transaction affects earnings. We use interest rate derivatives in our cash flow hedge transactions. Such derivatives are designed to be highly effective in offsetting changes in the cash flows related to the hedged liability. For derivative instruments designated as cash flow hedges, the ineffective portion of the change in expected cash flows of the hedged item are recognized currently in the income statement.

For hedge transactions that do not qualify for the short-cut method, at the hedge's inception and on a regular basis thereafter, a formal assessment is performed to determine whether changes in the fair values or cash flows of the derivative instruments have been highly effective in offsetting changes in cash flows of the hedged items and whether they are expected to be highly effective in the future.

The fair value of interest rate swap agreements approximates the amount at which they could be settled, based on estimates obtained from the counterparties. We assess the effectiveness of our hedge instruments on a quarterly basis. We performed periodic assessments of the cash flow hedge instruments during 2014 and the first six months of 2015 and determined the hedges to be highly effective. We also determined that any portion of the hedges deemed to be ineffective was de minimis and therefore there was no material effect on our consolidated financial position, operations or cash flows. The counterparties to the interest rate swap agreements expose us to credit risk in the event of nonperformance. However, at June 30, 2015 and December 31, 2014, each swap agreement entered into by us was in a net liability position which would require us to make the settlement payments to the counterparties. We do not anticipate nonperformance by our counterparties. We do not hold or issue derivative financial instruments for trading purposes.

Seven interest rate swaps on a total notional amount of $825 million matured in May, 2015. Four of these swaps, with a total notional amount of $600 million, became effective in December, 2011 and provided that we receive three-month LIBOR while the average fixed rate payable was 2.38%. The remaining three swaps, with a total notional amount of $225 million, became effective in March, 2011 and provided that we receive three-month LIBOR while the average fixed rate payable was 1.91%.

During the second quarter of 2015, we entered into four forward starting interest rate swaps whereby we pay a fixed rate on a total notional amount of $500 million and receive one-month LIBOR. Each of the four swaps became effective on July 15, 2015 and are scheduled to mature on April 15, 2019. The average fixed rate payable on these swaps is 1.40%.

In July, 2015, we entered into two additional forward starting interest rate swaps whereby we pay a fixed rate on a total notional amount of $200 million and receive one-month LIBOR. One swap on a notional amount of $100 million became effective on July 15, 2015 and another swap on a notional amount of $100 million becomes effective on September 15, 2015. Both of these swaps are scheduled to mature on April 15, 2019. The average fixed rate payable on these two swaps is 1.30%.

We measure our interest rate swaps at fair value on a recurring basis. The fair value of our interest rate swaps is based primarily on quotes from banks. We consider those inputs to be "level 2" in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with derivative instruments and hedging activities. The fair value of our interest rate swaps was a net liability of $2 million at June 30, 2015, of which $5 million is included in other current liabilities, partially offset by a $3 million asset which is included in other assets. The fair value of our interest rate swaps was a liability of $6 million at December 31, 2014, all of which is included in other current liabilities.

(5) Commitments and Contingencies

Professional and General Liability and Workers Compensation Liability:

Effective November, 2010, excluding certain subsidiaries acquired since 2010 as discussed below, the vast majority of our subsidiaries are self-insured for professional and general liability exposure up to $10 million and $3 million per occurrence, respectively. Our subsidiaries were provided with several excess policies through commercial insurance carriers which provide for coverage in excess of the applicable per occurrence self-insured retention (either $3 million or $10 million) up to $250 million per occurrence and in the aggregate for claims incurred in 2014 and up to $200 million per occurrence and in the aggregate for claims incurred from 2011 through 2013. We remain liable for 10% of the claims paid pursuant to the commercially insured coverage in excess of $10 million up to $60 million per occurrence and in the aggregate.

Since our acquisition of Psychiatric Solutions, Inc. (“PSI”) in November, 2010, the former PSI subsidiaries are self-insured for professional and general liability exposure up to $3 million per occurrence. The nine behavioral health facilities acquired from Ascend Health Corporation (“Ascend”) in October, 2012 have general and professional liability policies through commercial insurance carriers which provide for up to $12 million of aggregate coverage, subject to a $100,000 per occurrence deductible. The 17 facilities acquired from Cygnet Health Care Limited (“Cygnet”), consisting of 15 inpatient behavioral health hospitals and 2 nursing homes, have policies through a commercial insurance carrier located in the United Kingdom that provides for £10 million of professional liability coverage and £25 million of general liability coverage. The facilities acquired from PSI, Ascend and Cygnet, like our other facilities, are also provided excess coverage through commercial insurance carriers for coverage in excess of the underlying commercial policy limitations, as mentioned above.

Our estimated liability for self-insured professional and general liability claims is based on a number of factors including, among other things, the number of asserted claims and reported incidents, estimates of losses for these claims based on recent and historical settlement amounts, estimates of incurred but not reported claims based on historical experience, and estimates of amounts recoverable under our commercial insurance policies. While we continuously monitor these factors, our ultimate liability for professional and general liability claims could change materially from our current estimates due to inherent uncertainties involved in making this estimate. Given our significant self-insured exposure for professional and general liability claims, there can be no assurance that a sharp increase in the number and/or severity of claims asserted against us will not have a material adverse effect on our future results of operations.

As of June 30, 2015, the total accrual for our professional and general liability claims was $201 million, of which $51 million is included in current liabilities. As of December 31, 2014, the total accrual for our professional and general liability claims was $193 million, of which $51 million is included in current liabilities.

As of June 30, 2015, the total accrual for our workers’ compensation liability claims was $68 million, of which $32 million is included in current liabilities. As of December 31, 2014, the total accrual for our workers’ compensation liability claims was $67 million, of which $32 million is included in current liabilities.

Property Insurance:

We have commercial property insurance policies for our properties covering catastrophic losses, including windstorm damage, up to a $1 billion policy limit per occurrence, subject to a deductible ranging from $50,000 to $250,000 per occurrence. Losses resulting from named windstorms are subject to deductibles between 3% and 5% of the declared total insurable value of the property. In addition, we have commercial property insurance policies covering catastrophic losses resulting from earthquake and flood damage, each subject to aggregated loss limits (as opposed to per occurrence losses). Our earthquake limit is $250 million, subject to a deductible of $250,000, except for facilities located within documented fault zones. Earthquake losses that affect facilities located in fault zones within the United States are subject to a $100 million limit and will have applied deductibles ranging from 1% to 5% of the declared total insurable value of the property. The earthquake limit in Puerto Rico is $25 million, subject to a $25,000 deductible. Non-critical flood losses have either a $250,000 or $500,000 deductible, based upon the location of the facility. Since certain of our facilities have been designated by our insurer as flood prone, we have elected to purchase policies from The National Flood Insurance Program to cover a substantial portion of the applicable deductible. Property insurance for the facilities acquired from Cygnet are provided on an all risk basis up to a £180 million limit that includes coverage for real and personal property as well as business interruption losses.

Other

Our accounts receivable as of June 30, 2015 and December 31, 2014 include amounts due from Illinois of approximately $24 million and $44 million, respectively. Collection of the outstanding receivables continues to be delayed due to state budgetary and funding pressures. Approximately $8 million as of June 30, 2015 and $23 million as of December 31, 2014, of the receivables due from Illinois were outstanding in excess of 60 days, as of each respective date. In addition, our accounts receivable as of June 30, 2015 and December 31, 2014 includes approximately $97 million and $102 million, respectively, due from Texas in connection with Medicaid supplemental payment programs. The $97 million due from Texas as of June 30, 2015 consists of $52 million related to uncompensated care program revenues, $27 million related to disproportionate share hospital program revenues and $18 million to Delivery Service Reform Incentive Payment program revenues. Although the accounts receivable due from Illinois and Texas could remain outstanding for the foreseeable future, since we expect to eventually collect all amounts due to us, no related reserves have been established in our consolidated financial statements. However, we can provide no assurance that we will eventually collect all amounts due to us from Illinois and/or Texas. Failure to ultimately collect all outstanding amounts due from these states would have an adverse impact on our future consolidated results of operations and cash flows.

As of June 30, 2015 we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds which totaled $118 million consisting of: (i) $96 million related to our self-insurance programs, and; (ii) $22 million of other debt and public utility guarantees.

Legal Proceedings

We are subject to claims and suits in the ordinary course of business, including those arising from care and treatment afforded by our hospitals and are party to various government investigations, regulatory matters and litigation, as outlined below.

Office of Inspector General ("OIG") and Government Investigations:

In September, 2010, we, along with many other companies in the healthcare industry, received a letter from the United States Department of Justice ("DOJ") advising of a False Claim Act investigation being conducted in connection with the implantation of implantable cardioverter defibrillators ("ICDs") from 2003 to 2010 at several of our acute care facilities. The DOJ alleges that ICDs were implanted and billed by our facilities in contravention of a National Coverage Determination regarding these devices. We had previously established a reserve in connection with this matter which did not have a material impact on our consolidated financial statements. During the second quarter of 2015, we finalized a settlement agreement with the government which approximated our established reserve.

In February, 2013, the Office of Inspector General for the United States Department of Health and Human Services ("OIG") served a subpoena requesting various documents from January, 2008 to the date of the subpoena directed at Universal Health Services, Inc. ("UHS") concerning it and UHS of Delaware, Inc., and several UHS owned behavioral health facilities including: Keys of Carolina, Old Vineyard Behavioral Health, The Meadows Psychiatric Center, Streamwood Behavioral Health, Hartgrove Hospital, Rock River Academy and Residential Treatment Center, Roxbury Treatment Center, Harbor Point Behavioral Health Center, f/k/a, The Pines Residential Treatment Center, including the Crawford, Brighton and Kempsville campuses, Wekiva Springs Center and River Point Behavioral Health. Prior to receiving this subpoena: (i) the Keys of Carolina and Old Vineyard received notification during the second half of 2012 from the DOJ of its intent to proceed with an investigation following requests for documents for the period of January, 2007 to the date of the subpoenas from the North Carolina state Attorney General's Office; (ii) Harbor Point Behavioral Health Center received a subpoena in December, 2012 from the Attorney General of the Commonwealth of Virginia requesting various documents from July, 2006 to the date of the subpoena, and; (iii) The Meadows Psychiatric Center received a subpoena from the OIG in February, 2013 requesting certain documents from 2008 to the date of the subpoena. Unrelated to these matters, the Keys of Carolina was closed and the real property was sold in January, 2013. We were advised that a qui tam action had been filed against Roxbury Treatment Center but the government declined to intervene and the case was dismissed.

In April, 2013, the OIG served facility specific subpoenas on Wekiva Springs Center and River Point Behavioral Health requesting various documents from January, 2005 to the date of the subpoenas. In July, 2013, another subpoena was issued to Wekiva Springs Center and River Point Behavioral Health requesting additional records. In October, 2013, we were advised by the DOJ's Criminal Frauds Section that they received a referral from the DOJ Civil Division and opened an investigation of River Point Behavioral Health and Wekiva Springs Center. Subsequent subpoenas have since been issued to River Point Behavioral Health and Wekiva Springs Center requesting additional documentation. In April, 2014, the Centers for Medicare and Medicaid Services ("CMS") instituted a Medicare payment suspension at River Point Behavioral Health in accordance with federal regulations regarding suspension of payments during certain investigations. The Florida Agency for Health Care Administration subsequently issued a Medicaid payment suspension for the facility. River Point Behavioral Health submitted a rebuttal statement disputing the basis of the suspension and requesting revocation of the suspension. Notwithstanding, CMS continued the payment suspension. River Point Behavioral Health provided additional information to CMS in an effort to obtain relief from the payment suspension but the suspension remains in effect. In March 2015, we received notification from CMS that the payment suspension will be continued for another 180 days. We cannot predict if and/or when the facility's suspended payments will resume. Although the operating results of River Point Behavioral Health did not have a material impact on our consolidated results of operations during the six-month period ended June 30, 2015 or the year ended December 31, 2014, the payment suspension has had a material adverse effect on the facility's results of operations and financial condition.

In June, 2013, the OIG served a subpoena on Coastal Harbor Health System in Savannah, Georgia requesting documents from January, 2009 to the date of the subpoena.

In February, 2014, we were notified that the investigation conducted by the Criminal Frauds Section had been expanded to include the National Deaf Academy. In March, 2014, a Civil Investigative Demand ("CID") was served on the National Deaf Academy requesting documents and information from the facility from January 1, 2008 through the date of the CID. We have been advised by the government that the National Deaf Academy has been added to the facilities which are the subject of the coordinated investigation referenced above.

In March, 2014, CIDs were served on Hartgrove Hospital, Rock River Academy and Streamwood Behavioral Health requesting documents and information from those facilities from January, 2008 through the date of the CID.

In September, 2014, the DOJ Civil Division advised us that they were expanding their investigation to include four additional facilities and were requesting production of documents from these facilities. These facilities are Arbour-HRI Hospital, Behavioral Hospital of Bellaire, St. Simons by the Sea, and Turning Point Care Center.

In December 2014, the DOJ Civil Division requested that Salt Lake Behavioral Health produce documents responsive to the original subpoenas issued in February, 2013.

In March, 2015, the OIG issued subpoenas to Central Florida Behavioral Hospital and University Behavioral Center requesting certain documents from January, 2008 to the date of the subpoena.

In late March, 2015, we were notified that the investigation conducted by the Criminal Frauds Section has been expanded to include UHS as a corporate entity arising out of the coordinated investigation of the facilities described above and, in particular, Hartgrove Hospital.

The DOJ has advised us that the civil aspect of the coordinated investigation referenced above is a False Claim Act investigation focused on billings submitted to government payers in relation to services provided at those facilities. At present, we are uncertain as to potential liability and/or financial exposure of the Company and/or named facilities, if any, in connection with these matters.

Regulatory Matters:

On July 23, 2015, Timberlawn Mental Health System ("Timberlawn") received notification from CMS of its intent to terminate Timberlawn's Medicare provider agreement effective August 7, 2015. This notification resulted from surveys conducted which allege that Timberlawn is out of compliance with conditions of participation required for participation in the Medicare/Medicaid program. Some of the deficiencies were considered by CMS to be an "immediate jeopardy" situation. We have filed a request for expedited administrative appeal with the U.S. Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, seeking review and reversal of the termination action. In conjunction with the administrative appeal, we have filed litigation in the U.S District Court for the Northern District of Texas seeking a temporary restraining order and preliminary injunction to have the termination stayed pending the conclusion of the administrative appeal. The termination date has been extended to August 13, 2015 pending further review and rulings by the U.S. District Court. We can provide no assurance that we will be successful in the administrative appeal or litigation or that Timberlawn will not ultimately lose its Medicare/Medicaid certification. Any such termination of Timerlawn's Medicare/Medicaid certification, should it ultimately occur, would have a material adverse effect on the facility's future results of operations and financial condition and could result in closure of the facility. The operating results of Timberlawn did not have a material impact on our consolidated results of operations or financial condition for the six-month period ended June 30, 2015 or the year ended December 31, 2014.

During the second quarter of 2015, Texoma Medical Center ("Texoma"), which includes TMC Behavioral Health Center, entered into a Systems Improvement Agreement ("SIA") with CMS. The SIA abated a termination action from CMS following surveys which identified alleged failures to comply with conditions of participation primarily involving Texoma's behavioral health operations. The terms of the SIA required Texoma to engage independent consultants/experts approved by CMS to analyze and develop implementation plans at Texoma to meet Medicare conditions of participation. At the conclusion of the SIA, CMS will conduct a full certification survey to determine if Texoma is in substantial compliance with the Medicare conditions of participation. The term of agreement is set to conclude October 2, 2016 unless the terms of the agreement are fulfilled earlier. During the term of the SIA, Texoma remains eligible to receive reimbursements from Medicare and Medicaid for services rendered to Medicare and Medicaid beneficiaries.

Matters Relating to Psychiatric Solutions, Inc. ("PSI"):

The following matters pertain to PSI or former PSI facilities (owned by subsidiaries of PSI) which were in existence prior to the acquisition of PSI and for which we have assumed the defense as a result of our acquisition which was completed in November, 2010.

Department of Justice Investigation of Friends Hospital:

In October, 2010, Friends Hospital in Philadelphia, Pennsylvania, received a subpoena from the DOJ requesting certain documents from the facility. The requested documents were collected and provided to the DOJ for review and examination. Another subpoena was issued to the facility in July, 2011 requesting additional documents, which have also been delivered to the DOJ. All documents requested and produced pertained to the operations of the facility while under PSI's ownership prior to our acquisition. At present, we are uncertain as to the focus, scope or extent of the investigation, liability of the facility and/or potential financial exposure, if any, in connection with this matter.

Department of Justice Investigation of Riveredge Hospital:

In 2008, Riveredge Hospital in Chicago, Illinois received a subpoena from the DOJ requesting certain information from the facility. Additional requests for documents were also received from the DOJ in 2009 and 2010. The requested documents have been provided to the DOJ. All documents requested and produced pertained to the operations of the facility while under PSI's ownership prior to our acquisition. At present, we are uncertain as to the focus, scope or extent of the investigation, liability of the facility and/or potential financial exposure, if any, in connection with this matter.

General:

We operate in a highly regulated and litigious industry which subjects us to various claims and lawsuits in the ordinary course of business as well as regulatory proceedings and government investigations. These claims or suits include claims for damages for personal injuries, medical malpractice, commercial/contractual disputes, wrongful restriction of, or interference with, physicians' staff privileges, and employment related claims, In addition, health care companies are subject to investigations and/or actions by various state and federal governmental agencies or those bringing claims on their behalf. Government action has increased with respect to investigations and/or allegations against healthcare providers concerning possible violations of fraud and abuse and false claims statutes as well as compliance with clinical and operational regulations. Currently, and from time to time, we and some of our facilities are subjected to inquiries in the form of subpoenas, Civil Investigative Demands, audits and other document requests from various federal and state agencies. These inquiries can lead to notices and/or actions including repayment obligations from state and federal government agencies associated with potential non-compliance with laws and regulations. Further, the federal False Claim Act allows private individuals to bring lawsuits (qui tam actions) against healthcare providers that submit claims for payments to the government. Various states have also adopted similar statutes. When such a claim is filed, the government will investigate the matter and decide if they are going to intervene in the pending case. These qui tam lawsuits are placed under seal by the court to comply with the False Claims Act's requirements. If the government chooses not to intervene, the private individual(s) can proceed independently on behalf of the government. Health care providers that are found to violate the False Claims Act may be subject to substantial monetary fines/penalties as well as face potential exclusion from participating in government health care programs or be required to comply with Corporate Integrity Agreements as a condition of a settlement of a False Claim Act matter. In September 2014, the Criminal Division of the DOJ, announced that all qui tam cases will be shared with their Division to determine if a parallel criminal investigation should be opened. The Criminal Division has also stated an intention to pursue corporations in criminal prosecutions. In addition, health care facilities are subject to monitoring by state and federal surveyors to ensure compliance with program Conditions of Participation. In the event a facility is found to be out of compliance with a Condition of Participation and unable to remedy the alleged deficiency(s), the facility faces termination from the Medicare and Medicaid programs or compliance with a System Improvement Agreement to remedy deficiencies and ensure compliance.

The laws and regulations governing the healthcare industry are complex covering, among other things, government healthcare participation requirements, licensure, certification and accreditation, privacy of patient information, reimbursement for patient services as well as fraud and abuse compliance. These laws and regulations are constantly evolving and expanding. Further, the Affordable Care Act has added additional obligations on healthcare providers to report and refund overpayments by government healthcare programs and authorizes the suspension of Medicare and Medicaid payments "pending an investigation of a credible allegation of fraud." We monitor our business and have developed an ethics and compliance program with respect to these complex laws, rules and regulations. Although we believe our policies, procedures and practices comply with government regulations, there is no assurance that we will not be faced with the sanctions referenced above which include fines, penalties and/or substantial damages, repayment obligations, payment suspensions, licensure revocation, and expulsion from government healthcare programs. Even if we were to ultimately prevail in any action brought against us or our facilities or in responding to any inquiry, such action or inquiry could have a material adverse effect on us.

The outcome of any current or future litigation or governmental or internal investigations, including the matters described above, cannot be accurately predicted, nor can we predict any resulting penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities. We record accruals for such contingencies to the extent that we conclude it is probable that a liability has been incurred and the amount of the loss can be reasonably estimated. No estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made at this time regarding the matters specifically described above because the inherently unpredictable nature of legal proceedings may be exacerbated by various factors, including, but not limited to: (i) the damages sought in the proceedings are unsubstantiated or indeterminate; (ii) discovery is not complete; (iii) the proceeding is in its early stages; (iv) the matters present legal uncertainties; (v) there are significant facts in dispute; (vi) there are a large number of parties, or; (vii) there is a wide range of potential outcomes. It is possible that the outcome of these matters could have a material adverse impact on our future results of operations, financial position, cash flows and, potentially, our reputation.

In addition, various suits and claims arising against us in the ordinary course of business are pending. In the opinion of management, the outcome of such claims and litigation will not materially affect our consolidated financial position or results of operations.

(6) Segment Reporting

Our reportable operating segments consist of acute care hospital services and behavioral health care services. The "Other" segment column below includes centralized services including information services, purchasing, reimbursement, accounting, taxation, legal, advertising, design and construction and patient accounting as well as the operating results for our other operating entities including outpatient surgery and radiation centers. The chief operating decision making group for our acute care hospital services and behavioral health care services is comprised of the Chief Executive Officer, the President and the Presidents of each operating segment. The Presidents of each operating segment also manage the profitability of each respective segment's various facilities. The operating segments are managed separately because each operating segment represents a business unit that offers different types of healthcare services or operates in different healthcare environments. The accounting policies of the operating segments are the same as those described in the summary of significant accounting policies included in our Annual Report on Form 10-K for the year ended December 31, 2014.

	Three months ended June 30, 2015			
	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 4,188,933	$ 1,865,070	—	$ 6,054,003
Gross outpatient revenues	$ 2,403,044	$ 217,013	$ 8,284	$ 2,628,341
Total net revenues	$ 1,164,516	$ 1,106,860	$ 3,828	$ 2,275,204
Income/(loss) before allocation of corporate overhead and income taxes	$ 140,584	$ 268,413	($ 101,289)	$ 307,708
Allocation of corporate overhead	($ 49,422)	($ 29,721)	$ 79,143	0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 91,162	$ 238,692	($ 22,146)	$ 307,708
Total assets as of 6/30/15	$ 3,425,974	$ 5,320,163	$ 332,422	$ 9,078,559

	Six months ended June 30, 2015			
	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 8,517,700	$ 3,688,495	—	$12,206,195
Gross outpatient revenues	$ 4,687,756	$ 421,582	$ 16,111	$ 5,125,449
Total net revenues	$ 2,310,456	$ 2,183,205	$ 6,896	$ 4,500,557
Income/(loss) before allocation of corporate overhead and income taxes	$ 295,784	$ 521,855	($ 212,914)	$ 604,725
Allocation of corporate overhead	($ 98,848)	($ 59,387)	$ 158,235	0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 196,936	$ 462,468	($ 54,679)	$ 604,725
Total assets as of 6/30/15	$ 3,425,974	$ 5,320,163	$ 332,422	$ 9,078,559

	Three months ended June 30, 2014			
	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 3,724,309	$ 1,686,512	—	$ 5,410,821
Gross outpatient revenues	$ 2,068,076	$ 204,480	$ 8,335	$ 2,280,891
Total net revenues	$ 1,037,065	$ 1,011,239	$ 3,462	$ 2,051,766
Income/(loss) before allocation of corporate overhead and income taxes	$ 118,345	$ 243,540	($ 103,540)	$ 258,345
Allocation of corporate overhead	($ 44,693)	($ 23,136)	$ 67,829	0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 73,652	$ 220,404	($ 35,711)	$ 258,345
Total assets as of 6/30/14	$ 3,319,048	$ 4,995,534	$ 233,490	$ 8,548,072

	Six months ended June 30, 2014			
	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 7,600,673	$ 3,295,411	—	$10,896,084
Gross outpatient revenues	$ 4,025,567	$ 388,595	$ 16,849	$ 4,431,011
Total net revenues	$ 2,011,712	$ 1,971,586	$ 6,782	$ 3,990,080
Income/(loss) before allocation of corporate overhead and income taxes	$ 229,994	$ 464,688	($ 200,554)	$ 494,128
Allocation of corporate overhead	($ 89,390)	($ 49,305)	$ 138,695	0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 140,604	$ 415,383	($ 61,859)	$ 494,128
Total assets as of 6/30/14	$ 3,319,048	$ 4,995,534	$ 233,490	$ 8,548,072

(7) Earnings Per Share Data ("EPS") and Stock Based Compensation

Basic earnings per share are based on the weighted average number of common shares outstanding during the period. Diluted earnings per share are based on the weighted average number of common shares outstanding during the period adjusted to give effect to common stock equivalents.

The following table sets forth the computation of basic and diluted earnings per share for the periods indicated (in thousands, except per share data):

	Three months ended June 30,		Six months ended June 30,	
	(amounts in thousands)			
	2015	2014	2015	2014
Basic and Diluted:				
Net income attributable to UHS	$182,193	$151,671	$356,492	$289,749
Less: Net income attributable to unvested restricted share grants	(71)	(77)	(139)	(147)
Net income attributable to UHS – basic and diluted	$182,122	$151,594	$356,353	$289,602
Weighted average number of common shares - basic	99,004	98,872	98,957	98,722

Net effect of dilutive stock options and grants based on the treasury stock method	1,923	1,363	1,830	1,474
Weighted average number of common shares and equivalents - diluted	100,927	100,235	100,787	100,196
Earnings per basic share attributable to UHS:	$ 1.84	$ 1.53	$ 3.60	$ 2.93
Earnings per diluted share attributable to UHS:	$ 1.80	$ 1.51	$ 3.54	$ 2.89

The "Net effect of dilutive stock options and grants based on the treasury stock method", for all periods presented above, excludes certain outstanding stock options applicable to each period since the effect would have been anti-dilutive. There were no significant anti-dilutive stock options during the three months ended June 30, 2015. The excluded weighted-average stock options totaled 1.5 million for the six months ended June 30, 2015. There were no significant anti-dilutive stock options during the three and six months ended June 30, 2014. All classes of our common stock have the same dividend rights.

Stock-Based Compensation: During the three-month periods ended June 30, 2015 and 2014, compensation cost of $9.1 million and $7.4 million, respectively, was recognized related to outstanding stock options. During the six-month periods ended June 30, 2015 and 2014, compensation cost of $19.5 million and $14.2 million, respectively, was recognized related to outstanding stock options. In addition, during the three-month periods ended June 30, 2015 and 2014, compensation cost of approximately $274,000 and $358,000, respectively, was recognized related to restricted stock. During the six-month periods ended June 30, 2015 and 2014, compensation cost of approximately $493,000 and $648,000, respectively, was recognized related to restricted stock. As of June 30, 2015 there was $84.6 million of unrecognized compensation cost related to unvested options and restricted stock which is expected to be recognized over the remaining weighted average vesting period of 3.1 years. There were 2,943,850 stock options granted (net of cancellations) during the first six months of 2015 with a weighted-average grant date fair value of $21.28 per share.

The expense associated with share-based compensation arrangements is a non-cash charge. In the Consolidated Statements of Cash Flows, share-based compensation expense is an adjustment to reconcile net income to cash provided by operating activities and aggregated to $20.5 million and $14.9 million during the six-month periods ended June 30, 2015 and 2014, respectively. In accordance with ASC 718, excess income tax benefits related to stock based compensation are classified as cash inflows from financing activities on the Consolidated Statement of Cash Flows. During each of the first six months of 2015 and 2014, we generated $28.5 million of excess income tax benefits related to stock based compensation which are reflected as cash inflows from financing activities in our Consolidated Statements of Cash Flows.

(8) Dispositions and acquisitions

Six-month period ended June 30, 2015:

Acquisitions:

During the first six months of 2015, we paid approximately $35 million to acquire: (i) the Orchard Portman House Hospital (now called Cygnet Hospital-Taunton), a 46-bed behavioral health care facility located near Taunton, United Kingdom; (ii) certain assets and a management contract related to the operations of a 24-bed critical access hospital located in Bonham, Texas, and; (iii) various other businesses and real property assets.

There were no divestitures during the first six months of 2015.

Six-month period ended June 30, 2014:

Acquisitions:

During the first six months of 2014, we spent $71 million to: (i) acquire and fund the required capital reserves related to a commercial health insurer headquartered in Reno, Nevada; (ii) acquire the Psychiatric Institute of Washington ("PIW"), a 124-bed behavioral health care facility and outpatient treatment center located in Washington, D.C., and; (iii) to acquire the operations of Palo Verde Behavioral Health, a 48-bed behavioral health facility in Tucson, Arizona. As part of the acquisition of PIW, we also acquired the Arbor Group, L.L.C., which operates three management contracts covering 66 beds in the Washington, D.C. and Maryland market.

Divestitures:

During the first six months of 2014, we received approximately $11 million of cash proceeds for the divestiture of a non-operating investment (sold during the first quarter of 2014). This transaction resulted in a pre-tax gain of approximately $10 million which is included in our consolidated results of operations during the six-month period ended June 30, 2014.

(9) Dividends

We declared and paid dividends of $9.9 million, or $.10 per share, during the second quarter of 2015 and $5.0 million, or $.05 per share, during the second quarter of 2014. We declared and paid dividends of $19.8 million and $9.9 million during the six-month periods ended June 30, 2015 and 2014, respectively.

(10) Income Taxes

As of January 1, 2015, our unrecognized tax benefits were approximately $2 million. The amount, if recognized, that would affect the effective tax rate is approximately $2 million. During the quarter ended June 30, 2015, changes to the estimated liabilities for uncertain tax positions (including accrued interest) relating to tax positions taken during prior and current periods did not have a material impact on our financial statements.

We recognize accrued interest and penalties associated with uncertain tax positions as part of the tax provision. As of June 30, 2015, we have less than $1 million of accrued interest and penalties. The U.S. federal statute of limitations remains open for the 2011 and subsequent years. Foreign and U.S. state and local jurisdictions have statutes of limitations generally ranging from 3 to 4 years. The statute of limitations on certain jurisdictions could expire within the next twelve months. It is reasonably possible that the amount of uncertain tax benefits will change during the next 12 months, however, it is anticipated that any such change, if it were to occur, would not have a material impact on our results of operations.

We operate in multiple jurisdictions with varying tax laws. We are subject to audits by any of these taxing authorities. Our tax returns have been examined by the Internal Revenue Service (“IRS”) through the year ended December 31, 2006. We believe that adequate accruals have been provided for federal, foreign and state taxes.

(11) Supplemental Condensed Consolidating Financial Information

Certain of our senior notes are guaranteed by a group of subsidiaries (the “Guarantors”). The Guarantors, each of which is a 100% directly owned subsidiary of Universal Health Services, Inc., fully and unconditionally guarantee the senior notes on a joint and several basis, subject to certain customary release provisions.

The following financial statements present condensed consolidating financial data for (i) Universal Health Services, Inc. (on a parent company only basis), (ii) the combined Guarantors, (iii) the combined non guarantor subsidiaries (all other subsidiaries), (iv) an elimination column for adjustments to arrive at the information for the parent company, Guarantors, and non guarantors on a consolidated basis, and (v) the parent company and our subsidiaries on a consolidated basis.

Investments in subsidiaries are accounted for by the parent company and the Guarantors using the equity method for this presentation. Results of operations of subsidiaries are therefore classified in the parent company’s and Guarantors’ investment in subsidiaries accounts. The elimination entries set forth in the following condensed consolidating financial statements eliminate distributed and undistributed income of subsidiaries, investments in subsidiaries, and intercompany balances and transactions between the parent, Guarantors, and non guarantors.

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF INCOME
FOR THE THREE MONTHS ENDED JUNE 30, 2015
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net revenues before provision for doubtful accounts	$ 0	$1,690,272	$ 770,481	$ (8,073)	$2,452,680
Less: Provision for doubtful accounts	0	114,894	62,582	0	177,476
Net revenues	0	1,575,378	707,899	(8,073)	2,275,204
Operating charges:					
Salaries, wages and benefits	0	745,230	298,834	0	1,044,064
Other operating expenses	0	367,145	176,236	(7,670)	535,711
Supplies expense	0	145,631	95,348	0	240,979
Depreciation and amortization	0	69,057	28,200	0	97,257
Lease and rental expense	0	14,144	9,455	(403)	23,196
Electronic health records incentive income	0	(1,395)	0	0	(1,395)
	0	1,339,812	608,073	(8,073)	1,939,812
Income from operations	0	235,566	99,826	0	335,392
Interest expense	26,032	1,166	486	0	27,684
Interest (income) expense, affiliate	0	23,055	(23,055)	0	0
Equity in net income of consolidated affiliates	(198,261)	(60,788)	0	259,049	0
Income before income taxes	172,229	272,133	122,395	(259,049)	307,708
Provision for income taxes	(9,964)	90,739	25,529	0	106,304
Net income	182,193	181,394	96,866	(259,049)	201,404
Less: Income attributable to noncontrolling interests	0	0	19,211	0	19,211
Net income attributable to UHS	$ 182,193	$ 181,394	$ 77,655	$ (259,049)	$ 182,193

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF INCOME
FOR THE SIX MONTHS ENDED JUNE 30, 2015
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net revenues before provision for doubtful accounts	$ 0	$3,351,884	$1,496,561	$ (15,664)	$4,832,781
Less: Provision for doubtful accounts	0	221,198	111,026	0	332,224
Net revenues	0	3,130,686	1,385,535	(15,664)	4,500,557
Operating charges:					
Salaries, wages and benefits	0	1,485,784	589,983	0	2,075,767
Other operating expenses	0	718,725	337,922	(14,970)	1,041,677
Supplies expense	0	286,992	192,728	0	479,720
Depreciation and amortization	0	138,702	57,553	0	196,255
Lease and rental expense	0	27,899	18,882	(694)	46,087
Electronic health records incentive income	0	(1,395)	0	0	(1,395)
	0	2,656,707	1,197,068	(15,664)	3,838,111
Income from operations	0	473,979	188,467	0	662,446
Interest expense	54,544	2,393	784	0	57,721
Interest (income) expense, affiliate	0	46,109	(46,109)	0	0
Equity in net income of consolidated affiliates	(390,159)	(120,303)	0	510,462	0
Income before income taxes	335,615	545,780	233,792	(510,462)	604,725
Provision for income taxes	(20,877)	182,869	47,006	0	208,998
Net income	356,492	362,911	186,786	(510,462)	395,727
Less: Income attributable to noncontrolling interests	0	0	39,235	0	39,235
Net income attributable to UHS	$ 356,492	$ 362,911	$ 147,551	$ (510,462)	$ 356,492

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF INCOME
FOR THE THREE MONTHS ENDED JUNE 30, 2014
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net revenues before provision for doubtful accounts	$ 0	$1,547,499	$ 687,743	$ (7,521)	$2,227,721
Less: Provision for doubtful accounts	0	121,531	54,424	0	175,955
Net revenues	0	1,425,968	633,319	(7,521)	2,051,766
Operating charges:					
Salaries, wages and benefits	0	688,041	273,879	0	961,920
Other operating expenses	0	311,145	156,596	(7,076)	460,665
Supplies expense	0	136,754	87,020	0	223,774
Depreciation and amortization	0	64,622	26,069	0	90,691
Lease and rental expense	0	14,444	9,459	(445)	23,458
Electronic health records incentive income	0	(1,704)	(470)	0	(2,174)
	0	1,213,302	552,553	(7,521)	1,758,334
Income from operations	0	212,666	80,766	0	293,432
Interest expense	33,589	1,147	351	0	35,087
Interest (income) expense, affiliate	0	22,112	(22,112)	0	0
Equity in net income of consolidated affiliates	(172,404)	(49,911)	0	222,315	0
Income before income taxes	138,815	239,318	102,527	(222,315)	258,345
Provision for income taxes	(12,856)	84,448	20,139	0	91,731
Net income	151,671	154,870	82,388	(222,315)	166,614
Less: Income attributable to noncontrolling interests	0	0	14,943	0	14,943
Net income attributable to UHS	$ 151,671	$ 154,870	$ 67,445	$ (222,315)	$ 151,671

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF INCOME
FOR THE SIX MONTHS ENDED JUNE 30, 2014
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net revenues before provision for doubtful accounts	$ 0	$3,025,958	$1,362,939	$ (14,678)	$4,374,219
Less: Provision for doubtful accounts	0	257,517	126,622	0	384,139
Net revenues	0	2,768,441	1,236,317	(14,678)	3,990,080
Operating charges:					
Salaries, wages and benefits	0	1,357,294	539,991	0	1,897,285
Other operating expenses	0	565,860	308,730	(14,017)	860,573
Supplies expense	0	268,229	171,343	0	439,572
Depreciation and amortization	0	132,336	51,714	0	184,050
Lease and rental expense	0	28,793	18,664	(661)	46,796
Electronic health records incentive income	0	(2,134)	(470)	0	(2,604)
	0	2,350,378	1,089,972	(14,678)	3,425,672
Income from operations	0	418,063	146,345	0	564,408
Interest expense	67,162	1,971	1,147	0	70,280
Interest (income) expense, affiliate	0	44,224	(44,224)	0	0
Equity in net income of consolidated affiliates	(331,205)	(92,863)	0	424,068	0
Income before income taxes	264,043	464,731	189,422	(424,068)	494,128
Provision for income taxes	(25,706)	163,201	38,167	0	175,662
Net income	289,749	301,530	151,255	(424,068)	318,466
Less: Income attributable to noncontrolling interests	0	0	28,717	0	28,717
Net income attributable to UHS	$ 289,749	$ 301,530	$ 122,538	$ (424,068)	$ 289,749

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME
FOR THE THREE MONTHS ENDED JUNE 30, 2015
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net income	$182,193	$ 181,394	$ 96,866	$ (259,049)	$ 201,404
Other comprehensive income (loss):					
Unrealized derivative gains on cash flow hedges	806	0	0	0	806
Amortization of terminated hedge	(84)	0	0	0	(84)
Foreign currency translation adjustment	2,626	2,626	0	(2,626)	2,626
Other comprehensive income before tax	3,348	2,626	0	(2,626)	3,348
Income tax expense related to items of other comprehensive income	715	0	0	0	715
Total other comprehensive income, net of tax	2,633	2,626	0	(2,626)	2,633
Comprehensive income	184,826	184,020	96,866	(261,675)	204,037
Less: Comprehensive income attributable to noncontrolling interests	0	0	19,211	0	19,211
Comprehensive income attributable to UHS	$184,826	$ 184,020	$ 77,655	$ (261,675)	$ 184,826

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME
FOR THE SIX MONTHS ENDED JUNE 30, 2015
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net income	$356,492	$ 362,911	$ 186,786	$ (510,462)	$ 395,727
Other comprehensive income (loss):					
Unrealized derivative gains on cash flow hedges	4,938	0	0	0	4,938
Amortization of terminated hedge	(168)	0	0	0	(168)
Foreign currency translation adjustment	2,208	2,208	0	(2,208)	2,208
Other comprehensive income before tax	6,978	2,208	0	(2,208)	6,978
Income tax expense related to items of other comprehensive income	2,212	0	0	0	2,212
Total other comprehensive income, net of tax	4,766	2,208	0	(2,208)	4,766
Comprehensive income	361,258	365,119	186,786	(512,670)	400,493
Less: Comprehensive income attributable to noncontrolling interests	0	0	39,235	0	39,235
Comprehensive income attributable to UHS	$361,258	$ 365,119	$ 147,551	$ (512,670)	$ 361,258

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME
FOR THE THREE MONTHS ENDED JUNE 30, 2014
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net income	$151,671	$ 154,870	$ 82,388	$ (222,315)	$ 166,614
Other comprehensive income (loss):					
Unrealized derivative gains on cash flow hedges	4,465	0	0	0	4,465
Amortization of terminated hedge	(84)	0	0	0	(84)
Other comprehensive income before tax	4,381	0	0	0	4,381
Income tax expense related to items of other comprehensive income	1,620	0	0	0	1,620
Total other comprehensive income, net of tax	2,761	0	0	0	2,761
Comprehensive income	154,432	154,870	82,388	(222,315)	169,375
Less: Comprehensive income attributable to noncontrolling interests	0	0	14,943	0	14,943
Comprehensive income attributable to UHS	$154,432	$ 154,870	$ 67,445	$ (222,315)	$ 154,432

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME
FOR THE SIX MONTHS ENDED JUNE 30, 2014
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net income	$289,749	$ 301,530	$ 151,255	$ (424,068)	$ 318,466
Other comprehensive income (loss):					
Unrealized derivative gains on cash flow hedges	8,210	0	0	0	8,210
Amortization of terminated hedge	(168)	0	0	0	(168)
Other comprehensive income before tax	8,042	0	0	0	8,042
Income tax expense related to items of other comprehensive income	2,974	0	0	0	2,974
Total other comprehensive income, net of tax	5,068	0	0	0	5,068
Comprehensive income	294,817	301,530	151,255	(424,068)	323,534
Less: Comprehensive income attributable to noncontrolling interests	0	0	28,717	0	28,717
Comprehensive income attributable to UHS	$294,817	$ 301,530	$ 122,538	$ (424,068)	$ 294,817

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING BALANCE SHEET
AS OF JUNE 30, 2015
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Assets					
Current assets:					
Cash and cash equivalents	$ 0	$ 29,556	12,908	$ 0	$ 42,464
Accounts receivable, net	0	947,030	413,943	0	1,360,973
Supplies	0	67,001	42,116	0	109,117
Deferred income taxes	122,658	2,199	0	0	124,857
Other current assets	0	60,873	10,675	0	71,548
Total current assets	122,658	1,106,659	479,642	0	1,708,959
Investments in subsidiaries	7,405,907	1,781,599	0	(9,187,506)	0
Intercompany receivable	0	0	517,996	(517,996)	0
Intercompany note receivable	0	0	1,222,637	(1,222,637)	0
Property and equipment	0	4,579,230	1,792,537	0	6,371,767
Less: accumulated depreciation	0	(1,794,709)	(891,021)	0	(2,685,730)
	0	2,784,521	901,516	0	3,686,037
Other assets:					
Goodwill	0	2,789,994	526,951	0	3,316,945
Deferred charges	28,887	5,659	2,381	0	36,927
Other	11,906	272,316	45,469	0	329,691
	$7,569,358	$ 8,740,748	$3,696,592	$(10,928,139)	$ 9,078,559
Liabilities and Stockholders' Equity					
Current liabilities:					
Current maturities of long-term debt	$ 50,074	$ 1,206	$ 22,527	$ 0	$ 73,807
Accounts payable and accrued liabilities	17,137	1,004,946	73,998	0	1,096,081
Federal and state taxes	24,423	0	0	0	24,423
Total current liabilities	91,634	1,006,152	96,525	0	1,194,311
Intercompany payable	208,304	309,692	0	(517,996)	0
Other noncurrent liabilities	1,385	207,405	70,491	0	279,281
Long-term debt	2,935,170	17,401	8,944	0	2,961,515
Intercompany note payable	0	1,222,637	0	(1,222,637)	0
Deferred income taxes	271,109	0	0	0	271,109
Redeemable noncontrolling interests	0	0	250,533	0	250,533
UHS common stockholders' equity	4,061,756	5,977,461	3,210,045	(9,187,506)	4,061,756
Noncontrolling interest	0	0	60,054	0	60,054
Total equity	4,061,756	5,977,461	3,270,099	(9,187,506)	4,121,810
	$7,569,358	$ 8,740,748	$3,696,592	$(10,928,139)	$ 9,078,559

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING BALANCE SHEET
AS OF DECEMBER 31, 2014
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Assets					
Current assets:					
Cash and cash equivalents	$ 0	$ 21,784	$ 10,285	$ 0	$ 32,069
Accounts receivable, net	0	933,971	348,764	0	1,282,735
Supplies	0	67,847	40,268	0	108,115
Deferred income taxes	113,822	743	0	0	114,565
Other current assets	0	62,431	15,223	0	77,654
Total current assets	113,822	1,086,776	414,540	0	1,615,138
Investments in subsidiaries	7,013,540	1,661,296	0	(8,674,836)	0
Intercompany receivable	103,808	0	408,682	(512,490)	0
Intercompany note receivable	0	0	1,222,637	(1,222,637)	0
Property and equipment	0	4,494,567	1,717,463	0	6,212,030
Less: accumulated depreciation	0	(1,686,192)	(846,149)	0	(2,532,341)
	0	2,808,375	871,314	0	3,679,689
Other assets:					
Goodwill	0	2,764,555	526,658	0	3,291,213
Deferred charges	32,379	5,402	2,538	0	40,319
Other	9,601	283,302	55,181	0	348,084
	$7,273,150	$ 8,609,706	$3,501,550	$(10,409,963)	$ 8,974,443
Liabilities and Stockholders' Equity					
Current liabilities:					
Current maturities of long-term debt	$ 44,874	1,260	22,185	0	$ 68,319
Accounts payable and accrued liabilities	20,245	1,051,309	41,508	0	1,113,062
Federal and state taxes	1,446	0	0	0	1,446
Total current liabilities	66,565	1,052,569	63,693	0	1,182,827
Intercompany payable	0	512,490	0	(512,490)	0
Other noncurrent liabilities	1,322	189,456	77,777	0	268,555
Long-term debt	3,187,103	20,212	2,900	0	3,210,215
Intercompany note payable	0	1,222,637	0	(1,222,637)	0
Deferred income taxes	282,214	0	0	0	282,214
Redeemable noncontrolling interests	0	0	239,552	0	239,552
UHS common stockholders' equity	3,735,946	5,612,342	3,062,494	(8,674,836)	3,735,946
Noncontrolling interest	0	0	55,134	0	55,134
Total equity	3,735,946	5,612,342	3,117,628	(8,674,836)	3,791,080
	$7,273,150	$ 8,609,706	$3,501,550	$(10,409,963)	$ 8,974,443

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
FOR THE SIX MONTHS ENDED JUNE 30, 2015
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net cash (used in) provided by operating activities	$ (9,690)	333,512	207,781	$	$ 531,603
Cash Flows from Investing Activities:					
Property and equipment additions, net of disposals	0	(97,857)	(72,723)	0	(170,580)
Acquisition of property and businesses	0	(22,513)	(11,987)	0	(34,500)
Net cash used in investing activities	0	(120,370)	(84,710)	0	(205,080)
Cash Flows from Financing Activities:					
Reduction of long-term debt	(252,189)	(2,865)	(604)	0	(255,658)
Additional borrowings	5,200	0	0	0	5,200
Repurchase of common shares	(68,157)	0	0	0	(68,157)
Dividends paid	(19,804)	0	0	0	(19,804)
Issuance of common stock	4,039	0	0	0	4,039
Excess income tax benefits related to stock-based compensation	28,489	0	0	0	28,489
Profit distributions to noncontrolling interests	0	0	(23,295)	0	(23,295)
Proceeds received from sale/leaseback of real property	0	0	12,765	0	12,765
Changes in intercompany balances with affiliates, net	312,112	(202,798)	(109,314)	0	0
Net cash provided by (used in) financing activities	9,690	(205,663)	(120,448)	0	(316,421)
Effect of exchange rate changes on cash and cash equivalents	0	293	0	0	293
Increase in cash and cash equivalents	0	7,772	2,623	0	10,395
Cash and cash equivalents, beginning of period	0	21,784	10,285	0	32,069
Cash and cash equivalents, end of period	$ 0	$ 29,556	$ 12,908	$ 0	$ 42,464

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
FOR THE SIX MONTHS ENDED JUNE 30, 2014
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net cash provided by operating activities	$ 6,497	256,770	195,149	$ 0	$ 458,416
Cash Flows from Investing Activities:					
Property and equipment additions, net of disposals	0	(116,688)	(70,098)	0	(186,786)
Proceeds received from sale of assets and businesses	0	11,450	0	0	11,450
Cash paid/reserved related to acquisition of property and businesses	0	(67,699)	(3,301)	0	(71,000)
Costs incurred for purchase and implementation of electronic health records application	0	(8,399)	0	0	(8,399)
Net cash used in investing activities	0	(181,336)	(73,399)	0	(254,735)
Cash Flows from Financing Activities:					
Reduction of long-term debt	(167,755)	(317)	(11,054)	0	(179,126)
Repurchase of common shares	(35,773)	0	0	0	(35,773)
Dividends paid	(9,884)	0	0	0	(9,884)
Issuance of common stock	3,287	0	0	0	3,287
Excess income tax benefits related to stock-based compensation	28,493	0	0	0	28,493
Profit distributions to noncontrolling interests	0	0	(13,184)	0	(13,184)
Changes in intercompany balances with affiliates, net	175,135	(78,577)	(96,558)	0	0
Net cash (used in) provided by financing activities	(6,497)	(78,894)	(120,796)	0	(206,187)
(Decrease) increase in cash and cash equivalents	0	(3,460)	954	0	(2,506)
Cash and cash equivalents, beginning of period	0	7,990	9,248	0	17,238
Cash and cash equivalents, end of period	$ 0	$ 4,530	$ 10,202	$ 0	$ 14,732

(12) Recent Accounting Standards

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2014-09, "Revenue from Contracts with Customers", which provides guidance for revenue recognition. The standard's core principle is that a company will recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods or services. This ASU also requires additional disclosures. ASU 2014-09 is effective for annual reporting periods beginning after December 15, 2016. We are currently in the process of evaluating the impact of adoption of this ASU on our consolidated financial statements.

In August 2014, FASB issued ASU No. 2014-15, "Preparation of Financial Statements—Going Concern (Subtopic 205-40), Disclosure of Uncertainties about an Entity's Ability to Continue as a Going Concern" (ASU 2014-15). Continuation of a reporting entity as a going concern is presumed as the basis for preparing financial statements unless and until the entity's liquidation becomes imminent. Preparation of financial statements under this presumption is commonly referred to as the going concern basis of accounting. If and when an entity's liquidation becomes imminent, financial statements should be prepared under the liquidation basis of accounting in accordance with Subtopic 205-30, "Presentation of Financial Statements—Liquidation Basis of Accounting". Even when an entity's liquidation is not imminent, there may be conditions or events that raise substantial doubt about the entity's ability to continue as a going concern. In those situations, financial statements should continue to be prepared under the going concern basis of accounting, but the new criteria in ASU 2014-15 should be followed to determine whether to disclose information about the relevant conditions and events. The amendments in ASU 2014-15 are effective for the annual period ending after December 15, 2016, and for annual periods and interim periods thereafter. Early application is permitted. We will evaluate the going concern considerations in this ASU.

In April 2015, the FASB issued an update to the accounting standard relating to the presentation of debt issuance costs. Under the new guidance, debt issuance costs related to a recognized debt liability will be presented on the balance sheet as a direct deduction from the debt liability. This amendment becomes effective for annual periods beginning on or after December 15, 2015, and interim periods beginning on or after December 15, 2015; however, early adoption is permitted. We do not expect the adoption of this guidance to have a material impact on our condensed consolidated financial statements.

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations

Overview

Our principal business is owning and operating, through our subsidiaries, acute care hospitals, behavioral health centers, surgical hospitals, ambulatory surgery centers and radiation oncology centers. As of June 30, 2015, we owned and operated 24 acute care hospitals and 215 behavioral health centers located in 37 states, Washington, D.C., the United Kingdom, Puerto Rico and the U.S. Virgin Islands. In addition, we are building a newly-constructed acute care hospital located in Henderson, Nevada. As part of our ambulatory treatment centers division, we manage and/or own outright or in partnerships with physicians, 5 surgical hospitals and surgery and radiation oncology centers located in 4 states.

As a percentage of our consolidated net revenues, net revenues from our acute care hospitals, surgical hospitals, commercial health insurer (Prominence Health Plan), surgery centers and radiation oncology centers accounted for 51% during each of the three and six-month periods ended June 30, 2015 and 2014. Net revenues from our behavioral health care facilities accounted for 49% of our consolidated net revenues during each of the three and six-month periods ended June 30, 2015 and 2014.

Services provided by our hospitals include general and specialty surgery, internal medicine, obstetrics, emergency room care, radiology, oncology, diagnostic care, coronary care, pediatric services, pharmacy services and/or behavioral health services. We provide capital resources as well as a variety of management services to our facilities, including central purchasing, information services, finance and control systems, facilities planning, physician recruitment services, administrative personnel management, marketing and public relations.

Forward-Looking Statements and Risk Factors

You should carefully review the information contained in this Quarterly Report, and should particularly consider any risk factors that we set forth in this Quarterly Report and in other reports or documents that we file from time to time with the Securities and Exchange Commission (the "SEC"). In this Quarterly Report, we state our beliefs of future events and of our future financial performance. This Quarterly Report contains "forward-looking statements" that reflect our current estimates, expectations and projections about our future results, performance, prospects and opportunities. Forward-looking statements include, among other things, the information concerning our possible future results of operations, business and growth strategies, financing plans, expectations that regulatory developments or other matters will not have a material adverse effect on our business or financial condition, our competitive position and the effects of competition, the projected growth of the industry in which we operate, and the benefits and synergies to be obtained from our completed and any future acquisitions, and statements of our goals and objectives, and other similar expressions concerning matters that are not historical facts. Words such as "may," "will," "should," "could," "would," "predicts," "potential," "continue," "expects," "anticipates," "future," "intends," "plans," "believes," "estimates," "appears," "projects" and similar expressions, as well as statements in future tense, identify forward-looking statements. In evaluating those statements, you should specifically consider various factors, including the risks related to healthcare industry trends and those detailed in our filings with the SEC including those set forth herein and in our Annual Report on Form 10-K for the year ended December 31, 2014 in *Item 1A Risk Factors* and in *Item 7 Management's Discussion and Analysis of Financial Condition and Results of Operations – Forward Looking Statements and Risk Factors*. Those factors may cause our actual results to differ materially from any of our forward-looking statements.

Forward-looking statements should not be read as a guarantee of future performance or results, and will not necessarily be accurate indications of the times at, or by which, such performance or results will be achieved. Forward-looking information is based on information available at the time and/or our good faith belief with respect to future events, and is subject to risks and uncertainties that could cause actual performance or results to differ materially from those expressed in the statements. Such factors include, among other things, the following:

- our ability to comply with the existing laws and government regulations, and/or changes in laws and government regulations;
- an increasing number of legislative initiatives have been passed into law that may result in major changes in the health care delivery system on a national or state level. No assurances can be given that the implementation of these laws will not have a material adverse effect on our business, financial condition or results of operations;
- possible unfavorable changes in the levels and terms of reimbursement for our charges by third party payors or government based payors, including Medicare or Medicaid in the United States, and government based payors in the United Kingdom;
- our ability to enter into managed care provider agreements on acceptable terms and the ability of our competitors to do the same, including contracts with United/Sierra Healthcare in Las Vegas, Nevada;
- the outcome of known and unknown litigation, government investigations, false claim act allegations, and liabilities and other claims asserted against us and other matters as disclosed in *Item 1. Legal Proceedings*;

- the potential unfavorable impact on our business of deterioration in national, regional and local economic and business conditions, including a worsening of unfavorable credit market conditions;
- competition from other healthcare providers (including physician owned facilities) in certain markets;
- technological and pharmaceutical improvements that increase the cost of providing, or reduce the demand for healthcare;
- our ability to attract and retain qualified personnel, nurses, physicians and other healthcare professionals and the impact on our labor expenses resulting from a shortage of nurses and other healthcare professionals;
- demographic changes;
- our ability to successfully integrate and improve our recent acquisitions and the availability of suitable acquisitions and divestiture opportunities;
- as discussed below in *Sources of Revenue*, we receive revenues from various state and county based programs, including Medicaid in all the states in which we operate, (we receive Medicaid revenues in excess of $90 million annually from each of Texas, Washington, D.C., California, Nevada, Illinois, Pennsylvania, Virginia, Florida and Massachusetts); CMS-approved Medicaid supplemental programs in certain states including Texas, Oklahoma, Illinois, Mississippi, Arkansas and California, and; state Medicaid disproportionate share hospital payments in certain states including Texas and South Carolina. We are therefore particularly sensitive to potential reductions in Medicaid and other state based revenue programs as well as regulatory, economic, environmental and competitive changes in those states. We can provide no assurance that reductions to revenues earned pursuant to these programs, particularly in the above-mentioned states, will not have a material adverse effect on our future results of operations;
- our ability to continue to obtain capital on acceptable terms, including borrowed funds, to fund the future growth of our business;
- some of our acute care facilities experience decreasing inpatient admission trends;
- our financial statements reflect large amounts due from various commercial and private payors and there can be no assurance that failure of the payors to remit amounts due to us will not have a material adverse effect on our future results of operations;
- in March, 2010, the Health Care and Education Reconciliation Act of 2010 and the Patient Protection and Affordable Care Act were enacted into law and created significant changes to health insurance coverage for U.S. citizens as well as material revisions to the federal Medicare and state Medicaid programs. The two combined primary goals of these acts are to provide for increased access to coverage for healthcare and to reduce healthcare-related expenses. Medicare, Medicaid and other health care industry changes are scheduled to be implemented at various times during this decade. We cannot predict the effect, if any, these enactments will have on our future results of operations;
- the Department of Health and Human Services (“HHS”) published final regulations in July, 2010 implementing the health information technology (“HIT”) provisions of the American Recovery and Reinvestment Act (referred to as the “HITECH Act”). The final regulation defines the “meaningful use” of Electronic Health Records (“EHR”) and establishes the requirements for the Medicare and Medicaid EHR payment incentive programs. The implementation period for these new Medicare and Medicaid incentive payments started in federal fiscal year 2011 and can end as late as 2016 for Medicare and 2021 for the state Medicaid programs. Hospitals that do not qualify as a meaningful user of EHR by 2015 are subject to a reduced market basket update to the inpatient prospective payment system (“IPPS”) standardized amount in 2015 and each subsequent fiscal year. We believe that all of our acute care hospitals have met the applicable meaningful use criteria and therefore are not subject to a reduced market basked update to the IPPS standardized amount in federal fiscal year 2015. However, under the HITECH Act, hospitals must continue to meet the applicable meaningful use criteria in each fiscal year or they will be subject to a market basket update reduction in a subsequent fiscal year. Failure of our acute care hospitals to continue to meet the applicable meaningful use criteria would have an adverse effect on our future net revenues and results of operations. There will likely be timing differences in the recognition of the incentive income and expenses recorded in connection with the implementation of the EHR applications which may cause material period-to-period changes in our future results of operations;
- in August, 2011, the Budget Control Act of 2011 (the “2011 Act”) was enacted into law. The 2011 Act imposed annual spending limits for most federal agencies and programs aimed at reducing budget deficits by $917 billion between 2012 and 2021, according to a report released by the Congressional Budget Office. Among its other provisions, the law established a bipartisan Congressional committee, known as the Joint Select Committee on Deficit Reduction (the “Joint Committee”), which was tasked with making recommendations aimed at reducing future federal budget deficits by an additional $1.5 trillion over 10 years. The Joint Committee was unable to reach an agreement by the November 23, 2011 deadline and, as a result, across-the-board cuts to discretionary, national defense and Medicare spending were implemented on March 1, 2013 resulting in Medicare payment reductions of up to 2% per fiscal year (approximately $35 million annual reduction to our Medicare net revenues effective as of April 1, 2013) with a uniform percentage reduction across all Medicare programs. We cannot predict whether Congress will restructure the implemented Medicare payment reductions or what other federal budget deficit reduction initiatives may be proposed by Congress;

- our accounts receivable as of June 30, 2015 and December 31, 2014 include amounts due from Illinois of approximately $24 million and $44 million, respectively. Collection of the outstanding receivables continues to be delayed due to state budgetary and funding pressures. Approximately $8 million as of June 30, 2015 and $23 million as of December 31, 2014, of the receivables due from Illinois were outstanding in excess of 60 days, as of each respective date. In addition, our accounts receivable as of June 30, 2015 and December 31, 2014 includes approximately $97 million and $102 million, respectively, due from Texas in connection with Medicaid supplemental payment programs. The $97 million due from Texas as of June 30, 2015 consists of $52 million related to uncompensated care program revenues, $27 million related to disproportionate share hospital program revenues and $18 million to Delivery Service Reform Incentive Payment program revenues. Although the accounts receivable due from Illinois and Texas could remain outstanding for the foreseeable future, since we expect to eventually collect all amounts due to us, no related reserves have been established in our consolidated financial statements. However, we can provide no assurance that we will eventually collect all amounts due to us from Illinois and/or Texas. Failure to ultimately collect all outstanding amounts due from these states would have an adverse impact on our future consolidated results of operations and cash flows;
- there have been several attempts in Congress to repeal or modify various provisions of the Patient Protection and Affordable Care Act (the "PPACA"). We cannot predict whether or not any of these proposed changes to the PPACA will become law and therefore can provide no assurance that changes to the PPACA, as currently implemented, will not have a material adverse effect on our future results of operations;
- uninsured and self-pay patients treated at our acute care facilities unfavorably impact our ability to satisfactorily and timely collect our self-pay patient accounts;
- the ability to obtain adequate levels of general and professional liability insurance on current terms;
- changes in our business strategies or development plans;
- fluctuations in the value of our common stock, and;
- other factors referenced herein or in our other filings with the Securities and Exchange Commission.

Given these uncertainties, risks and assumptions, as outlined above, you are cautioned not to place undue reliance on such forward-looking statements. Our actual results and financial condition could differ materially from those expressed in, or implied by, the forward-looking statements. Forward-looking statements speak only as of the date the statements are made. We assume no obligation to publicly update any forward-looking statements to reflect actual results, changes in assumptions or changes in other factors affecting forward-looking information, except as may be required by law. All forward-looking statements attributable to us or persons acting on our behalf are expressly qualified in their entirety by this cautionary statement.

Critical Accounting Policies and Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires us to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes. We consider our critical accounting policies to be those that require us to make significant judgments and estimates when we prepare our consolidated financial statements. For a summary of our significant accounting policies, please see *Note 1 to the Consolidated Financial Statements* as included in our Annual Report on Form 10-K for the year ended December 31, 2014.

Revenue recognition: We record revenues and related receivables for health care services at the time the services are provided. Medicare and Medicaid revenues represented 34% and 38% of our net patient revenues during the three-month periods ended June 30, 2015 and 2014, respectively, and 35% and 38% of our net patient revenues during the six-month periods ended June 30, 2015 and 2014, respectively. Revenues from managed care entities, including health maintenance organizations and managed Medicare and Medicaid programs, accounted for 52% and 50% of our net patient revenues during the three-month periods ended June 30, 2015 and 2014, respectively, and 51% and 50% of our net patient revenues during the six-month periods ended June 30, 2015 and 2014, respectively.

Charity Care, Uninsured Discounts and Provision for Doubtful Accounts: See disclosure below in *Results of Operations, Acute Care Hospital Services-Charity Care, Uninsured Discounts and Provision for Doubtful Accounts.*

Accounting for Medicare and Medicaid Electronic Health Records Incentive Payments: In July 2010, the Department of Health and Human Services published final regulations implementing the health information technology provisions of the American Recovery and Reinvestment Act. The regulation defines the "meaningful use" of Electronic Health Records ("EHR") and established the requirements for the Medicare and Medicaid EHR payment incentive programs. The implementation period for these new Medicare and Medicaid incentive payments started in federal fiscal year 2011 and can end as late as 2016 for Medicare and 2021 for the state Medicaid programs. We recognize income related to Medicare and Medicaid incentive payments using a gain contingency model that is based upon when our eligible hospitals have demonstrated "meaningful use" of certified EHR technology for the applicable period and the cost report information for the full cost report year that will determine the final calculation of the incentive payment is available.

Medicare EHR incentive payments: Federal regulations require that Medicare EHR incentive payments be computed based on the Medicare cost report that begins in the federal fiscal period in which a hospital meets the applicable "meaningful use" requirements. Since the annual Medicare cost report periods for each of our acute care hospitals ends on December 31st, we will recognize Medicare EHR incentive income for each hospital during the fourth quarter of the year in which the facility meets the "meaningful use" criteria and during the fourth quarter of each applicable subsequent year.

Medicaid EHR incentive payments: Medicaid EHR incentive payments are determined based upon prior period cost report information available at the time our hospitals met the "meaningful use" criteria. Therefore, the majority of the Medicaid EHR incentive income recognition occurred in the period in which the applicable hospitals were deemed to have met initial "meaningful use" criteria. Upon meeting subsequent fiscal year "meaningful use" criteria, our hospitals may become entitled to additional Medicaid EHR incentive payments which will be recognized as incentive income in future periods. Medicaid EHR incentive payments received prior to our hospitals meeting the "meaningful use" criteria were included in other current liabilities (as deferred EHR incentive income) in our consolidated balance sheet.

Self-Insured/Other Insurance Risks: We provide for self-insured risks, primarily general and professional liability claims and workers' compensation claims. Our estimated liability for self-insured professional and general liability claims is based on a number of factors including, among other things, the number of asserted claims and reported incidents, estimates of losses for these claims based on recent and historical settlement amounts, estimate of incurred but not reported claims based on historical experience, and estimates of amounts recoverable under our commercial insurance policies. All relevant information, including our own historical experience is used in estimating the expected amount of claims. While we continuously monitor these factors, our ultimate liability for professional and general liability claims could change materially from our current estimates due to inherent uncertainties involved in making this estimate. Our estimated self-insured reserves are reviewed and changed, if necessary, at each reporting date and changes are recognized currently as additional expense or as a reduction of expense. In addition, we also: (i) own a commercial health insurer headquartered in Reno, Nevada, and; (ii) maintain self-insured employee benefits programs for employee healthcare and dental claims. The ultimate costs related to these programs/operations include expenses for claims incurred and paid in addition to an accrual for the estimated expenses incurred in connection with claims incurred but not yet reported. Given our significant insurance-related exposure, there can be no assurance that a sharp increase in the number and/or severity of claims asserted against us will not have a material adverse effect on our future results of operations.

The total accrual for our professional and general liability claims and workers' compensation claims was $269 million as of June 30, 2015, of which $83 million is included in current liabilities. The total accrual for our professional and general liability claims and workers' compensation claims was $260 million as of December 31, 2014, of which $83 million is included in current liabilities.

Recent Accounting Standards: For a summary of accounting standards, please see *Note 12 to the Consolidated Financial Statements*, as included herein.

Results of Operations

Three-month periods ended June 30, 2015 and 2014:

The following table summarizes our results of operations and is used in the discussion below for the three-month periods ended June 30, 2015 and 2014 (dollar amounts in thousands):

	Three months ended June 30, 2015		Three months ended June 30, 2014	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$2,452,680		$2,227,721	
Less: Provision for doubtful accounts	177,476		175,955	
Net revenues	2,275,204	100.0%	2,051,766	100.0%
Operating charges:				
Salaries, wages and benefits	1,044,064	45.9%	961,920	46.9%
Other operating expenses	535,711	23.5%	460,665	22.5%
Supplies expense	240,979	10.6%	223,774	10.9%
Depreciation and amortization	97,257	4.3%	90,691	4.4%
Lease and rental expense	23,196	1.0%	23,458	1.1%
EHR incentive income	(1,395)	-0.1%	(2,174)	-0.1%
Subtotal-operating expenses	1,939,812	85.3%	1,758,334	85.7%
Income from operations	335,392	14.7%	293,432	14.3%
Interest expense, net	27,684	1.2%	35,087	1.7%
Income before income taxes	307,708	13.5%	258,345	12.6%
Provision for income taxes	106,304	4.7%	91,731	4.5%
Net income	201,404	8.9%	166,614	8.1%
Less: Income attributable to noncontrolling interests	19,211	0.8%	14,943	0.7%
Net income attributable to UHS	$ 182,193	8.0%	$ 151,671	7.4%

Net revenues increased 11%, or $223 million, to $2.28 billion during the three-month period ended June 30, 2015 as compared to $2.05 billion during the comparable quarter of the prior year. The net increase was primarily attributable to a $136 million or 7% increase in net revenues generated from our acute care hospital services and behavioral health services operated during both periods (which we refer to as “same facility”).

Income before income taxes (before deduction for income attributable to noncontrolling interests) increased $49 million to $308 million during the three-month period ended June 30, 2015 as compared to $258 million during the comparable quarter of the prior year. The net increase in our income before income taxes during the second quarter of 2015, as compared to the comparable prior year quarter, was due to:

a. an increase of $22 million at our acute care facilities as discussed below in Acute Care Hospital Services;

b. an increase of $25 million at our behavioral health care facilities, as discussed below in Behavioral Health Services, and;

c. $2 million of other combined net increases.

Net income attributable to UHS increased $31 million to $182 million during the three-month period ended June 30, 2015 as compared to $152 million during the comparable prior year quarter. The increase during the second quarter of 2015, as compared to the comparable prior year quarter, consisted of:

- an increase of $49 million in income before income taxes, as discussed above;
- a decrease of $4 million due to an increase in income attributable to noncontrolling interests, and;
- a decrease of $14 million resulting primarily from an increase in the provision for income taxes resulting from the income tax provision recorded on the $45 million increase in pre-tax income ($49 million increase in income before income taxes less the $4 million increase in the income attributable to noncontrolling interests).

Six-month periods ended June 30, 2015 and 2014:

The following table summarizes our results of operations and is used in the discussion below for the six-month periods ended June 30, 2015 and 2014 (dollar amounts in thousands):

	Six months ended June 30, 2015		Six months ended June 30, 2014	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$4,832,781		$4,374,219	
Less: Provision for doubtful accounts	332,224		384,139	
Net revenues	4,500,557	100.0%	3,990,080	100.0%
Operating charges:				
Salaries, wages and benefits	2,075,767	46.1%	1,897,285	47.6%
Other operating expenses	1,041,677	23.1%	860,573	21.6%
Supplies expense	479,720	10.7%	439,572	11.0%
Depreciation and amortization	196,255	4.4%	184,050	4.6%
Lease and rental expense	46,087	1.0%	46,796	1.2%
EHR incentive income	(1,395)	0.0%	(2,604)	-0.1%
Subtotal-operating expenses	3,838,111	85.3%	3,425,672	85.9%
Income from operations	662,446	14.7%	564,408	14.1%
Interest expense, net	57,721	1.3%	70,280	1.8%
Income before income taxes	604,725	13.4%	494,128	12.4%
Provision for income taxes	208,998	4.6%	175,662	4.4%
Net income	395,727	8.8%	318,466	8.0%
Less: Income attributable to noncontrolling interests	39,235	0.9%	28,717	0.7%
Net income attributable to UHS	$ 356,492	7.9%	$ 289,749	7.3%

Net revenues increased 13%, or $510 million, to $4.50 billion during the six-month period ended June 30, 2015 as compared to $3.99 billion during the comparable period of the prior year. The net increase was primarily attributable to a $314 million or 8% increase in net revenues generated from our acute care hospital services and behavioral health care services, on a same facility basis.

Income before income taxes (before deduction for income attributable to noncontrolling interests) increased $111 million to $605 million during the six-month period ended June 30, 2015 as compared to $494 million during the comparable period of the prior year. The net increase in our income before income taxes during the first six months of 2015, as compared to the comparable prior year period, was due to:

a. an increase of $66 million at our acute care facilities as discussed below in Acute Care Hospital Services;

b. an increase of $57 million at our behavioral health care facilities, as discussed below in Behavioral Health Services;

c. a decrease of $10 million due to the pre-tax gain recorded during the first quarter of 2014 resulting from the divestiture of a non-operating investment, and;

d. $2 million of other combined net decreases.

Net income attributable to UHS increased $67 million to $356 million during the six-month period ended June 30, 2015 as compared to $290 million during the comparable prior year period. The increase during the first six months of 2015, as compared to the comparable prior year period, consisted of:

- an increase of $111 million in income before income taxes, as discussed above;
- a decrease of $11 million due to an increase in income attributable to noncontrolling interests, and;
- a decrease of $33 million resulting primarily from an increase in the provision for income taxes resulting from the income tax provision recorded on the $100 million increase in pre-tax income ($111 million increase in income before income taxes less the $11 million increase in the income attributable to noncontrolling interests).

Acute Care Hospital Services

Same Facility Basis Acute Care Hospital Services

We believe that providing our results on a “Same Facility” basis, which includes the operating results for facilities and businesses operated in both the current year and prior year periods, is helpful to our investors as a measure of our operating performance. Our Same Facility results also neutralize the impact of the EHR applications, the effect of items that are non-operational in nature including items such as, but not limited to, gains on sales of assets and businesses, impacts of settlements, legal judgments and lawsuits and other amounts that may be reflected in the current or prior year financial statements that relate to prior periods. Our Same Facility basis results reflected on the table below also exclude from net revenues and

other operating expenses, provider tax assessments incurred in each period as discussed below *Sources of Revenue-Various State Medicaid Supplemental Payment Programs.* The provider tax assessments had no impact on the income before income taxes as reflected on a Same Facility basis since the amounts offset between net revenues and other operating expenses. However, these provider tax assessments are included in net revenues and other operating expenses as reflected in the table below under *All Acute Care Hospitals*.

The following table summarizes the results of operations for our acute care facilities, on a same facility and all acute care basis, and is used in the discussion below for the three and six-month periods ended June 30, 2015 and 2014 (dollar amounts in thousands):

	Three months ended June 30, 2015		Three months ended June 30, 2014		Six months ended June 30, 2015		Six months ended June 30, 2014	
	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$1,256,387		$1,173,067		$2,469,396		$2,326,806	
Less: Provision for doubtful accounts	146,565		149,056		270,002		331,406	
Net revenues	1,109,822	100.0%	1,024,011	100.0%	2,199,394	100.0%	1,995,400	100.0%
Operating charges:								
Salaries, wages and benefits	459,459	41.4%	429,079	41.9%	911,480	41.4%	850,129	42.6%
Other operating expenses	239,201	21.6%	225,057	22.0%	450,675	20.5%	418,053	21.0%
Supplies expense	191,199	17.2%	178,087	17.4%	382,023	17.4%	348,574	17.5%
Depreciation and amortization	55,393	5.0%	52,503	5.1%	111,704	5.1%	104,791	5.3%
Lease and rental expense	12,382	1.1%	12,684	1.2%	24,722	1.1%	25,668	1.3%
Subtotal-operating expenses	957,634	86.3%	897,410	87.6%	1,880,604	85.5%	1,747,215	87.6%
Income from operations	152,188	13.7%	126,601	12.4%	318,790	14.5%	248,185	12.4%
Interest expense, net	968	0.1%	1,082	0.1%	1,988	0.1%	2,156	0.1%
Income before income taxes	151,220	13.6%	125,519	12.3%	316,802	14.4%	246,029	12.3%

Three-month periods ended June 30, 2015 and 2014:

During the three-month period ended June 30, 2015, as compared to the comparable prior year quarter, net revenues from our acute care hospital services, on a same facility basis, increased $86 million or 8.4%. Income before income taxes (and before income attributable to noncontrolling interests) increased $26 million or 20% to $151 million or 13.6% of net revenues during the second quarter of 2015 as compared to $126 million or 12.3% of net revenues during the comparable prior year quarter.

During the three-month period ended June 30, 2015, net revenue per adjusted admission increased 3.2% and net revenue per adjusted patient day increased 3.7%, as compared to the comparable quarter of the prior year. During the three-month period ended June 30, 2015, as compared to the comparable prior year quarter, inpatient admissions to our acute care hospitals increased 5.0% and adjusted admissions (adjusted for outpatient activity) increased 5.7%. Patient days at these facilities increased 4.4% and adjusted patient days increased 5.2% during the three-month period ended June 30, 2015 as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities was 4.6 days and 4.7 days during the three-month periods ended June 30, 2015 and 2014, respectively. The occupancy rate, based on the average available beds at these facilities, was 59% and 57% during the three-month periods ended June 30, 2015 and 2014, respectively.

Six-month periods ended June 30, 2015 and 2014:

During the six-month period ended June 30, 2015, as compared to the comparable prior year period, net revenues from our acute care hospital services, on a same facility basis, increased $204 million or 10.2%. Income before income taxes (and before income attributable to noncontrolling interests) increased $71 million or 29% to $317 million or 14.4% of net revenues during the six months of 2015 as compared to $246 million or 12.3% of net revenues during the comparable prior year period.

The increased operating performance experienced at our acute care facilities during the six months of 2015, as compared to the comparable period in 2014, was due in part to continued improvement in general economic conditions as well as a decrease in the number of uninsured patients treated at our hospitals. The decrease in the number of uninsured patients treated at our acute care hospitals was due primarily to the favorable impact of the Affordable Care Act which includes the expansion of Medicaid in certain states in which we operate and the enrollment of patients in newly created commercial exchanges.

During the six-month period ended June 30, 2015, net revenue per adjusted admission increased 4.6% and net revenue per adjusted patient day increased 4.0%, as compared to the comparable period of the prior year. During the six-month period ended June 30, 2015, as compared to the comparable prior year period, inpatient admissions to our acute care hospitals increased 4.6% and adjusted admissions (adjusted for outpatient activity) increased 5.7%. Patient days at these facilities increased 5.2% and adjusted patient days increased 6.3% during the six-month period ended June 30, 2015 as compared to the comparable prior year period. The average length of inpatient stay at these facilities was 4.8 days and 4.7 days during the six-month periods ended June 30, 2015 and 2014, respectively. The occupancy rate, based on the average available beds at these facilities, was 61% and 59% during the six-month periods ended June 30, 2015 and 2014, respectively.

Charity Care, Uninsured Discounts and Provision for Doubtful Accounts: Collection of receivables from third-party payers and patients is our primary source of cash and is critical to our operating performance. Our primary collection risks relate to uninsured patients and the portion of the bill which is the patient's responsibility, primarily co-payments and deductibles. We estimate our provisions for doubtful accounts based on general factors such as payer mix, the agings of the receivables and historical collection experience. We routinely review accounts receivable balances in conjunction with these factors and other economic conditions which might ultimately affect the collectability of the patient accounts and make adjustments to our allowances as warranted. At our acute care hospitals, third party liability accounts are pursued until all payment and adjustments are posted to the patient account. For those accounts with a patient balance after third party liability is finalized or accounts for uninsured patients, the patient receives statements and collection letters. Our hospitals establish a partial reserve for self-pay accounts in the allowance for doubtful accounts for both unbilled balances and those that have been billed and are under 90 days old. All self-pay accounts are fully reserved at 90 days from the date of discharge. Third party liability accounts are fully reserved in the allowance for doubtful accounts when the balance ages past 180 days from the date of discharge. Patients that express an inability to pay are reviewed for potential sources of financial assistance including our charity care policy. If the patient is deemed unwilling to pay, the account is written-off as bad debt and transferred to an outside collection agency for additional collection effort.

Historically, a significant portion of the patients treated throughout our portfolio of acute care hospitals are uninsured patients which, in part, has resulted from patients who are employed but do not have health insurance or who have policies with relatively high deductibles. Patients treated at our hospitals for non-elective services, who have gross income less than 400% of the federal poverty guidelines, are deemed eligible for charity care. The federal poverty guidelines are established by the federal government and are based on income and family size. Because we do not pursue collection of amounts that qualify as charity care, they are not reported in our net revenues or in our accounts receivable, net.

A portion of the accounts receivable at our acute care facilities are comprised of Medicaid accounts that are pending approval from third-party payers but we also have smaller amounts due from other miscellaneous payers such as county indigent programs in certain states. Our patient registration process includes an interview of the patient or the patient's responsible party at the time of registration. At that time, an insurance eligibility determination is made and an insurance plan code is assigned. There are various pre-established insurance profiles in our patient accounting system which determine the expected insurance reimbursement for each patient based on the insurance plan code assigned and the services rendered. Certain patients may be classified as Medicaid pending at registration based upon a screening evaluation if we are unable to definitively determine if they are currently Medicaid eligible. When a patient is registered as Medicaid eligible or Medicaid pending, our patient accounting system records net revenues for services provided to that patient based upon the established Medicaid reimbursement rates, subject to the ultimate disposition of the patient's Medicaid eligibility. When the patient's ultimate eligibility is determined, reclassifications may occur which impacts the reported amounts in future periods for the provision for doubtful accounts and other accounts such as Medicaid pending. Although the patient's ultimate eligibility determination may result in amounts being reclassified among these accounts from period to period, these reclassifications did not have a material impact on our results of operations during the three or six-month periods ended June 30, 2015 and 2014 since our facilities make estimates at each financial reporting period to reserve for amounts that are deemed to be uncollectible.

We also provide discounts to uninsured patients (included in "uninsured discounts" amounts below) who do not qualify for Medicaid or charity care. Because we do not pursue collection of amounts classified as uninsured discounts, they are not reported in our net revenues or in our net accounts receivable. In implementing the discount policy, we first attempt to qualify uninsured patients for governmental programs, charity care or any other discount program. If an uninsured patient does not qualify for these programs, the uninsured discount is applied. Our accounts receivable are recorded net of allowance for doubtful accounts of $363 million and $325 million at June 30, 2015 and December 31, 2014, respectively.

The following tables show the amounts recorded at our acute care hospitals for charity care and uninsured discounts, based on charges at established rates, for the three and six-month periods ended June 30, 2015 and 2014:

Uncompensated care:

Amounts in millions	Three Months Ended				Six Months Ended			
	June 30, 2015	%	June 30, 2014	%	June 30, 2015	%	June 30, 2014	%
Charity care	$ 117	44%	$ 113	42%	$ 249	45%	$ 247	42%
Uninsured discounts	146	56%	153	58%	301	55%	339	58%
Total uncompensated care	$ 263	100%	$ 266	100%	$ 550	100%	$ 586	100%

As reflected on the table below in All Acute Care Hospitals, the provision for doubtful accounts at our acute care hospitals amounted to approximately $149 million during each of the three-month periods ended June 30, 2015 and 2014, and $274 million and $331 million during the six-month periods ended June 30, 2015 and 2014, respectively. During the three and six-month periods ended June 30, 2015, as compared to the comparable periods of 2014, our acute care hospitals experienced a decrease in the aggregate of charity care, uninsured discounts and provision for doubtful accounts as a percentage of gross charges.

Estimated cost of providing uncompensated care:

The estimated costs of providing uncompensated care as reflected below were based on a calculation which multiplied the percentage of operating expenses for our acute care hospitals to gross charges for those hospitals by the above-mentioned total uncompensated care amounts. Amounts included in the provision for doubtful accounts, as mentioned above, are not included in the calculation of estimated costs of providing uncompensated care. The percentage of cost to gross charges is calculated based on the total operating expenses for our acute care facilities divided by gross patient service revenue for those facilities.

Estimated cost of providing uncompensated care

Amounts in millions	Three Months Ended		Six Months Ended	
	June 30, 2015	June 30, 2014	June 30, 2015	June 30, 2014
Estimated cost of providing charity care	$ 20	$ 16	$ 38	$ 35
Estimated cost of providing uninsured discounts related care	24	22	46	49
Estimated cost of providing uncompensated care	$ 44	$ 38	$ 84	$ 84

All Acute Care Hospitals

The following table summarizes the results of operations for all our acute care operations during the three and six-month periods ended June 30, 2015 and 2014. These amounts include: (i) our acute care results on a same facility basis, as indicated above; (ii) the impact of the implementation of EHR applications at our acute care hospitals; (iii) the operating results of a commercial health insurer acquired in June of 2014 (the operating results for the month of June of 2015 and June of 2014 are also included in the same facility basis results reflected above); (iv) the impact of provider tax assessments which increased net revenues and other operating expenses but had no impact on income before income taxes, and; (v) certain other amounts. Dollar amounts below are reflected in thousands.

	Three months ended June 30, 2015		Three months ended June 30, 2014		Six months ended June 30, 2015		Six months ended June 30, 2014	
	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$1,313,813		$1,186,121		$2,584,103		$2,343,118	
Less: Provision for doubtful accounts	149,297		149,056		273,647		331,406	
Net revenues	1,164,516	100.0%	1,037,065	100.0%	2,310,456	100.0%	2,011,712	100.0%
Operating charges:								
Salaries, wages and benefits	465,045	39.9%	429,079	41.4%	921,817	39.9%	850,129	42.3%
Other operating expenses	289,729	24.9%	238,150	23.0%	552,384	23.9%	434,404	21.6%
Supplies expense	191,243	16.4%	178,087	17.2%	382,525	16.6%	348,574	17.3%
Depreciation and amortization	65,769	5.6%	61,813	6.0%	132,230	5.7%	123,391	6.1%
Lease and rental expense	12,367	1.1%	12,684	1.2%	24,920	1.1%	25,668	1.3%
EHR incentive income	(1,395)	-0.1%	(2,174)	-0.2%	(1,395)	-0.1%	(2,604)	-0.1%
Subtotal-operating expenses	1,022,758	87.8%	917,639	88.5%	2,012,481	87.1%	1,779,562	88.5%
Income from operations	141,758	12.2%	119,426	11.5%	297,975	12.9%	232,150	11.5%
Interest expense, net	1,174	0.1%	1,082	0.1%	2,191	0.1%	2,156	0.1%
Income before income taxes	140,584	12.1%	118,344	11.4%	295,784	12.8%	229,994	11.4%

Three-month periods ended June 30, 2015 and 2014:

Income before income taxes increased $22 million or 19% to $141 million during the second quarter of 2015 as compared to $118 million during the second quarter of 2014. The increase in income before income taxes at our acute care facilities resulted from:

- a $26 million increase at our acute care facilities on a same facility basis, as discussed above, and;
- a decrease of $4 million from other combined net changes, including the net operating loss incurred from our commercial health insurance company that was acquired in June, 2014.

Six-month periods ended June 30, 2015 and 2014:

Income before income taxes increased $66 million or 29% to $296 million during the first six months of 2015 as compared to $230 million during the comparable period of 2014. The increase in income before income taxes at our acute care facilities resulted from:

- a $71 million increase at our acute care facilities on a same facility basis, as discussed above, and;
- a decrease of $5 million from other combined net changes, including the net operating loss incurred from our commercial health insurance company that was acquired in June, 2014.

Behavioral Health Services

The following table summarizes the results of operations for our behavioral health care facilities, on a same facility basis, and is used in the discussion below for the three and six-month periods ended June 30, 2015 and 2014. Our same facility basis results reflected on the table below also exclude from net revenues and other operating expenses, provider tax assessments incurred in each period as discussed below *Sources of Revenue-Various State Medicaid Supplemental Payment Programs*. The provider tax assessments had no impact on the income before income taxes as reflected on a same facility basis since the amounts offset between net revenues and other operating expenses. However, these provider tax assessments are included in net revenues and other operating expenses as reflected in the table below under *All Behavioral Health Care Facilities.* Dollar amounts below are reflected in thousands.

Same Facility—Behavioral Health

	Three months ended June 30, 2015		Three months ended June 30, 2014		Six months ended June 30, 2015		Six months ended June 30, 2014	
	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$1,067,858		$1,017,843		$2,101,485		$1,988,553	
Less: Provision for doubtful accounts	27,126		27,455		56,339		53,357	
Net revenues	1,040,732	100.0%	990,388	100.0%	2,045,146	100.0%	1,935,196	100.0%
Operating charges:								
Salaries, wages and benefits	493,946	47.5%	479,317	48.4%	974,011	47.6%	940,424	48.6%
Other operating expenses	202,638	19.5%	184,584	18.6%	394,746	19.3%	362,237	18.7%
Supplies expense	47,155	4.5%	44,900	4.5%	92,034	4.5%	89,392	4.6%
Depreciation and amortization	28,224	2.7%	26,566	2.7%	55,875	2.7%	56,140	2.9%
Lease and rental expense	10,221	1.0%	10,378	1.0%	19,748	1.0%	20,353	1.1%
Subtotal-operating expenses	782,184	75.2%	745,745	75.3%	1,536,414	75.1%	1,468,546	75.9%
Income from operations	258,548	24.8%	244,643	24.7%	508,732	24.9%	466,650	24.1%
Interest expense, net	480	0.0%	401	0.0%	532	0.0%	921	0.0%
Income before income taxes	258,068	24.8%	244,242	24.7%	508,200	24.8%	465,729	24.1%

Three-month periods ended June 30, 2015 and 2014:

On a same facility basis during the second quarter of 2015, as compared to the second quarter of 2014, net revenues at our behavioral health care facilities increased 5% or $50 million to $1.04 billion from $990 million. Income before income taxes increased $14 million or 6% to $258 million or 24.8% of net revenues during the three-month period ended June 30, 2015, as compared to $244 million or 24.7% of net revenues during the comparable prior year quarter.

During the three-month period ended June 30, 2015, net revenue per adjusted admission increased 0.5% and net revenue per adjusted patient day increased 4.1%, as compared to the comparable quarter of the prior year. On a same facility basis, inpatient admissions and adjusted admissions to our behavioral health facilities increased 4.4% and 4.2%, respectively, during the three-month period ended June 30, 2015 as compared to the comparable quarter of 2014. Patient days and adjusted patient days increased 0.8% and 0.6%, respectively, during the three-month period ended June 30, 2015 as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities was 12.5 days and 12.9 days during the three-month periods ended June 30, 2015 and 2014, respectively. The occupancy rate, based on the average available beds at these facilities, was 77% during each of the three-month periods ended June 30, 2015 and 2014.

Six-month periods ended June 30, 2015 and 2014:

On a same facility basis during the first six months of 2015, as compared to the comparable period of 2014, net revenues at our behavioral health care facilities increased 6% or $110 million to $2.05 billion from $1.94 billion. Income before income taxes increased $42 million or 9% to $508 million or 24.8% of net revenues during the six-month period ended June 30, 2015, as compared to $466 million or 24.1% of net revenues during the comparable period of the prior year.

During the six-month period ended June 30, 2015, net revenue per adjusted admission increased 0.5% and net revenue per adjusted patient day increased 3.9%, as compared to the comparable period of the prior year. On a same facility basis, inpatient admissions and adjusted admissions to our behavioral health facilities increased 5.1% and 5.0%, respectively, during the six-month period ended June 30, 2015 as compared to the comparable period of 2014. Patient days and adjusted patient days increased 1.6% and 1.5%, respectively, during the six-month period ended June 30, 2015 as compared to the comparable prior year period. The average length of inpatient stay at these facilities was 12.4 days and 12.9 days during the six-month periods ended June 30, 2015 and 2014, respectively. The occupancy rate, based on the average available beds at these facilities, was 77% and 76% during the six-month periods ended June 30, 2015 and 2014, respectively.

All Behavioral Health Care Facilities

The following table summarizes the results of operations for all our behavioral health care facilities during the three and six-month periods ended June 30, 2015 and 2014 which includes our behavioral health results on a same facility basis, the impact of the facilities acquired or opened within the previous twelve months, and the impact of provider tax assessments which increased net revenues and other operating expenses but had no impact on income before income taxes (dollar amounts in thousands):

	Three months ended June 30, 2015		Three months ended June 30, 2014		Six months ended June 30, 2015		Six months ended June 30, 2014	
	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$1,134,967		$1,038,619		$2,241,668		$2,024,831	
Less: Provision for doubtful accounts	28,107		27,380		58,463		53,245	
Net revenues	1,106,860	100.0%	1,011,239	100.0%	2,183,205	100.0%	1,971,586	100.0%
Operating charges:								
Salaries, wages and benefits	522,156	47.2%	480,655	47.5%	1,036,031	47.5%	942,067	47.8%
Other operating expenses	227,236	20.5%	204,152	20.2%	448,415	20.5%	396,869	20.1%
Supplies expense	48,369	4.4%	44,974	4.4%	94,914	4.3%	89,490	4.5%
Depreciation and amortization	29,657	2.7%	27,023	2.7%	60,363	2.8%	56,977	2.9%
Lease and rental expense	10,564	1.0%	10,494	1.0%	20,687	0.9%	20,574	1.0%
Subtotal-operating expenses	837,982	75.7%	767,298	75.9%	1,660,410	76.1%	1,505,977	76.4%
Income from operations	268,878	24.3%	243,941	24.1%	522,795	23.9%	465,609	23.6%
Interest expense, net	465	0.0%	401	0.0%	940	0.0%	921	0.0%
Income before income taxes	268,413	24.2%	243,540	24.1%	521,855	23.9%	464,688	23.6%

Three-month periods ended June 30, 2015 and 2014:

Income before income taxes increased $25 million or 10% to $268 million during the second quarter of 2015 as compared to $244 million during the second quarter of 2014. The increase in income before income taxes at our behavioral health care facilities resulted from:

- a $14 million increase at our behavioral health care facilities on a same facility basis, as discussed above, and;
- an increase of $11 million from other combined net changes, including the income generated at the behavioral health care facilities acquired during the third quarter of 2014 in connection with our acquisition of Cygnet Health Care Limited.

Six-month periods ended June 30, 2015 and 2014:

Income before income taxes increased $57 million or 12% to $522 million during the first six months of 2015 as compared to $465 million during the comparable period of 2014. The increase in income before income taxes at our behavioral health care facilities resulted from:

- a $42 million increase at our behavioral health care facilities on a same facility basis, as discussed above, and;
- an increase of $15 million from other combined net changes, including the income generated at the behavioral health care facilities acquired during the third quarter of 2014 in connection with our acquisition of Cygnet Health Care Limited.

Sources of Revenue

Overview: We receive payments for services rendered from private insurers, including managed care plans, the federal government under the Medicare program, state governments under their respective Medicaid programs and directly from patients.

Hospital revenues depend upon inpatient occupancy levels, the medical and ancillary services and therapy programs ordered by physicians and provided to patients, the volume of outpatient procedures and the charges or negotiated payment rates for such services. Charges and reimbursement rates for inpatient routine services vary depending on the type of services provided (e.g., medical/surgical, intensive care or behavioral health) and the geographic location of the hospital. Inpatient occupancy levels fluctuate for various reasons, many of which are beyond our control. The percentage of patient service revenue attributable to outpatient services has generally increased in recent years, primarily as a result of advances in medical technology that allow more services to be provided on an outpatient basis, as well as increased pressure from Medicare, Medicaid and private insurers to reduce hospital stays and provide services, where possible, on a less expensive outpatient basis. We believe that our experience with respect to our increased outpatient levels mirrors the general trend occurring in the health care industry and we are unable to predict the rate of growth and resulting impact on our future revenues.

Patients are generally not responsible for any difference between customary hospital charges and amounts reimbursed for such services under Medicare, Medicaid, some private insurance plans, and managed care plans, but are responsible for services not covered by such plans, exclusions, deductibles or co-insurance features of their coverage. The amount of such exclusions, deductibles and co-insurance has generally been increasing each year. Indications from recent federal and state legislation are that this trend will continue. Collection of amounts due from individuals is typically more difficult than from governmental or business payers which unfavorably impacts the collectability of our patient accounts.

The following table shows the approximate percentages of net patient revenue for the three and six-month periods ended June 30, 2015 and 2014 presented on: (i) a combined basis for both our acute care and behavioral health facilities; (ii) for our acute care facilities only, and; (iii) for our behavioral health facilities only. Net patient revenue is defined as revenue from all sources after deducting contractual allowances and discounts from established billing rates, which we derived from various sources of payment for the periods indicated.

Acute Care and Behavioral Health Facilities Combined	**Percentage of Net Patient Revenues Three Months Ended June 30,**		**Percentage of Net Patient Revenues Six Months Ended June 30,**	
	2015	**2014**	**2015**	**2014**
Third Party Payors:				
Medicare	20%	22%	21%	23%
Medicaid	14%	16%	14%	15%
Managed Care (HMO and PPOs)	52%	50%	51%	50%
Other Sources	14%	12%	14%	12%
Total	100%	100%	100%	100%

Acute Care Facilities	Percentage of Net Patient Revenues Three Months Ended June 30,		Percentage of Net Patient Revenues Six Months Ended June 30,	
	2015	2014	2015	2014
Third Party Payors:				
Medicare	25%	27%	26%	28%
Medicaid	7%	9%	7%	8%
Managed Care (HMO and PPOs)	64%	60%	62%	60%
Other Sources	4%	4%	5%	4%
Total	100%	100%	100%	100%

Behavioral Health Facilities	Percentage of Net Patient Revenues Three Months Ended June 30,		Percentage of Net Patient Revenues Six Months Ended June 30,	
	2015	2014	2015	2014
Third Party Payors:				
Medicare	15%	18%	16%	18%
Medicaid	21%	24%	21%	22%
Managed Care (HMO and PPOs)	40%	39%	40%	39%
Other Sources	24%	19%	23%	21%
Total	100%	100%	100%	100%

Medicare: Medicare is a federal program that provides certain hospital and medical insurance benefits to persons aged 65 and over, some disabled persons and persons with end-stage renal disease. All of our acute care hospitals and many of our behavioral health centers are certified as providers of Medicare services by the appropriate governmental authorities. Amounts received under the Medicare program are generally significantly less than a hospital's customary charges for services provided. Since a substantial portion of our revenues will come from patients under the Medicare program, our ability to operate our business successfully in the future will depend in large measure on our ability to adapt to changes in this program.

Under the Medicare program, for inpatient services, our general acute care hospitals receive reimbursement under the inpatient prospective payment system ("IPPS"). Under the IPPS, hospitals are paid a predetermined fixed payment amount for each hospital discharge. The fixed payment amount is based upon each patient's Medicare severity diagnosis related group ("MS-DRG"). Every MS-DRG is assigned a payment rate based upon the estimated intensity of hospital resources necessary to treat the average patient with that particular diagnosis. The MS-DRG payment rates are based upon historical national average costs and do not consider the actual costs incurred by a hospital in providing care. This MS-DRG assignment also affects the predetermined capital rate paid with each MS-DRG. The MS-DRG and capital payment rates are adjusted annually by the predetermined geographic adjustment factor for the geographic region in which a particular hospital is located and are weighted based upon a statistically normal distribution of severity. While we generally will not receive payment from Medicare for inpatient services, other than the MS-DRG payment, a hospital may qualify for an "outlier" payment if a particular patient's treatment costs are extraordinarily high and exceed a specified threshold.

MS-DRG rates are adjusted by an update factor each federal fiscal year, which begins on October 1. The index used to adjust the MS-DRG rates, known as the "hospital market basket index," gives consideration to the inflation experienced by hospitals in purchasing goods and services. Generally, however, the percentage increases in the MS-DRG payments have been lower than the projected increase in the cost of goods and services purchased by hospitals.

In July, 2015, CMS published its IPPS 2016 final payment rule which provides for a 2.4% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments and Health Care Reform mandated adjustments are considered, without consideration for the decreases related to the required Medicare Disproportionate Share Hospital ("DSH") payment changes and decrease to the Medicare Outlier threshold, the overall increase in IPPS payments would approximate 1.1%. Including the estimated decreases to our Medicare Disproportionate Share Hospital ("DSH") payments (approximating 1.6%), we estimate our overall decrease from the final IPPS 2016 rule (covering the period of October 1, 2015 through September 30, 2016) will approximate -0.1%. This projected impact from the IPPS 2016 final rule includes both the impact of the American Taxpayer Relief Act of 2012 documentation and coding adjustment and the required changes to the DSH payments related to the traditional Medicare fee for service, however, it excludes the impact of the sequestration reductions related to the Budget Control Act of 2011, as discussed below.

In August, 2014, CMS published its IPPS 2015 payment rule which provides for a 2.9% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments and Health Care Reform mandated adjustments are considered, without consideration for the decreases related to the required DSH payment changes and increase to the Medicare Outlier threshold, the overall increase in IPPS payments would approximate 0.6%. Including the estimated decreases to our DSH payments (–1.9%) and Medicare Outlier threshold (–0.6%), we estimate our overall decrease from the IPPS 2015 rule (covering the period of October 1, 2014 through September 30, 2015) will approximate (–1.9%), or approximately $13 million annually. This projected impact from the IPPS 2015 rule includes both the impact of the American Taxpayer Relief Act of 2012 documentation and coding adjustment and the required changes to the DSH payments related to the traditional Medicare fee for service, however, it excludes the impact of the sequestration reductions related to the Budget Control Act of 2011, as discussed below.

In August, 2013, CMS published its final IPPS 2014 payment rule which provided for a 2.5% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments and Health Care Reform mandated adjustments are considered, we estimate our overall increase from the final federal fiscal year 2014 rule (covering the period of October 1, 2013 through September 30, 2014) approximated 1.0%. This projected impact from the IPPS 2014 final rule includes both the impact of the ATRA of 2012 documentation and coding adjustment and the required changes to the DSH payments related to the traditional Medicare fee for service, however, it excludes the impact of the sequestration reductions related to the Budget Control Act of 2011, as discussed below. The final rule also expands CMS's policy under which it defines inpatient admissions to include the use of an objective time of care standard. Specifically, it would require Medicare's external review contractors to presume that hospital inpatient admissions are reasonable and necessary when beneficiaries receive a physician order for admission and receive medically necessary services for at least two midnights (the "Two Midnight" rule). Correspondingly, under the final rule, CMS presumes that hospital services spanning less than two midnights should have been provided on an outpatient basis and paid under Medicare Part B unless the medical record contains clear documentation supporting the physician's order and an expectation that the Medicare beneficiary would need medically necessary care for more than two midnights, or is receiving services which CMS designates as inpatient only. Our acute care hospitals have begun to comply with the Two Midnight rule and, although we are unable to determine the ultimate impact at this time, its application could have a material unfavorable impact on our future results of operations. Excluding the potential impact of the Two Midnight rule, we do not expect the final IPPS 2014 payment rule to have a material impact on our future results of operations. In April, 2015, Congress voted to extend an enforcement moratorium on the Two Midnight rule through the end of fiscal year 2015. As a result, Medicare Recovery Audit Contractors will not audit inpatient hospital claims through September 30, 2015.

In July, 2015 as part of the 2016 Medicare Outpatient Prospective Payment System ("OPPS") proposed rule (additional related disclosure below), CMS proposes to allow payment for one-midnight stays under the Medicare Part A benefit on a case-by case basis for rare and unusual exceptions based the presence of certain clinical factors. CMS also announced in the proposed rule that, effective October 1, 2015, Quality Improvement Organizations ("QIOs") will conduct reviews of short inpatient stay reviews rather than Medicare Administrative Contractors ("MACs"). Additionally, CMS also announced that RACs may resume patient status reviews for claims with admission dates of October 1, 2015 or later, and the agency indicates that RACs will conduct these reviews focused on providers with high denial rates that are referred by the QIOs.

In August, 2011, the Budget Control Act of 2011 (the "2011 Act") was enacted into law. Included in this law are the imposition of annual spending limits for most federal agencies and programs aimed at reducing budget deficits by $917 billion between 2012 and 2021, according to a report released by the Congressional Budget Office. Among its other provisions, the law established a bipartisan Congressional committee, known as the Joint Committee, which was responsible for developing recommendations aimed at reducing future federal budget deficits by an additional $1.5 trillion over 10 years. The Joint Committee was unable to reach an agreement by the November 23, 2011 deadline and, as a result, across-the-board cuts to discretionary, national defense and Medicare spending were implemented on March 1, 2013 resulting in Medicare payment reductions of up to 2% per fiscal year (approximately $35 million annual reduction to our Medicare net revenues effective as of April 1, 2013) with a uniform percentage reduction across all Medicare programs.

On January 2, 2013 ATRA was enacted which, among other things, includes a requirement for CMS to recoup $11 billion from hospitals from Medicare IPPS rates during federal fiscal years 2014 to 2017. The recoupment relates to IPPS documentation and coding adjustments for the period 2008 to 2013 for which adjustments were not previously applied by CMS. Both the 2014 and 2015 IPPS final rules include a -0.8% recoupment adjustment. CMS has proposed the same 0.8% recoupment adjustment in fiscal year 2016 and expects to make similar adjustment in federal fiscal year 2017 in order to recover the entire $11 billion. This adjustment is reflected in the 2014, 2015 and 2016 IPPS estimated impact amounts noted above. On April 16, 2015, the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2) was enacted and an anticipated 3.2% payment increase in 2018 is scheduled to be phased in at 0.5% per year over 6 years beginning in fiscal year 2018.

On January 1, 2005, CMS implemented a new Psychiatric Prospective Payment System (“Psych PPS”) for inpatient services furnished by psychiatric hospitals under the Medicare program. This system replaced the cost-based reimbursement guidelines with a per diem Psych PPS with adjustments to account for certain facility and patient characteristics. The Psych PPS also contained provisions for outlier payments and an adjustment to a psychiatric hospital’s base payment if it maintains a full-service emergency department. In August, 2012, CMS published its final Psych PPS rate notice for the federal fiscal year beginning October 1, 2012. That final notice contained a Psych PPS market basket update of 2.7%, which was reduced by 0.7% to reflect a productivity adjustment, and reduced by 0.1% to reflect an “other adjustment” required by the Social Security Act for rate years 2010 through 2019. In July, 2013, CMS released its final Psych PPS rate notice for the federal fiscal year 2014. The final notice contains a Psych PPS market basket update of 2.6% which is reduced by 0.5% to reflect a productivity adjustment, and reduced by 0.1% to reflect an “other adjustment” required by the Social Security Act.

In July, 2015, CMS published it Psych PPS final rule for the federal fiscal year 2016. Under this final rule, payments to psychiatric hospitals and units are estimated to increase by 1.7% compared to federal fiscal year 2015. This amount includes the effect of the 2.4% market basket update less a 0.2% adjustment as required by the Affordable Care Act and a 0.5% productivity adjustment. The final rule also updates the Inpatient Psychiatric Quality Reporting Program, which requires psychiatric facilities to report on quality measures or incur a reduction in their annual payment update.

On July 31, 2014, CMS published it Psych PPS final rule for the federal fiscal year 2015. Under this final rule, payments to psychiatric hospitals and units are estimated to increase by 2.1% compared to federal fiscal year 2014. This amount includes the effect of the 2.9% market basket update adjusted by the Affordable Care Act required 0.3% reduction and the -0.5% productivity adjustment. The final rule also updates the Inpatient Psychiatric Quality Reporting Program, which requires psychiatric facilities to report on quality measures or incur a reduction in their annual payment update.

In July, 2015, CMS published its OPPS proposed rule for 2016. The hospital market basket increase is 2.7%. The Medicare statute requires a productivity adjustment reduction of 0.6% and 0.2% reduction to the 2016 OPPS market basket. Additionally, CMS also proposes a reduction of 2.0%, which the CMS claims is necessary to eliminate $1 billion in excess laboratory payments that CMS packaged into OPPS payment rates in 2014 resulting in a 2016 OPPS market basket update at -0.1%. When other statutorily required adjustments and hospital patient service mix are considered, we estimate that our overall Medicare OPPS update for 2016 will aggregate to a net increase of 1.0% which includes a 5.1% increase to behavioral health division partial hospitalization rates. When the behavioral health division’s partial hospitalization rate impact is excluded, we estimate that our Medicare 2016 OPPS payments will result in no change in payment levels for our acute care division, as compared to 2015.

In October, 2014, CMS published its Medicare Outpatient Prospective Payment System (“OPPS”) final rule for 2015. The hospital market basket increase is 2.9%. The Medicare statute requires a productivity adjustment reduction of 0.5% and 0.2% reduction to the 2015 OPPS market basket resulting in a 2015 OPPS market basket update at 2.2%. In the final rule, CMS will reduce the 2015 Medicare rates for both hospital-based and community mental health center partial hospitalization programs. When other statutorily required adjustments, hospital patient service mix and the aforementioned partial hospitalization rates are considered, we estimate that our overall Medicare OPPS for 2015 will aggregate to a net increase of 0.2%. Excluding the behavioral health division partial hospitalization rate impact, our Medicare OPPS payment increase for 2015 is estimated to be 1.5%.

Medicaid: Medicaid is a joint federal-state funded health care benefit program that is administered by the states to provide benefits to qualifying individuals who are unable to afford care. Most state Medicaid payments are made under a PPS-like system, or under programs that negotiate payment levels with individual hospitals. Amounts received under the Medicaid program are generally significantly less than a hospital’s customary charges for services provided. In addition to revenues received pursuant to the Medicare program, we receive a large portion of our revenues either directly from Medicaid programs or from managed care companies managing Medicaid. All of our acute care hospitals and most of our behavioral health centers are certified as providers of Medicaid services by the appropriate governmental authorities.

We receive Medicaid revenues in excess of $90 million annually from each of Texas, Washington, D.C., California, Nevada, Illinois, Pennsylvania, Virginia, Florida and Massachusetts, making us particularly sensitive to reductions in Medicaid and other state based revenue programs as well as regulatory, economic, environmental and competitive changes in those states. Based upon the state budgets for those states for the 2015 fiscal year (which generally began at various times during the second half of 2014), we estimate that, on a blended basis, our average Medicaid rates increased approximately 1% from the 2014 fiscal year rates.

The Affordable Care Act substantially increases the federally and state-funded Medicaid insurance program, and authorizes states to establish federally subsidized non-Medicaid health plans for low-income residents not eligible for Medicaid starting in 2014. However, the Supreme Court has struck down portions of the Affordable Care Act requiring states to expand their Medicaid programs in exchange for increased federal funding. Accordingly, there can be no assurance that states in which we operate will expand Medicaid coverage to individuals at 133% of the federal poverty level. Facilities in states not opting to expand Medicaid coverage under the Affordable Care Act may be additionally penalized by corresponding reductions to Medicaid disproportionate share hospital payments, as discussed below. We can provide no assurance that further reductions to Medicaid revenues, particularly in the above-mentioned states, will not have a material adverse effect on our future results of operations.

Texas and South Carolina Medicaid Disproportionate Share Hospital Payments:

Hospitals that have an unusually large number of low-income patients (i.e., those with a Medicaid utilization rate of at least one standard deviation above the mean Medicaid utilization, or having a low income patient utilization rate exceeding 25%) are eligible to receive a DSH adjustment. Congress established a national limit on DSH adjustments. Although this legislation and the resulting state broad-based provider taxes have affected the payments we receive under the Medicaid program, to date the net impact has not been materially adverse.

Upon meeting certain conditions and serving a disproportionately high share of Texas' and South Carolina's low income patients, five of our facilities located in Texas and one facility located in South Carolina received additional reimbursement from each state's DSH fund. The South Carolina and Texas DSH programs were renewed for each state's 2015 DSH fiscal year (covering the period of October 1, 2014 through September 30, 2015). During the second quarter of 2015, the Texas Health and Human Services Commission ("THHSC") finalized DSH payments for federal fiscal year 2014 which resulted in a $6 million annualized reduction in our Texas Medicaid DSH payments retroactive to October, 2013. In connection with these DSH programs, included in our financial results was an aggregate of $2 million and $12 million during the three-month periods ended June 30, 2015 and 2014, respectively, and $15 million and $25 million during the six-month period ended June 30, 2015 and 2014, respectively. Assuming that the Texas and South Carolina programs are renewed for each state's 2016 fiscal year, at amounts similar to the 2015 fiscal year amounts, we estimate our aggregate reimbursements pursuant to these programs to be approximately $20 million during the remaining six months of 2015.

The Affordable Care Act and subsequent federal legislation provides for a significant reduction in Medicaid disproportionate share payments beginning in federal fiscal year 2018 (see below in *Sources of Revenues and Health Care Reform-Medicaid Revisions* for additional disclosure). The U.S. Department of Health and Human Services is to determine the amount of Medicaid DSH payment cuts imposed on each state based on a defined methodology. As Medicaid DSH payments to states will be cut, consequently, payments to Medicaid-participating providers, including our hospitals in Texas and South Carolina, will likely be reduced in the coming years. We are unable to estimate the impact of this federally required reduction at this time.

In May, 2013 the state of Texas enacted legislation that would increase the state's contribution of the non-federal DSH share for the 2013 DSH year to $138 million as compared to the $100 million previously expected. Similarly, the state's approved 2014-2015 General Appropriations bill ("Rider 86") passed in May, 2013 authorized $160 million for 2014 and $140 million for 2015, respectively, for the non-federal DSH share.

Various State Medicaid Supplemental Payment Programs:

We incur health-care related taxes ("Provider Taxes") imposed by states in the form of a licensing fee, assessment or other mandatory payment which are related to: (i) healthcare items or services; (ii) the provision of, or the authority to provide, the health care items or services, or; (iii) the payment for the health care items or services. Such Provider Taxes are subject to various federal regulations that limit the scope and amount of the taxes that can be levied by states in order to secure federal matching funds as part of their respective state Medicaid programs. We derive a related Medicaid reimbursement benefit from assessed Provider Taxes in the form of Medicaid claims based payment increases and/or lump sum Medicaid supplemental payments.

Under these programs, including the impact of Uncompensated Care and Upper Payment Limit programs, and the Texas Delivery System Reform Incentive program, we earned revenues (before Provider Taxes) of approximately $92 million and $75 million during the three-month periods ended June 30, 2015 and 2014, respectively, and $159 million and $124 million during the six-month periods ended June 30, 2015 and 2014, respectively. These revenues were offset by Provider Taxes of $39 million and $32 million during the three-month periods ended June 30, 2015 and 2014, respectively, and $67 million and $50 million during the six-month periods ended June 30, 2015 and 2014, respectively, which are recorded in other operating expenses on the Condensed Consolidated Statements of Income as included herein.

Texas Uncompensated Care/Upper Payment Limit Payments:

Certain of our acute care hospitals located in various counties of Texas (Hidalgo, Maverick, Potter and Webb) participate in Medicaid supplemental payment Section 1115 Waiver indigent care programs. Section 1115 Waiver Uncompensated Care ("UC") payments replace the former Upper Payment Limit ("UPL") payments. These hospitals also have affiliation agreements with third-party hospitals to provide free hospital and physician care to qualifying indigent residents of these counties. Our hospitals receive both supplemental payments from the Medicaid program and indigent care payments from third-party, affiliated hospitals. The supplemental payments are contingent on the county or hospital district making an Inter-Governmental Transfer ("IGT") to the state Medicaid program while the indigent care payment is contingent on a transfer of funds from the applicable affiliated hospitals. However, the county or hospital district is prohibited from entering into an agreement to condition any IGT on the amount of any private hospital's indigent care obligation. During the second quarter of 2015, THHSC finalized the UC for federal fiscal year 2014 which resulted in an annualized $3 million increase in UC payments retroactive to October 1, 2013. We recorded net revenues/benefit from UC and affiliated hospital indigent care revenues of $20 million (net of Provider Taxes of less than $1 million) and $21 million (net of Provider Taxes of $9 million) during the three-month periods ended June 30, 2015 and 2014, respectively, and $34 million (net of Provider Taxes of $3 million) and $35 million (net of Provider Taxes of $10 million) during the six-month periods ended June 30, 2015 and 2014, respectively. Included in the UC and affiliated hospital indigent care revenues for the three and six-month periods ended June 30, 2014 was approximately $9 million (net of Provider Taxes) applicable to the period of April 1, 2013 through June 30, 2014. If the applicable hospital district or county makes IGTs consistent with 2014 levels, we believe we would be entitled to aggregate net revenues/benefit earned pursuant to these programs of approximately $29 million during the remaining six months of 2015 (net of Provider Taxes of $8 million). In April, 2015, THHSC published a final rule that would shift $136 million in funding from the private hospital UC pool to the large public hospital UC pool for the 2014 UC program year only. The impact from this final rule is incorporated into 2014 and 2015 UC amounts, as mentioned above.

On September 30, 2014, CMS notified the Texas Health and Human Services Commission that it was deferring the federal matching funds (approximately $75 million) on Texas Medicaid UC payments made to providers in certain counties. A deferral results in CMS withholding funds from the state representing the federal portion of Medicaid payments the state has previously made to providers. A deferral goes into effect when CMS questions the basis for all or part of the amount of Medicaid payments made to certain providers, and remains in place subject to CMS's final determination. Our Texas hospitals are not located in the geographic areas impacted by this deferral. On January 7, 2015, CMS removed the aforementioned deferral but indicated they will continue their review and assessment of the underlying UC financing arrangements as to ensure their compliance with the applicable federal regulations and eligibility for federal matching dollars. In May, 2015, THHSC was informed by CMS that current private-hospital funding arrangements can continue for waiver-payment dates through August, 2017, without risk of disallowance of federal matching funds on the same grounds questioned in last year's deferral.

For state fiscal year 2015, Texas Medicaid will continue to operate under a CMS-approved Section 1115 five-year Medicaid waiver demonstration program. During the first five years of this program that started in state fiscal year 2012, the THHSC transitioned away from UPL payments to new waiver incentive payment programs, UC payments and Delivery System Reform Incentive Payments ("DSRIP"). During the first year of transition, which commenced on October 1, 2011, THHSC made payments to Medicaid UPL recipient providers that received payments during the state's prior fiscal year. During demonstration years two through five (October 1, 2012 through September 30, 2016), THHSC has, and will continue to, make incentive payments under the program after certain qualifying criteria are met by hospitals. Supplemental payments are also subject to aggregate statewide caps based on CMS approved Medicaid waiver amounts.

Texas Delivery System Reform Incentive Payments:

In addition, the Texas Medicaid Section 1115 Waiver includes a DSRIP pool to incentivize hospitals and other providers to transform their service delivery practices to improve quality, health status, patient experience, coordination, and cost-effectiveness. DSRIP pool payments are incentive payments to hospitals and other providers that develop programs or strategies to enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. In May, 2014, CMS formally approved specific DSRIP projects for certain of our hospitals for demonstration years 3 to 5 (our facilities did not materially participate in the DSRIP pool during demonstration years 1 or 2). DSRIP payments are contingent on the hospital meeting certain pre-determined milestones, metrics and clinical outcomes. Additionally, DSRIP payments are contingent on a governmental entity providing an IGT for the non-federal share component of the DSRIP payment. THHSC generally approves DSRIP reported metrics, milestones and clinical outcomes on a semi-annual basis in June and December. We recorded net DSRIP revenues/benefit of approximately $10 million during the three and six-month periods ended June 30, 2015 (net of Provider Taxes of $6 million) and approximately $6 million during the three and six-month periods ended June 30, 2014 (net of Provider Taxes of $3 million). In connection with the DSRIP program and THHSC's approval for specific programs at certain of our hospitals and availability of a governmental IGT, we recorded approximately $17 million of net revenues/benefit during 2014 applicable to the period of October 1,

2013 through September 30, 2014, net of Provider Taxes of $8 million (amounts recorded during the second and fourth quarters of 2014). Although we can provide no assurance that we will ultimately qualify for additional DSRIP revenues, subject to CMS's approval and other conditions as outlined above, we estimate that we may be entitled to additional DSRIP net revenues/benefit of approximately $18 million (net of Provider Taxes of $9 million) during the remaining six months of 2015.

Nevada SPA:

In Nevada, CMS approved a state plan amendment ("SPA") in August, 2014 that implemented a hospital supplemental payment program retroactive to January 1, 2014 and effective to June 30, 2015. Included in our results of operations were approximately $2 million and $4 million of net revenues earned during the three and six-month periods ended June 30, 2015, respectively, in connection with this program. We estimate that our reimbursements pursuant to this program will approximate $3 million during the remaining six months of 2015.

Various Other State Medicaid Supplemental Payment Programs:

Including the impact of the programs in various states applicable to each year, and excluding the impact of various programs in Texas and the Nevada SPA, as discussed above, we earned an aggregate net revenues/benefit from Medicaid supplemental payments of approximately $24 million (net of Provider Taxes of $32 million) and $18 million (net of Provider Taxes of $20 million) during the three-month periods ended June 30, 2015 and 2014, respectively, and approximately $47 million (net of Provider Taxes of $58 million) and $34 million (net of Provider Taxes of $37 million) during the six-month periods ended June 30, 2015 and 2014, respectively . We estimate that our aggregate net revenues/benefit from Provider Tax programs will approximate $32 million (net of Provider Taxes of $53 million) during the remaining six months of 2015. These amounts include the impact of the CMS approved California Provider Tax and related Medicaid supplemental payment programs, which did not have a material impact on our operating results. The aggregate net benefit is earned from multiple states and therefore no particular state's portion is individually material to our consolidated financial statements. However, Provider Taxes are governed by both federal and state laws and are subject to future legislative changes that, if reduced from current rates in several states, could have a material adverse impact on our consolidated future results of operations.

As outlined above, we receive substantial reimbursement from multiple states in connection with various supplemental Medicaid payment programs. Failure to renew these programs beyond their scheduled termination dates, failure of the public hospitals to provide the necessary IGTs for the states' share of the DSH programs, failure of our hospitals that currently receive supplemental Medicaid revenues to qualify for future funds under these programs, or reductions in reimbursements, could have a material adverse effect on our future results of operations.

HITECH Act: In July 2010, the Department of Health and Human Services ("HHS") published final regulations implementing the health information technology ("HIT") provisions of the American Recovery and Reinvestment Act (referred to as the "HITECH Act"). The final regulation defines the "meaningful use" of Electronic Health Records ("EHR") and establishes the requirements for the Medicare and Medicaid EHR payment incentive programs. The final rule established an initial set of standards and certification criteria. The implementation period for these new Medicare and Medicaid incentive payments started in federal fiscal year 2011 and can end as late as 2016 for Medicare and 2021 for the state Medicaid programs. State Medicaid program participation in this federally funded incentive program is voluntary but all of the states in which our eligible hospitals operate have chosen to participate. Our acute care hospitals may qualify for these EHR incentive payments upon implementation of the EHR application assuming they meet the "meaningful use" criteria. The government's ultimate goal is to promote more effective (quality) and efficient healthcare delivery through the use of technology to reduce the total cost of healthcare for all Americans and utilizing the cost savings to expand access to the healthcare system.

Pursuant to HITECH Act regulations, hospitals that do not qualify as a meaningful user of EHR by 2015 are subject to a reduced market basket update to the IPPS standardized amount in 2015 and each subsequent fiscal year. We believe that all of our acute care hospitals have met the applicable meaningful use criteria and therefore are not subject to a reduced market basked update to the IPPS standardized amount in federal fiscal year 2015. However, under the HITECH Act, hospitals must continue to meet the applicable meaningful use criteria in each fiscal year or they will be subject to a market basket update reduction in a subsequent fiscal year. Failure of our acute care hospitals to continue to meet the applicable meaningful use criteria would have an adverse effect on our future net revenues and results of operations.

Our consolidated results of operations during the three-month periods ended June 30, 2015 and 2014 include the unfavorable pre-tax impact of approximately $7 million and $6 million, respectively, related primarily to the depreciation and amortization expense incurred in connection with the implementation of electronic health records applications ("EHR") at our acute care hospitals (net of amounts attributable to noncontrolling interests and incentive income of $1 million and $2 million during the three-month periods ended June 30, 2015 and 2014, respectively). Our consolidated results of operations during the six-month periods ended June 30, 2015 and 2014 include the unfavorable pre-tax impact of approximately $15 million and $14 million, respectively, related primarily to the depreciation and amortization expense incurred in connection with the implementation of electronic health records applications ("EHR") at our acute care hospitals (net of amounts attributable to noncontrolling interests and incentive income of $1 million and $3 million during the six-month periods ended June 30, 2015 and 2014, respectively).

Federal regulations require that Medicare EHR incentive payments be computed based on the Medicare cost report that begins in the federal fiscal period in which a hospital meets the applicable "meaningful use" requirements. Since the annual Medicare cost report periods for each of our acute care hospitals ends on December 31st , we will recognize Medicare EHR incentive income for each hospital during the fourth quarter of the year in which the facility meets the "meaningful use" criteria and during the fourth quarter of each applicable subsequent year.

Managed Care: A significant portion of our net patient revenues are generated from managed care companies, which include health maintenance organizations, preferred provider organizations and managed Medicare (referred to as Medicare Part C or Medicare Advantage) and Medicaid programs. In general, we expect the percentage of our business from managed care programs to continue to grow. The consequent growth in managed care networks and the resulting impact of these networks on the operating results of our facilities vary among the markets in which we operate. Typically, we receive lower payments per patient from managed care payors than we do from traditional indemnity insurers, however, during the past few years we have secured price increases from many of our commercial payors including managed care companies.

Commercial Insurance: Our hospitals also provide services to individuals covered by private health care insurance. Private insurance carriers typically make direct payments to hospitals or, in some cases, reimburse their policy holders, based upon the particular hospital's established charges and the particular coverage provided in the insurance policy. Private insurance reimbursement varies among payors and states and is generally based on contracts negotiated between the hospital and the payor.

Commercial insurers are continuing efforts to limit the payments for hospital services by adopting discounted payment mechanisms, including predetermined payment or DRG-based payment systems, for more inpatient and outpatient services. To the extent that such efforts are successful and reduce the insurers' reimbursement to hospitals and the costs of providing services to their beneficiaries, such reduced levels of reimbursement may have a negative impact on the operating results of our hospitals.

Other Sources: Our hospitals provide services to individuals that do not have any form of health care coverage. Such patients are evaluated, at the time of service or shortly thereafter, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other state assistance programs, as well as our local hospitals' indigent and charity care policy. Patients without health care coverage who do not qualify for Medicaid or indigent care write-offs are offered substantial discounts in an effort to settle their outstanding account balances.

Sources of Revenues and Health Care Reform: Given increasing budget deficits, the federal government and many states are currently considering additional ways to limit increases in levels of Medicare and Medicaid funding, which could also adversely affect future payments received by our hospitals. In addition, the uncertainty and fiscal pressures placed upon the federal government as a result of, among other things, the War on Terrorism, economic recovery stimulus packages, responses to natural disasters, the expansion of a Medicare drug benefit and the federal budget deficit in general may affect the availability of federal funds to provide additional relief in the future. We are unable to predict the effect of future policy changes on our operations.

In March, 2010, the Health Care and Education Reconciliation Act of 2010 (H.R. 4872, P.L. 111-152), (the "Reconciliation Act") and the Patient Protection and Affordable Care Act (P.L. 111-148), (the "Affordable Care Act"), were enacted into law and created significant changes to health insurance coverage for U.S. citizens as well as material revisions to the federal Medicare and state Medicaid programs. Medicare, Medicaid and other health care industry changes which are scheduled to be implemented at various times during this decade are noted below.

Implemented Medicare Reductions and Reforms:

- The Reconciliation Act reduced the market basket update for inpatient and outpatient hospitals and inpatient behavioral health facilities by 0.25% in each of 2010 and 2011, by 0.10% in each of 2012 and 2013 and 0.30% in 2014.
- The Affordable Care Act implemented certain reforms to Medicare Advantage payments, effective in 2011.
- A Medicare shared savings program, effective in 2012.
- A hospital readmissions reduction program, effective in 2012.
- A value-based purchasing program for hospitals, effective in 2012.
- A national pilot program on payment bundling, effective in 2013.
- Reduction to Medicare disproportionate share hospital ("DSH") payments, effective in 2014, as discussed above.

Medicaid Revisions:

- Expanded Medicaid eligibility and related special federal payments, effective in 2014.
- The Affordable Care Act (as amended by subsequent federal legislation) requires annual aggregate reductions in federal DSH funding from federal fiscal year ("FFY") 2018 through FFY 2025. The aggregate annual reduction amounts are:

  $2.0 billion for FFY 2018

  $3.0 billion for FFY 2019

  $4.0 billion for FFY 2020

  $5.0 billion for FFY 2021

  $6.0 billion for FFY 2022

  $7.0 billion for FFY 2023

  $8.0 billion for FFY 2024

  $8.0 billion for FFY 2025

Health Insurance Revisions:

- Large employer insurance reforms, effective in 2015.
- Individual insurance mandate and related federal subsidies, effective in 2014.
- Federally mandated insurance coverage reforms, effective in 2010 and forward.

The Affordable Care Act seeks to increase competition among private health insurers by providing for transparent federal and state insurance exchanges. The Affordable Care Act also prohibits private insurers from adjusting insurance premiums based on health status, gender, or other specified factors. We cannot provide assurance that these provisions will not adversely affect the ability of private insurers to pay for services provided to insured patients, or that these changes will not have a negative material impact on our results of operations going forward.

Value-Based Purchasing:

There is a trend in the healthcare industry toward value-based purchasing of healthcare services. These value-based purchasing programs include both public reporting of quality data and preventable adverse events tied to the quality and efficiency of care provided by facilities. Governmental programs including Medicare and Medicaid currently require hospitals to report certain quality data to receive full reimbursement updates. In addition, Medicare does not reimburse for care related to certain preventable adverse events. Many large commercial payers currently require hospitals to report quality data, and several commercial payers do not reimburse hospitals for certain preventable adverse events.

The Affordable Care Act contains a number of provisions intended to promote value-based purchasing. The Affordable Care Act prohibits the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat hospital acquired conditions ("HAC"). Beginning in FFY 2015, hospitals that fall into the top 25% of national risk-adjusted HAC rates for all hospitals in the previous year will receive a 1% reduction in their total Medicare payments. Hospitals with excessive readmissions for conditions designated by HHS will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard.

The Affordable Care Act also required HHS to implement a value-based purchasing program for inpatient hospital services which became effective on October 1, 2012. The Affordable Care Act requires HHS to reduce inpatient hospital payments for all discharges by a percentage beginning at 1% in FFY 2013 and increasing by 0.25% each fiscal year up to 2% in FFY 2017 and subsequent years. HHS will pool the amount collected from these reductions to fund payments to reward hospitals that meet or exceed certain quality performance standards established by HHS. HHS will determine the amount each hospital that meets or exceeds the quality performance standards will receive from the pool of dollars created by these payment reductions. In its fiscal year 2016 IPPS final rule, CMS will fund the value-based purchasing program by reducing base operating DRG payment amounts to participating hospitals by 1.75%.

Readmission Reduction Program:

In the Affordable Care Act, Congress also mandated implementation of the hospital readmission reduction program ("HRRP"). The HRRP assesses penalties on hospitals having excess readmission rates when compared to expected rates, effective for discharges beginning October 1, 2012. In the fiscal year 2013 IPPS final rule, CMS finalized certain policies with regard to payment under the

HRRP, including which hospitals are subject to the HRRP, the methodology to calculate the hospital readmission payment adjustment factor, and what portion of the IPPS payment is used to calculate the readmission adjustment factor. In the fiscal year 2014 IPPS final rule, CMS finalized revisions to the three 30-day admission measures in the program—heart failure, myocardial infarction, and pneumonia—to exclude planned readmissions. Under the Affordable Care Act, beginning in fiscal year 2015, the maximum reduction in payments under the HRRP will increase from 2% to 3%. CMS will expand the program and add two readmission measures, one, acute exacerbation of chronic obstructive pulmonary disease (COPD) and, two, patients admitted for elective total hip arthroplasty (THA) and total knee arthroplasty (TKA). In the fiscal year 2015 IPPS final rule, CMS added readmissions for coronary artery bypass graft (CABG) surgical procedures beginning in fiscal year 2017. We do not believe impact of HRRP for federal fiscal year 2015 had or will have a material adverse effect on our results of operations.

Accountable Care Organizations:

The Affordable Care Act requires HHS to establish a Medicare Shared Savings Program that promotes accountability and coordination of care through the creation of accountable care organizations ("ACOs"). The ACO program allows providers (including hospitals), physicians and other designated professionals and suppliers to voluntarily work together to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS will be eligible to share in a portion of the amounts saved by the Medicare program.

In addition to statutory and regulatory changes to the Medicare and each of the state Medicaid programs, our operations and reimbursement may be affected by administrative rulings, new or novel interpretations and determinations of existing laws and regulations, post-payment audits, requirements for utilization review and new governmental funding restrictions, all of which may materially increase or decrease program payments as well as affect the cost of providing services and the timing of payments to our facilities. The final determination of amounts we receive under the Medicare and Medicaid programs often takes many years, because of audits by the program representatives, providers' rights of appeal and the application of numerous technical reimbursement provisions. We believe that we have made adequate provisions for such potential adjustments. Nevertheless, until final adjustments are made, certain issues remain unresolved and previously determined allowances could become either inadequate or more than ultimately required.

Finally, we expect continued third-party efforts to aggressively manage reimbursement levels and cost controls. Reductions in reimbursement amounts received from third-party payors could have a material adverse effect on our financial position and our results of operations.

Other Operating Results

Interest Expense:

As reflected on the schedule below, interest expense was $28 million and $35 million during the three-month periods ended June 30, 2015 and 2014, respectively, and $58 million and $70 million during the six-month periods ended June 30, 2015 and 2014, respectively, (amounts in thousands):

	Three Months Ended June 30, 2015	Three Months Ended June 30, 2014	Six Months Ended June 30, 2015	Six Months Ended June 30, 2014
Revolving credit & demand notes (a.)	$ 520	$ 552	$ 1,318	$ 1,109
$400 million, 7.125% Senior Notes due 2016	7,124	7,124	14,248	14,248
$250 million, 7.00% Senior Notes due 2018(b.)	0	4,375	0	8,750
$300 million, 3.75% Senior Notes due 2019(c.)	2,813	0	5,625	0
$300 million, 4.75% Senior Notes due 2022(c.)	3,562	0	7,125	0
Term loan facility A/new 8/2014 (a.)	7,519	0	15,047	0
Term loan facility A/original (a.)	0	4,058	0	8,147
Term loan facility B/B-1 (a.)	0	3,339	0	6,651
Term loan facility A2 (a.)	0	3,637	0	7,273
Accounts receivable securitization program (d.)	748	484	1,529	1,019
Subtotal-revolving credit, demand notes, Senior Notes, term loan facilities and accounts receivable securitization program	22,286	23,569	44,892	47,197
Interest rate swap expense, net	2,032	4,785	6,180	9,498
Amortization of financing fees	1,758	5,238	3,521	10,474
Other combined interest expense	1,654	1,500	3,179	3,121

	Three Months Ended June 30, 2015	Three Months Ended June 30, 2014	Six Months Ended June 30, 2015	Six Months Ended June 30, 2014
Capitalized interest on major projects	(41)	0	(41)	0
Interest income	(5)	(5)	(10)	(10)
Interest expense, net	$ 27,684	$ 35,087	$ 57,721	$ 70,280

(a.) In August, 2014 we entered into a fourth amendment to our credit agreement dated November 15, 2010, as amended. The credit agreement, as amended, which is scheduled to expire in August, 2019, consists of: (i) an $800 million revolving credit facility, and; (ii) a $1.775 billion Term Loan A facility, which combined our previously outstanding term loan A and term loan A2 facilities (which were scheduled to mature in 2016). Interest rates were not impacted by the fourth amendment to the credit agreement. The Term Loan B-1 facility was repaid in August, 2014 utilizing other borrowed funds.

(b.) In July, 2014, we redeemed the entire $250 million aggregate principal amount of our 7% Senior Notes due in 2018. An $11 million make-whole premium was paid in connection with this early extinguishment.

(c.) In August, 2014, we completed an offering of $300 million aggregate principal amount of 3.750% Senior Secured Notes due in 2019 and $300 million aggregate principal amount of 4.750% Senior Secured Notes due in 2022.

(d.) Effective August 1, 2014, we increased the borrowing capacity on our existing accounts receivable securitization program, which is scheduled to expire in October, 2016, to $360 million from $275 million.

Interest expense decreased $7 million during the three-month period ended June 30, 2015, as compared to the comparable quarter of 2014. The decrease was due primarily to: (i) a $1 million decrease in aggregate interest expense on our revolving credit and demand notes, Senior Notes, term loan facilities and accounts receivable securitization program primarily due to a decrease in the average outstanding borrowings and the average cost of borrowings; (ii) a $3 million decrease in interest rate swap expense, resulting primarily from the May, 2015, maturity of our previously outstanding interest rate swaps, and; (iii) a $3 million decrease in amortization of financing fees, resulting primarily from the write-off of certain deferred financing costs and original issue discounts in connection with the various financing transactions that occurred during the third quarter of 2014, as discussed above.

Interest expense decreased $13 million during the six-month period ended June 30, 2015, as compared to the comparable period of 2014. The decrease was due primarily to: (i) a $2 million decrease in aggregate interest expense on our revolving credit and demand notes, Senior Notes, term loan facilities and accounts receivable securitization program primarily due to a decrease in the average outstanding borrowings and the average cost of borrowings; (ii) a $3 million decrease in interest rate swap expense, resulting primarily from the May, 2015, maturity of our previously outstanding interest rate swaps, and; (iii) a $7 million decrease in amortization of financing fees, resulting primarily from the write-off of certain deferred financing costs and original issue discounts in connection with the various financing transactions that occurred during the third quarter of 2014, as discussed above.

Provision for Income Taxes and Effective Tax Rates:

The effective tax rates, as calculated by dividing the provision for income taxes by income before income taxes, were as follows for the three and six-month periods ended June 30, 2015 and 2014 (dollar amounts in thousands):

	Three months ended		Six months ended	
	June 30, 2015	June 30, 2014	June 30, 2015	June 30, 2014
Provision for income taxes	$106,304	$ 91,731	$208,998	$175,662
Income before income taxes	307,708	258,345	604,725	494,128
Effective tax rate	34.5%	35.5%	34.6%	35.5%

Outside owners hold various noncontrolling, minority ownership interests in seven of our acute care facilities (excluding a new acute care hospital located in Henderson, Nevada which is currently under construction) and one behavioral health care facility. Each of these facilities are owned and operated by limited liability companies (“LLC”) or limited partnerships (“LP”). As a result, since there is no income tax liability incurred at the LLC/LP level (since it passes through to the members/partners), the net income attributable to noncontrolling interests does not include any income tax provision/benefit. When computing the provision for income taxes, as reflected on our consolidated statements of income, the net income attributable to noncontrolling interests is deducted from income before income taxes since it represents the third-party members’/partners’ share of the income generated by the joint-venture entities. In addition to providing the effective tax rates, as indicated above (as calculated from dividing the provision for income taxes by the income before income taxes as reflected on the consolidated statements of income), we believe it is helpful to our investors that we also provide our effective tax rate as calculated after giving effect to the portion of our pre-tax income that is attributable to the third-party members/partners.

The effective tax rates, as calculated by dividing the provision for income taxes by the difference in income before income taxes, minus net income attributable to noncontrolling interests, were as follows for each of the three and six-month periods ended June 30, 2015 and 2014 (dollar amounts in thousands):

	Three months ended		Six months ended	
	June 30, 2015	June 30, 2014	June 30, 2015	June 30, 2014
Provision for income taxes	$106,304	$ 91,731	$208,998	$175,662
Income before income taxes	307,708	258,345	604,725	494,128
Less: Net income attributable to noncontrolling interests	(19,211)	(14,943)	(39,235)	(28,717)
Income before income taxes and after net income attributable to noncontrolling interests	288,497	243,402	565,490	465,411
Effective tax rate	36.8%	37.7%	37.0%	37.7%

The decrease in the effective tax rate during the three and six-month periods ended June 30, 2015, as compared to the comparable prior year periods, was due primarily to lower effective income tax rates applicable to the income generated during the first six months of 2015 at the behavioral health care facilities located in the United Kingdom that were acquired during the third quarter of 2014.

Liquidity

Net cash provided by operating activities

Net cash provided by operating activities was $532 million during the six-month period ended June 30, 2015 and $458 million during the comparable period of 2014. The net increase of $73 million was primarily attributable to the following:

- a favorable change of $105 million due to an increase in net income plus/minus depreciation and amortization expense, stock-based compensation expense and gains on sales of assets and businesses;
- a $33 million unfavorable change in accounts receivable;
- a $29 million unfavorable other working capital accounts due primarily to timing of payments related to accrued liabilities;
- a $20 million favorable change in accrued and deferred income taxes;
- an $11 million favorable change in accrued insurance expense net of payment made in settlement of self-insured claims, and;
- $1 million of other combined net unfavorable changes.

Days sales outstanding ("DSO"): Our DSO are calculated by dividing our net revenue by the number of days in the six-month periods. The result is divided into the accounts receivable balance at June 30th of each year to obtain the DSO. Our DSO were 55 days at June 30, 2015 and 54 days at June 30, 2014.

Our accounts receivable as of June 30, 2015 and December 31, 2014 include amounts due from Illinois of approximately $24 million and $44 million, respectively. Collection of the outstanding receivables continues to be delayed due to state budgetary and funding pressures. Approximately $8 million as of June 30, 2015 and $23 million as of December 31, 2014, of the receivables due from Illinois were outstanding in excess of 60 days, as of each respective date. In addition, our accounts receivable as of June 30, 2015 and December 31, 2014 includes approximately $97 million and $102 million, respectively, due from Texas in connection with Medicaid supplemental payment programs. The $97 million due from Texas as of June 30, 2015 consists of $52 million related to uncompensated care program revenues, $27 million related to disproportionate share hospital program revenues and $18 million to Delivery Service Reform Incentive Payment program revenues. Although the accounts receivable due from Illinois and Texas could remain outstanding for the foreseeable future, since we expect to eventually collect all amounts due to us, no related reserves have been established in our consolidated financial statements. However, we can provide no assurance that we will eventually collect all amounts due to us from Illinois and/or Texas. Failure to ultimately collect all outstanding amounts due from these states would have an adverse impact on our future consolidated results of operations and cash flows.

Net cash used in investing activities

The $205 million of net cash used in investing activities during the first six months of 2015 consisted of: (i) $171 million spent on capital expenditures, and; (ii) $35 million spent related to the acquisition of businesses and property including the acquisition of a 46-bed behavioral health care facility located near Taunton, United Kingdom.

The $255 million of net cash used in investing activities during the first six months of 2014 consisted of: (i) $187 million spent on capital expenditures; (ii) $8 million spent in connection with the purchase and implementation of a electronic health records applications; (iii) spent $71 million to acquire and fund the required capital reserves related to a commercial health insurer headquartered in Reno, Nevada, acquire a 124-bed behavioral health care facility and outpatient treatment center located in Washington, D.C., and acquire the operations of a 48-bed behavioral health facility in Tucson, Arizona, and; (iv) $11 million received in connection with the divestiture of a non-operating investment which generated a $10 million pre-tax gain which is included in our results of operations during the first quarter of 2014.

Net cash used in financing activities

During the first six months of 2015, we used $316 million of net cash in financing activities as follows:

- spent $256 million on net repayments of debt due primarily to repayments pursuant to our revolving credit facility ($140 million), term loan A facility ($22 million), accounts receivable securitization program ($90 million) and various other debt facilities ($4 million);
- generated $5 million of proceeds from new borrowings pursuant to our on-demand credit facility;
- generated $28 million of excess income tax benefits related to stock-based compensation;
- spent $68 million to repurchase shares of our Class B Common Stock in connection with: (i) income tax withholding obligations related to stock-based compensation programs ($32 million), and; (ii) open market purchases pursuant to our $400 million stock repurchase program ($36 million);
- generated $13 million from the sale/leaseback of two free-standing emergency departments;
- spent $20 million to pay quarterly cash dividends of $.10 per share;
- spent $23 million to pay profit distributions related to noncontrolling interests in majority owned businesses, and;
- generated $4 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

During the first six months of 2014, we used $206 million of net cash in financing activities as follows:

- spent $179 million on net repayments of debt due primarily to repayments pursuant to our: (i) previously outstanding term loan A and A2 facilities ($36 million), accounts receivable securitization program ($110 million), on-demand line of credit ($22 million), and various other debt facilities ($11 million);
- generated $28 million of excess income tax benefits related to stock-based compensation;
- spent $36 million to repurchase shares of our Class B Common Stock in connection with income tax withholding obligations related to stock-based compensation programs;
- spent $10 million to pay quarterly cash dividends of $.05 per share;
- spent $13 million to pay profit distributions related to noncontrolling interests in majority owned businesses, and;
- generated $3 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

Expected Capital Expenditures During the Remainder of 2015:

During the remaining six months of 2015, we expect to spend approximately $200 million to $230 million on capital expenditures. We believe that our capital expenditure program is adequate to expand, improve and equip our existing hospitals. We expect to finance all capital expenditures and acquisitions with internally generated funds and/or additional funds, as discussed below.

Capital Resources

Credit Facilities and Outstanding Debt Securities

During the third quarter of 2014, we completed the following financing transactions:

- In August, 2014, we entered into a fourth amendment to our credit agreement dated as of November 15, 2010, as amended (“Credit Agreement”). The Credit Agreement, which is scheduled to mature in August, 2019, consists of: (i) an $800 million revolving credit facility (no borrowings outstanding as of June 30, 2015), and; (ii) a $1.775 billion term loan A facility ($1.742 billion of borrowings outstanding as of June 30, 2015) which combined our previously outstanding term loan A and term loan A2 facilities which were scheduled to mature in 2016;

- Repaid $550 million of outstanding borrowings pursuant to our previously outstanding term loan B facility which was scheduled to mature in 2016;
- Increased the borrowing capacity on our existing accounts receivable securitization program ("Securitization") to $360 million from $275 million, effective August 1, 2014. The Securitization, the terms of which remain the same as the previous agreement, as discussed below, is scheduled to mature in October, 2016;
- Issued $300 million aggregate principal amount of 3.750% senior secured notes due in 2019 (see below for additional disclosure);
- Issued $300 million aggregate principal amount of 4.750% senior secured notes due in 2022 (see below for additional disclosure);
- Redeemed our previously outstanding $250 million, 7.00% senior unsecured notes due in 2018 on July 31, 2014 for an aggregate price equal to 104.56% of the principal amount.

Borrowings under the Credit Agreement bear interest at either (1) the ABR rate which is defined as the rate per annum equal to, at our election: the greatest of (a) the lender's prime rate, (b) the weighted average of the federal funds rate, plus 0.5% and (c) one month LIBOR rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.50% to 1.25% for revolving credit and term loan-A borrowings, or (2) the one, two, three or six month LIBOR rate (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.50% to 2.25% for revolving credit and term loan-A borrowings. As of June 30, 2015, the applicable margins were 0.50% for ABR-based loans, 1.50% for LIBOR-based loans under the revolving credit and term loan-A facilities.

As of June 30, 2015, we had no borrowings outstanding pursuant to the terms of our $800 million revolving credit facility and we had $755 million of available borrowing capacity, net of $6 million of outstanding borrowings pursuant to a short-term, on-demand credit facility and $39 million of outstanding letters of credit. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Credit Agreement is secured by certain assets of the Company and our material subsidiaries and guaranteed by our material subsidiaries.

Pursuant to the terms of the Credit Agreement, term loan-A quarterly installment payments of approximately: (i) $11 million commenced during the fourth quarter of 2014 and are scheduled to continue through September, 2016, and; (ii) $22 million are scheduled from the fourth quarter of 2016 through June, 2019.

As discussed above, on August 1, 2014, our accounts receivable securitization program ("Securitization"), with a group of conduit lenders and liquidity banks which is scheduled to mature in October, 2016, was amended to increase the borrowing capacity to $360 million from $275 million. Substantially all of the patient-related accounts receivable of our acute care hospitals ("Receivables") serve as collateral for the outstanding borrowings. We have accounted for this Securitization as borrowings. We maintain effective control over the Receivables since, pursuant to the terms of the Securitization, the Receivables are sold from certain of our subsidiaries to special purpose entities that are wholly-owned by us. The Receivables, however, are owned by the special purpose entities, can be used only to satisfy the debts of the wholly-owned special purpose entities, and thus are not available to us except through our ownership interest in the special purpose entities. The wholly-owned special purpose entities use the Receivables to collateralize the loans obtained from the group of third-party conduit lenders and liquidity banks. The group of third-party conduit lenders and liquidity banks do not have recourse to us beyond the assets of the wholly-owned special purpose entities that securitize the loans. At June 30, 2015, we had $240 million of outstanding borrowings and $120 million of additional capacity pursuant to the terms of our accounts receivable securitization program.

On August 7, 2014, we issued $300 million aggregate principal amount of 3.750% Senior Secured Notes due 2019 (the "2019 Notes") and $300 million aggregate principal amount of 4.750% Senior Secured Notes due 2022 (the "2022 Notes", and together with the 2019 Notes, the "New Senior Secured Notes"). The New Senior Secured Notes were offered only to qualified institutional buyers under Rule 144A and to non-U.S. persons outside the United States in reliance on Regulation S under the Securities Act of 1933, as amended (the "Securities Act"). The New Senior Secured Notes have not been registered under the Securities Act and may not be offered or sold in the United States absent registration or an applicable exemption from registration requirements. Interest is payable on the New Senior Secured Notes on February 1 and August 1 of each year to the holders of record at the close of business on the January 15 and July 15 immediately preceding the related interest payment dates, commencing on February 1, 2015 until the maturity date of August 1, 2019 for the 2019 Notes and August 1, 2022 for the 2022 Notes.

On June 30, 2006, we issued $250 million of senior secured notes which have a 7.125% coupon rate and mature on June 30, 2016 (the "7.125% Notes"). Interest on the 7.125% Notes is payable semiannually in arrears on June 30th and December 30th of each year. In June, 2008, we issued an additional $150 million of 7.125% Notes which formed a single series with the original 7.125% Notes issued in June, 2006. Other than their date of issuance and initial price to the public, the terms of the 7.125% Notes issued in June, 2008 are identical to and trade interchangeably with, the 7.125% Notes which were originally issued in June, 2006.

On July 31, 2014, we redeemed the $250 million, 7.00% senior unsecured notes (the "Unsecured Notes"), which were scheduled to mature on October 1, 2018, at a redemption price equal to 104.56% of the principal amount of the Unsecured Notes resulting in a make-whole premium payment of approximately $11 million. The Unsecured Notes were issued on September 29, 2010 and registered in April, 2011. Interest on the Unsecured Note was payable semiannually in arrears on April 1st and October 1st of each year.

In connection with entering into the previous Credit Agreement on November 15, 2010, and in accordance with the Indenture dated January 20, 2000 governing the rights of our existing notes, we entered into a supplemental indenture pursuant to which our 7.125% Notes (due in 2016) were equally and ratably secured with the lenders under the Credit Agreement with respect to the collateral for so long as the lenders under the Credit Agreement are so secured.

Our Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens and indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage and minimum interest coverage ratios. We are in compliance with all required covenants as of June 30, 2015.

As of June 30, 2015, the carrying value of our debt was $3.0 billion and the fair-value of our debt was $3.1 billion. The fair value of our debt was computed based upon quotes received from financial institutions. We consider these to be "level 2" in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with debt instruments.

Our total debt as a percentage of total capitalization was 43% at June 30, 2015 and 47% at December 31, 2014.

We expect to finance all capital expenditures and acquisitions, pay dividends and potentially repurchase shares of our common stock utilizing internally generated and additional funds. Additional funds may be obtained through: (i) the issuance of equity; (ii) borrowings under our existing revolving credit facility or through refinancing the existing revolving credit agreement, and/or; (iii) the issuance of other long-term debt. We believe that our operating cash flows, cash and cash equivalents, available borrowing capacity under our $800 million revolving credit facility and $360 million accounts receivable securitization program, as well as access to the capital markets, provide us with sufficient capital resources to fund our operating, investing and financing requirements for the next twelve months. However, in the event we need to access the capital markets or other sources of financing, there can be no assurance that we will be able to obtain financing on acceptable terms or within an acceptable time. Our inability to obtain financing on terms acceptable to us could have a material unfavorable impact on our results of operations, financial condition and liquidity.

Off-Balance Sheet Arrangements

During the three months ended June 30, 2015, there have been no material changes in the off-balance sheet arrangements consisting of operating leases and standby letters of credit and surety bonds. Reference is made to *Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations – Contractual Obligations and Off-Balance Sheet Arrangements*, in our Annual Report on Form 10-K for the year ended December 31, 2014.

We have various obligations under operating leases or master leases for real property and under operating leases for equipment. The real property master leases are leases for buildings on or near hospital property for which we guarantee a certain level of rental income. We sublease space in these buildings and any amounts received from these subleases are offset against the expense. In addition, we lease three acute care hospitals from Universal Health Realty Income Trust (the "Trust") with terms scheduled to expire in 2016. These leases contain up to three, 5-year renewal options. We also lease two free-standing emergency departments and space in certain medical office buildings which are owned by the Trust.

As of June 30, 2015 we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds which totaled $118 million consisting of: (i) $96 million related to our self-insurance programs, and; (ii) $22 million of other debt and public utility guarantees.

Item 3. Quantitative and Qualitative Disclosures About Market Risk

Reference is made to *Item 7A. Quantitative and Qualitative Disclosures About Market Risk* in our Annual Report on Form 10-K for the year ended December 31, 2014.

As disclosed in Note 4 to the Condensed Consolidated Financial Statements (*Long-term debt and cash flow hedges)*, seven interest rate swaps on a total notional amount of $825 million matured in May, 2015. Four of these swaps, with a total notional amount of $600 million, became effective in December, 2011 and provided that we receive three-month LIBOR while the average fixed rate payable was 2.38%. The remaining three swaps, with a total notional amount of $225 million, became effective in March, 2011 and provided that we receive three-month LIBOR while the average fixed rate payable was 1.91%.

During the second quarter of 2015, we entered into four forward starting interest rate swaps whereby we pay a fixed rate on a total notional amount of $500 million and receive one-month LIBOR. Each of the four swaps became effective on July 15, 2015 and are scheduled to mature on April 15, 2019. The average fixed rate payable on these swaps is 1.40%.

In July, 2015, we entered into two additional forward starting interest rate swaps whereby we pay a fixed rate on a total notional amount of $200 million and receive one-month LIBOR. One swap on a notional amount of $100 million became effective on July 15, 2015 and another swap on a notional amount of $100 million becomes effective on September 15, 2015. Both of these swaps are scheduled to mature on April 15, 2019. The average fixed rate payable on these two swaps is 1.30%.

Item 4. Controls and Procedures

As of June 30, 2015, under the supervision and with the participation of our management, including our Chief Executive Officer (“CEO”) and Chief Financial Officer (“CFO”), we performed an evaluation of the effectiveness of our disclosure controls and procedures, as defined in Rule 13a-15(e) or Rule 15d-15(e) under the Securities Exchange Act of 1934, as amended (the “1934 Act”). Based on this evaluation, the CEO and CFO have concluded that our disclosure controls and procedures are effective to ensure that material information is recorded, processed, summarized and reported by management on a timely basis in order to comply with our disclosure obligations under the 1934 Act and the SEC rules thereunder.

Changes in Internal Control Over Financial Reporting

There have been no changes in our internal control over financial reporting or in other factors during the second quarter of 2015 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II. OTHER INFORMATION

Item 1. Legal Proceedings

We are subject to claims and suits in the ordinary course of business, including those arising from care and treatment afforded by our hospitals and are party to various government investigations, regulatory matters and litigation, as outlined below.

Office of Inspector General (“OIG”) and Government Investigations:

In September, 2010, we, along with many other companies in the healthcare industry, received a letter from the United States Department of Justice (“DOJ”) advising of a False Claim Act investigation being conducted in connection with the implantation of implantable cardioverter defibrillators (“ICDs”) from 2003 to 2010 at several of our acute care facilities. The DOJ alleges that ICDs were implanted and billed by our facilities in contravention of a National Coverage Determination regarding these devices. We had previously established a reserve in connection with this matter which did not have a material impact on our consolidated financial statements. During the second quarter of 2015, we finalized a settlement agreement with the government which approximated our established reserve.

In February, 2013, the Office of Inspector General for the United States Department of Health and Human Services (“OIG”) served a subpoena requesting various documents from January, 2008 to the date of the subpoena directed at Universal Health Services, Inc. (“UHS”) concerning it and UHS of Delaware, Inc., and several UHS owned behavioral health facilities including: Keys of Carolina, Old Vineyard Behavioral Health, The Meadows Psychiatric Center, Streamwood Behavioral Health, Hartgrove Hospital, Rock River Academy and Residential Treatment Center, Roxbury Treatment Center, Harbor Point Behavioral Health Center, f/k/a, The Pines Residential Treatment Center, including the Crawford, Brighton and Kempsville campuses, Wekiva Springs Center and River Point Behavioral Health. Prior to receiving this subpoena: (i) the Keys of Carolina and Old Vineyard received notification during the second half of 2012 from the DOJ of its intent to proceed with an investigation following requests for documents for the period of January, 2007 to the date of the subpoenas from the North Carolina state Attorney General’s Office; (ii) Harbor Point Behavioral Health Center received a subpoena in December, 2012 from the Attorney General of the Commonwealth of Virginia requesting various documents from July, 2006 to the date of the subpoena, and; (iii) The Meadows Psychiatric Center received a subpoena from the OIG in February, 2013 requesting certain documents from 2008 to the date of the subpoena. Unrelated to these matters, the Keys of Carolina was closed and the real property was sold in January, 2013. We were advised that a qui tam action had been filed against Roxbury Treatment Center but the government declined to intervene and the case was dismissed.

In April, 2013, the OIG served facility specific subpoenas on Wekiva Springs Center and River Point Behavioral Health requesting various documents from January, 2005 to the date of the subpoenas. In July, 2013, another subpoena was issued to Wekiva Springs Center and River Point Behavioral Health requesting additional records. In October, 2013, we were advised by the DOJ’s Criminal Frauds Section that they received a referral from the DOJ Civil Division and opened an investigation of River Point Behavioral Health and Wekiva Springs Center. Subsequent subpoenas have since been issued to River Point Behavioral Health and Wekiva Springs Center requesting additional documentation. In April, 2014, the Centers for Medicare and Medicaid Services (“CMS”) instituted a Medicare payment suspension at River Point Behavioral Health in accordance with federal regulations regarding suspension of payments during certain investigations. The Florida Agency for Health Care Administration subsequently issued a Medicaid payment suspension for the facility. River Point Behavioral Health submitted a rebuttal statement disputing the basis of the suspension and

requesting revocation of the suspension. Notwithstanding, CMS continued the payment suspension. River Point Behavioral Health provided additional information to CMS in an effort to obtain relief from the payment suspension but the suspension remains in effect. In March 2015, we received notification from CMS that the payment suspension will be continued for another 180 days. We cannot predict if and/or when the facility's suspended payments will resume. Although the operating results of River Point Behavioral Health did not have a material impact on our consolidated results of operations during the six-month period ended June 30, 2015 or the year ended December 31, 2014, the payment suspension has had a material adverse effect on the facility's results of operations and financial condition.

In June, 2013, the OIG served a subpoena on Coastal Harbor Health System in Savannah, Georgia requesting documents from January, 2009 to the date of the subpoena.

In February, 2014, we were notified that the investigation conducted by the Criminal Frauds Section had been expanded to include the National Deaf Academy. In March, 2014, a Civil Investigative Demand ("CID") was served on the National Deaf Academy requesting documents and information from the facility from January 1, 2008 through the date of the CID. We have been advised by the government that the National Deaf Academy has been added to the facilities which are the subject of the coordinated investigation referenced above.

In March, 2014, CIDs were served on Hartgrove Hospital, Rock River Academy and Streamwood Behavioral Health requesting documents and information from those facilities from January, 2008 through the date of the CID.

In September, 2014, the DOJ Civil Division advised us that they were expanding their investigation to include four additional facilities and were requesting production of documents from these facilities. These facilities are Arbour-HRI Hospital, Behavioral Hospital of Bellaire, St. Simons by the Sea, and Turning Point Care Center.

In December 2014, the DOJ Civil Division requested that Salt Lake Behavioral Health produce documents responsive to the original subpoenas issued in February, 2013.

In March, 2015, the OIG issued subpoenas to Central Florida Behavioral Hospital and University Behavioral Center requesting certain documents from January, 2008 to the date of the subpoena.

In late March, 2015, we were notified that the investigation conducted by the Criminal Frauds Section has been expanded to include UHS as a corporate entity arising out of the coordinated investigation of the facilities described above and, in particular, Hartgrove Hospital.

The DOJ has advised us that the civil aspect of the coordinated investigation referenced above is a False Claim Act investigation focused on billings submitted to government payers in relation to services provided at those facilities. At present, we are uncertain as to potential liability and/or financial exposure of the Company and/or named facilities, if any, in connection with these matters.

Regulatory Matters:

On July 23, 2015, Timberlawn Mental Health System ("Timberlawn") received notification from CMS of its intent to terminate Timberlawn's Medicare provider agreement effective August 7, 2015. This notification resulted from surveys conducted which allege that Timberlawn is out of compliance with conditions of participation required for participation in the Medicare/Medicaid program. Some of the deficiencies were considered by CMS to be an "immediate jeopardy" situation. We have filed a request for expedited administrative appeal with the U.S. Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, seeking review and reversal of the termination action. In conjunction with the administrative appeal, we have filed litigation in the U.S District Court for the Northern District of Texas seeking a temporary restraining order and preliminary injunction to have the termination stayed pending the conclusion of the administrative appeal. The termination date has been extended to August 13, 2015 pending further review and rulings by the U.S. District Court. We can provide no assurance that we will be successful in the administrative appeal or litigation or that Timberlawn will not ultimately lose its Medicare/Medicaid certification. Any such termination of Timerlawn's Medicare/Medicaid certification, should it ultimately occur, would have a material adverse effect on the facility's future results of operations and financial condition and could result in closure of the facility. The operating results of Timberlawn did not have a material impact on our consolidated results of operations or financial condition for the six-month period ended June 30, 2015 or the year ended December 31, 2014.

During the second quarter of 2015, Texoma Medical Center ("Texoma"), which includes TMC Behavioral Health Center, entered into a Systems Improvement Agreement ("SIA") with CMS. The SIA abated a termination action from CMS following surveys which identified alleged failures to comply with conditions of participation primarily involving Texoma's behavioral health operations. The terms of the SIA required Texoma to engage independent consultants/experts approved by CMS to analyze and develop implementation plans at Texoma to meet Medicare conditions of participation. At the conclusion of the SIA, CMS will conduct a full certification survey to determine if Texoma is in substantial compliance with the Medicare conditions of participation. The term of agreement is set to conclude October 2, 2016 unless the terms of the agreement are fulfilled earlier. During the term of the SIA, Texoma remains eligible to receive reimbursements from Medicare and Medicaid for services rendered to Medicare and Medicaid beneficiaries.

Matters Relating to Psychiatric Solutions, Inc. ("PSI"):

The following matters pertain to PSI or former PSI facilities (owned by subsidiaries of PSI) which were in existence prior to the acquisition of PSI and for which we have assumed the defense as a result of our acquisition which was completed in November, 2010.

Department of Justice Investigation of Friends Hospital:

In October, 2010, Friends Hospital in Philadelphia, Pennsylvania, received a subpoena from the DOJ requesting certain documents from the facility. The requested documents were collected and provided to the DOJ for review and examination. Another subpoena was issued to the facility in July, 2011 requesting additional documents, which have also been delivered to the DOJ. All documents requested and produced pertained to the operations of the facility while under PSI's ownership prior to our acquisition. At present, we are uncertain as to the focus, scope or extent of the investigation, liability of the facility and/or potential financial exposure, if any, in connection with this matter.

Department of Justice Investigation of Riveredge Hospital:

In 2008, Riveredge Hospital in Chicago, Illinois received a subpoena from the DOJ requesting certain information from the facility. Additional requests for documents were also received from the DOJ in 2009 and 2010. The requested documents have been provided to the DOJ. All documents requested and produced pertained to the operations of the facility while under PSI's ownership prior to our acquisition. At present, we are uncertain as to the focus, scope or extent of the investigation, liability of the facility and/or potential financial exposure, if any, in connection with this matter.

General:

We operate in a highly regulated and litigious industry which subjects us to various claims and lawsuits in the ordinary course of business as well as regulatory proceedings and government investigations. These claims or suits include claims for damages for personal injuries, medical malpractice, commercial/contractual disputes, wrongful restriction of, or interference with, physicians' staff privileges, and employment related claims, In addition, health care companies are subject to investigations and/or actions by various state and federal governmental agencies or those bringing claims on their behalf. Government action has increased with respect to investigations and/or allegations against healthcare providers concerning possible violations of fraud and abuse and false claims statutes as well as compliance with clinical and operational regulations. Currently, and from time to time, we and some of our facilities are subjected to inquiries in the form of subpoenas, Civil Investigative Demands, audits and other document requests from various federal and state agencies. These inquiries can lead to notices and/or actions including repayment obligations from state and federal government agencies associated with potential non-compliance with laws and regulations. Further, the federal False Claim Act allows private individuals to bring lawsuits (qui tam actions) against healthcare providers that submit claims for payments to the government. Various states have also adopted similar statutes. When such a claim is filed, the government will investigate the matter and decide if they are going to intervene in the pending case. These qui tam lawsuits are placed under seal by the court to comply with the False Claims Act's requirements. If the government chooses not to intervene, the private individual(s) can proceed independently on behalf of the government. Health care providers that are found to violate the False Claims Act may be subject to substantial monetary fines/penalties as well as face potential exclusion from participating in government health care programs or be required to comply with Corporate Integrity Agreements as a condition of a settlement of a False Claim Act matter. In September 2014, the Criminal Division of the DOJ, announced that all qui tam cases will be shared with their Division to determine if a parallel criminal investigation should be opened. The Criminal Division has also stated an intention to pursue corporations in criminal prosecutions. In addition, health care facilities are subject to monitoring by state and federal surveyors to ensure compliance with program Conditions of Participation. In the event a facility is found to be out of compliance with a Condition of Participation and unable to remedy the alleged deficiency(s), the facility faces termination from the Medicare and Medicaid programs or compliance with a System Improvement Agreement to remedy deficiencies and ensure compliance.

The laws and regulations governing the healthcare industry are complex covering, among other things, government healthcare participation requirements, licensure, certification and accreditation, privacy of patient information, reimbursement for patient services as well as fraud and abuse compliance. These laws and regulations are constantly evolving and expanding. Further, the Affordable Care Act has added additional obligations on healthcare providers to report and refund overpayments by government healthcare

programs and authorizes the suspension of Medicare and Medicaid payments "pending an investigation of a credible allegation of fraud." We monitor our business and have developed an ethics and compliance program with respect to these complex laws, rules and regulations. Although we believe our policies, procedures and practices comply with government regulations, there is no assurance that we will not be faced with the sanctions referenced above which include fines, penalties and/or substantial damages, repayment obligations, payment suspensions, licensure revocation, and expulsion from government healthcare programs. Even if we were to ultimately prevail in any action brought against us or our facilities or in responding to any inquiry, such action or inquiry could have a material adverse effect on us.

The outcome of any current or future litigation or governmental or internal investigations, including the matters described above, cannot be accurately predicted, nor can we predict any resulting penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities. We record accruals for such contingencies to the extent that we conclude it is probable that a liability has been incurred and the amount of the loss can be reasonably estimated. No estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made at this time regarding the matters specifically described above because the inherently unpredictable nature of legal proceedings may be exacerbated by various factors, including, but not limited to: (i) the damages sought in the proceedings are unsubstantiated or indeterminate; (ii) discovery is not complete; (iii) the proceeding is in its early stages; (iv) the matters present legal uncertainties; (v) there are significant facts in dispute; (vi) there are a large number of parties, or; (vii) there is a wide range of potential outcomes. It is possible that the outcome of these matters could have a material adverse impact on our future results of operations, financial position, cash flows and, potentially, our reputation.

In addition, various suits and claims arising against us in the ordinary course of business are pending. In the opinion of management, the outcome of such claims and litigation will not materially affect our consolidated financial position or results of operations.

Item 1A. Risk Factors

Our Annual Report on Form 10-K for the year ended December 31, 2014 includes a listing of risk factors to be considered by investors in our securities. There have been no material changes in our risk factors from those set forth in our Annual Report on Form 10-K for the year ended December 31, 2014.

Item 2. Unregistered Sales of Equity Securities and Use of Proceeds

In various prior years, our Board of Directors approved stock repurchase programs authorizing us to purchase shares of our outstanding Class B Common Stock on the open market at prevailing market prices or in negotiated transactions off the market. During July, 2014, our Board of Directors authorized a new stock repurchase program whereby, from time to time as conditions allow, we may spend up to $400 million to purchase shares of our Class B Common Stock on the open market or in negotiated private transactions. There is no expiration date for our stock repurchase program. Upon approval of the new stock repurchase program, our previously announced stock repurchase program was cancelled. As reflected below, during the three-month period ended June 30, 2015, 256,440 shares ($30.8 million in the aggregate) were repurchased pursuant to the terms of our stock repurchase program and 67,952 shares were repurchased in connection with income tax withholding obligations resulting from the exercise of stock options.

During the period of April 1, 2015 through June 30, 2015, we repurchased the following shares:

	Additional Dollars Authorized For Repurchase (in thousands)	Total number of shares purchased	Total number of shares cancelled	Average price paid per share for forfeited restricted shares	Total Number of shares purchased as part of publicly announced programs	Average price paid per share for shares purchased as part of publicly announced program	Aggregate purchase price paid (in thousands)	Maximum number of shares that may yet be purchased under the program	Maximum number of dollars that may yet be purchased under the program (in thousands)
April, 2015	—	92,922	—	N/A	76,440	$ 115.16	$ 8,803	—	$ 327,640
May, 2015	—	145,007	—	N/A	105,000	119.22	12,518	—	$ 315,122
June, 2015	—	86,463	—	N/A	75,000	126.76	9,508	—	$ 305,614
Total April through June	—	324,392	—	N/A	256,440	$ 120.22	$ 30,829		

Dividends

During the quarter ended June 30, 2015, we declared and paid dividends of $.10 per share.

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Item 6. Exhibits

(a) Exhibits:

10.1*	Universal Health Services, Inc. Third Amended and Restated 2005 Stock Incentive Plan.
10.2*	Amended and Restated Universal Health Services, Inc. 2010 Employees' Restricted Stock Purchase Plan.
10.3*	Universal Health Services, Inc. 2010 Executive Incentive Plan.
11	Statement re computation of per share earnings is set forth in Note 7 of the Notes to Condensed Consolidated Financial Statements.
31.1	Certification of the Company's Chief Executive Officer pursuant to Rule 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934.
31.2	Certification of the Company's Chief Financial Officer pursuant to Rule 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934.
32.1	Certification of the Company's Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of the Company's Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Instance Document
101.SCH	XBRL Taxonomy Extension Schema Document
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document
101.LAB	XBRL Taxonomy Extension Label Linkbase Document
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document

* Management contract or compensatory plan or arrangement.

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

Signatures

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

Universal Health Services, Inc.
(Registrant)

Date: August 7, 2015

/s/ ALAN B. MILLER

Alan B. Miller, Chairman of the Board and Chief Executive Officer (Principal Executive Officer)

/s/ STEVE FILTON

Steve Filton, Senior Vice President and Chief Financial Officer (Principal Financial Officer)

EXHIBIT INDEX

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* Management contract or compensatory plan or arrangement.

Exhibit 10.1

UNIVERSAL HEALTH SERVICES, INC.
THIRD AMENDED AND RESTATED
2005 STOCK INCENTIVE PLAN

1. *Purpose; Background*. The purpose of the Universal Health Services, Inc. Third Amended and Restated 2010 Stock Incentive Plan (the "Plan") is to provide a flexible vehicle through which Universal Health Services, Inc., a Delaware corporation (the "Company"), may offer equity-based compensation incentives to key personnel of the Company and its affiliates in order to attract, motivate, reward and retain such personnel and to further align the interests of such personnel with those of the stockholders of the Company.

The original effective date of the Plan was June 2, 2005 and the original term of the Plan expires on June 2, 2015. This third amendment and restatement of the Plan has been adopted by the Company's Board of Directors (the "Board"), subject to and effective upon the approval of the Company's stockholders at their 2015 annual meeting, and is intended, among other things, to extend the term of the Plan until the tenth anniversary of the date of such stockholder approval.

2. *Types of Awards*. Awards under the Plan may be in the form of (a) options to purchase shares of the Company's Class B Common Stock, $.01 par value (the "Common Stock") pursuant to Section 6 below, including options intended to qualify as "incentive stock options" ("ISOs") within the meaning of Section 422 of the Internal Revenue Code of 1986, as amended (the "Code"), and options which do not qualify as ISOs, and (b) stock appreciation rights ("SARs") pursuant to Section 7 below (collectively, "Awards").

3. *Share Limitations*.

(a) *Aggregate Share Limitation*. Subject to adjustment as provided in Section 9 below, the maximum number of shares of Common Stock which may be issued pursuant to the Plan shall not exceed 29,500,000 shares (the "Authorized Shares"). In determining the number of Authorized Shares available for issuance under the Plan: (i) shares subject to an Award that is forfeited, canceled, terminated or settled in cash shall be deemed not to have been issued (and shall remain available for issuance) pursuant to the Plan; (ii) shares withheld or tendered by the recipient of an Award as payment of the exercise price under an Award or the tax withholding obligations associated with an Award will not be available for future grant and issuance under the Plan; and (iii) the total number of shares covered by stock-settled SARs (and not just the number of shares issued in settlement of such SARs) shall be deemed to have been issued under the Plan. Shares of Class B Common Stock that may be repurchased by us on the open market with proceeds from the exercise of stock options granted under the Stock Incentive Plan may not be returned to the pool of shares available for awards under the Stock Incentive Plan.

(b) *Individual Award Limitation*. Subject to adjustment as provided in Section 9 below, the maximum number of shares of Common Stock with respect to which options or SARs may be granted hereunder during a calendar year to any employee is 1,000,000 shares.

4. *Administration*.

(a) *Committee*. The Plan shall be administered by the Compensation Committee of the Company's Board of Directors (the "Board"), or such other committee of directors designated by the Board (the "Committee"), provided that all of said designated directors qualify as "non-employee directors" (within the meaning of Rule 16b-3(b)(3) under the Securities Exchange Act of 1934, as amended (the "Exchange Act")) and as "outside directors" (within the meaning of Treas. Reg. Section 1.162-27(e)(3) under Section 162(m) of the Code). Notwithstanding the foregoing, the Board shall have sole responsibility and authority for matters relating to the grant and administration of Awards to non-employee directors of the Company, and reference herein to the Committee with respect to any such matters shall be deemed to refer to the Board.

(b) *Responsibility and Authority of Committee*. Subject to the provisions of the Plan, the Committee, acting in its discretion, shall have responsibility and full power and authority to (i) select the persons to whom Awards shall be made, (ii) prescribe the terms and conditions of each Award and make amendments thereto, (iii) construe, interpret and apply the provisions of the Plan and of any agreement or other instrument evidencing an Award made under the Plan, and (iv) make any and all determinations and take any and all other actions as it deems necessary or desirable in order to carry out the terms of the Plan. In exercising its responsibilities under the Plan, the Committee may obtain at the Company's expense such advice, guidance and other assistance from outside compensation consultants and other professional advisers as it deems appropriate.

(c) *Limitations on Committee Authority*. Notwithstanding anything to the contrary contained herein:

(i) *Minimum Vesting Period*. Each Award made under the Plan shall provide for a vesting period of at least one year from the date the Award is granted.

(ii) *Re-Pricing Prohibited*. Except in connection with a corporate transaction involving the Company (including, without limitation, any stock dividend, distribution (whether in the form of cash, shares of Common Stock, other securities or other property), stock split, extraordinary cash dividend, recapitalization, change in control, reorganization, merger, consolidation, split-up, spin-off, combination, repurchase or exchange of shares of Common Stock or other securities, or similar transaction(s)), the Company may not, without obtaining stockholder approval: (1) reduce the exercise price or base price under outstanding options or SARs; (2) cancel outstanding options or SARs in exchange for options or SARs with a lower exercise price or base price; or (3) cancel outstanding options or SARs in exchange for cash or other securities at a time when the per share exercise or base price under such options or SARs is higher than "Fair Market Value" (as defined in Section 8 below).

(iii) *No Reloading of Options*. The Committee may not grant an Option that includes a "reload" feature or make any other Plan Awards that have the effect of providing a "reload" feature with respect to Shares used to satisfy the Option exercise price or applicable withholding tax.

(d) *Delegation of Authority*. To the fullest extent authorized under Section 157(c) and other applicable provisions of the Delaware General Corporation Law, the Committee may delegate to any person or group or subcommittee of persons (who may, but need not be, members of the Committee) such Plan-related functions within the scope of its responsibility, power and authority as it deems appropriate to the extent that such delegation shall not cause Awards intended to qualify as "performance-based compensation" under Code Section 162(m) or intended to qualify for an exemption under Rule 16b-3 under the Exchange Act to fail to so qualify.

(e) *Committee Actions*. A majority of the members of the Committee shall constitute a quorum. The Committee may act by the vote of a majority of its members present at a meeting at which there is a quorum or by unanimous written consent. The decision of the Committee as to any disputed question, including questions of construction, interpretation and administration, shall be final and conclusive on all persons. The Committee shall keep a record of its proceedings and acts and shall keep or cause to be kept such books and records as may be necessary in connection with the proper administration of the Plan.

(f) *Indemnification*. The Company shall indemnify and hold harmless each member of the Board, the Committee or any subcommittee appointed by the Committee and any employee of the Company who provides assistance with the administration of the Plan from and against any loss, cost, liability (including any sum paid in settlement of a claim with the approval of the Board), damage and expense (including reasonable legal fees and other expenses incident thereto and, to the extent permitted by applicable law, advancement of such fees and expenses) arising out of or incurred in connection with the Plan, unless and except to the extent attributable to such person's fraud or willful misconduct.

5. *Eligibility*. Awards may be granted under the Plan to present or future employees of the Company or an affiliate of the Company and to directors of, or consultants to, the Company or an affiliate who are not employees. For purposes hereof, "affiliate" of the Company means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the Company, provided that such entity is an "eligible issuer of service recipient stock" within the meaning of Section 1.409A-1(b)(5)(iii)(E) of the Treasury Regulations.

6. *Stock Options*. Stock options granted under the Plan shall have such vesting and other terms and conditions as the Committee, acting in its discretion in accordance with the Plan, may determine, either at the time the option is granted or, if the holder's rights are not adversely affected, at any subsequent time. The Committee may impose restrictions on shares of Common Stock acquired upon the exercise of options granted under the Plan.

(a) *Exercise Price*. The exercise price per share of Common Stock covered by an option granted under the Plan may not be less than 100% of the Fair Market Value (as defined in Section 8 below) of a share of Common Stock on the date the option is granted (110% in the case of ISOs granted to an employee who is a 10% stockholder within the meaning of Section 422(b)(6) of the Code).

(b) *Option Term*. Unless sooner terminated in accordance with its terms, an option shall automatically expire on the tenth anniversary of the date it is granted (the fifth anniversary of the date it is granted in the case of an ISO granted to an employee who is a 10% stockholder).

(c) *Manner of Exercise*. An outstanding and exercisable option may be exercised by transmitting to the Company pursuant to its established procedures a written notice identifying the option that is being exercised and specifying the number of shares to be purchased pursuant to that option, together with payment of the exercise price, and by satisfying the applicable tax withholding obligations pursuant to Section 10. The Committee may establish such rules and procedures as it deems appropriate for the exercise of options under the Plan. The Committee, acting in its sole discretion, may permit the exercise price to be paid in whole or in part in cash or by check, by means of a cashless exercise procedure (including, without limitation, by the Company's issuance of net shares), in the form of unrestricted shares of Common Stock or, subject to applicable law, by any other form of consideration deemed appropriate. Shares withheld (pursuant to a net share exercise) or tendered to pay the exercise price shall be credited to the extent of the Fair Market Value thereof.

(d) *Rights as a Stockholder*. No shares of Common Stock shall be issued in respect of the exercise of an option until payment of the exercise price and the applicable tax withholding obligations have been satisfied or provided for to the satisfaction of the Company. The holder of an option shall have no rights as a stockholder with respect to any shares covered by the option until the option is validly exercised, the exercise price is paid fully and applicable withholding obligations are satisfied fully.

(e) *Nontransferability of Options*. No option granted under the Plan may be assigned or transferred except upon the option holder's death to a beneficiary designated by the option holder in a manner prescribed or approved for this purpose by the Committee or, if no designated beneficiary shall survive the option holder, pursuant to the option holder's will or by the laws of descent and distribution; and each such option may be exercised during the option holder's lifetime only by the option holder. Notwithstanding the preceding sentence, the Committee may, in its sole discretion, permit an option holder to transfer an option, other than an ISO, in whole or in part, to such persons and/or entities as are approved by the Committee from time to time and subject to such terms and conditions as the Committee may determine from time to time.

(f) *Termination of Employment or Other Service*. Unless otherwise determined by the Committee in its sole discretion, if an option holder ceases to be employed by or to perform other services for the Company and its affiliates for any reason other than death or disability (defined below), then each outstanding option granted to him or her under the Plan will terminate on the date of termination of employment or other service or, if earlier, the date specified in the option agreement. Unless otherwise determined by the Committee in its sole discretion, if an option holder's employment or service is terminated by reason of the option holder's death or disability (or if the option holder's employment or other service is terminated by reason of his or her disability and the option holder dies within one year after such termination of employment or service), then each outstanding option granted to the option holder under the Plan will terminate on the date one year after the date of such termination of employment or other service (or one year after the later death of a disabled option holder) or, if earlier, the date specified in the option agreement. For purposes hereof, unless otherwise determined by the Committee, the term "disability" means the inability of an Award holder to perform the customary duties of his or her employment or other service for the Company or its affiliates by reason of a physical or mental incapacity which is expected to result in death or be of indefinite duration.

7. *Stock Appreciation Rights*. SARs granted under the Plan shall have such vesting and other terms and conditions as the Committee, acting in its discretion in accordance with the Plan, may determine, either at the time the SAR is granted or, if the holder's rights are not adversely affected, at any subsequent time. The Committee may impose restrictions on shares acquired upon the exercise of SARs granted under the Plan.

(a) *Base Price*. The base price per share of Common Stock covered by an SAR granted under the Plan may not be less than the Fair Market Value of a share of Common Stock on the date the SAR is granted.

(b) *SAR Term*. Unless sooner terminated in accordance with its terms, a SAR shall automatically expire on the tenth anniversary of the date it is granted.

(c) *Exercise of SARs*. An outstanding and exercisable SAR may be exercised by transmitting to the Company pursuant to its established procedures a written notice identifying the SAR that is being exercised, specifying the number of shares covered by the exercise and containing such other information or statements as the Committee may require, and by satisfying the applicable tax withholding obligations pursuant to Section 10. The Committee may establish such rules and procedures as it deems appropriate for the exercise of SARs under the Plan. Upon the exercise of an SAR, the holder shall be entitled to receive cash and/or shares of Common Stock, as determined by the Committee, in an amount or having a Fair Market Value equal to the product of (i) the number of shares of Common Stock with respect to which the SAR is being exercised, multiplied by (ii) the excess of the Fair Market Value of a share of Common Stock on the date the SAR is exercised over the base price per share of the SAR.

(d) *Nontransferability of SARs*. No SARs granted under the Plan may be assigned or transferred except upon the SAR holder's death to a beneficiary designated by the SAR holder in a manner prescribed or approved for this purpose by the Committee or, if no designated beneficiary shall survive the SAR holder, pursuant to the SAR holder's will or by the laws of descent and distribution; and each such SAR may be exercised during the SAR holder's lifetime only by the SAR holder.

(e) *Termination of Employment or Other Service*. Unless otherwise determined by the Committee in its sole discretion, if a SAR holder ceases to be employed by or to perform other services for the Company and its affiliates for any reason other than death or disability (defined above), then each outstanding SAR granted to him or her under the Plan will terminate on the date of termination of employment or other service or, if earlier, the date specified in the SAR agreement. Unless otherwise determined by the Committee in its sole discretion, if a SAR holder's employment or service is terminated by reason of the SAR holder's death or disability (or if the SAR holder's employment or other service is terminated by reason of his or her disability and the SAR holder dies within one year after such termination of employment or service), then each outstanding SAR granted to the SAR holder under the Plan will terminate on the date one year after the date of such termination of employment or other service (or one year after the later death of a disabled SAR holder) or, if earlier, the date specified in the SAR agreement.

8. *Fair Market Value*. For Plan purposes, the term "Fair Market Value" means, as of any relevant date, (a) the closing price per share of Common Stock on such date on the principal securities exchange on which the shares are traded or, if no shares are traded on that date, the closing price per share on the next preceding date on which shares are traded, or (b) the value determined under such other method or convention as the Board or the Committee, acting in a consistent manner in accordance with the Plan and applicable tax law (including, without limitation, Section 409A of the Code), may prescribe.

9. *Capital Changes; Merger, Consolidation, Asset Sale*.

(a) *Adjustments upon Changes in Capitalization*. The maximum number and class of shares issuable pursuant to the Plan, the maximum number of shares with respect to which options or SARs may be granted to any employee in any calendar year, the number and class of shares and the exercise price per share covered by each outstanding option and the number and class of shares and the base price per share covered by each outstanding SAR shall all be adjusted proportionately or as otherwise appropriate to reflect any increase or decrease in the number of issued shares of Common Stock resulting from a split-up or consolidation of shares or any like capital adjustment, or the payment of any stock dividend, and/or to reflect a change in the character or class of shares covered by the Plan arising from a readjustment or recapitalization of the Company's capital stock.

(b) *Effect of Change in Control*. If a "Change in Control" (as defined below) occurs, the parties to the Change in Control may agree that outstanding Awards shall be assumed by, or converted into an award with respect to shares of common stock of, the successor or acquiring company (or a parent company thereof). In the event that the successor company does not assume or substitute any such outstanding Award, the Award shall be fully vested and, to the extent not exercised prior to the Change in Control, cancelled in exchange for the right to receive an amount equal to the excess, if any, of the per Share consideration received by the holders of outstanding Shares in the Change in Control transaction over the exercise or base price for such Shares. No consideration will be payable in respect of the cancellation of an Option or SAR with an exercise or base price per share that is equal to or greater than the value of the Change in Control transaction consideration per share. The Board may in its sole discretion accelerate, in whole or in part, the vesting of any outstanding Award upon the occurrence of a Change in Control (as defined below), whether or not the vesting requirements set forth in the applicable Award agreement have been satisfied and whether or not the Award is otherwise assumed or substituted by the successor company.

(c) *Definition of Change in Control*. For purposes hereof, a "Change in Control" of the Company shall be deemed to occur upon the occurrence of any of the following events:

(i) completion of a consolidation or merger in which the Company is not the continuing or surviving entity or pursuant to which each class of the Company's common stock would be converted into cash, securities or other property, other than (a) a consolidation or merger of the Company in which the holders of each class of common stock immediately prior to the consolidation or merger have the same proportionate ownership and voting power with respect to the common stock of the surviving corporation immediately after the consolidation or merger, or (b) a consolidation or merger which would result in the voting securities of the Company outstanding immediately prior thereto continuing to represent (by being converted into voting securities of the continuing or surviving entity) 50% or more of the combined voting power of the voting securities of the surviving or continuing entity immediately after such consolidation or merger and which would result in the members of the Board immediately prior to such consolidation or merger (including, for this purpose, any individuals whose election or nomination for election was approved by a vote of at least two-thirds of such members), constituting a majority of the board of directors (or equivalent governing body) of the surviving or continuing entity immediately after such consolidation or merger;

(ii) consummation of a plan of complete liquidation or dissolution of the Company or of a sale or disposition by the Company of all or substantially all of the Company's assets, in one transaction or a series of related transactions, other than a sale or disposition by the Company of all or substantially all of the Company's assets to an entity, more than 50% of the combined voting power of the voting securities of which is owned by stockholders of the Company in substantially the same proportion as their ownership of the Company immediately prior to such sale;

(iii) any person (as such term is used in Sections 13(d) and 14(d)(2) of the Exchange Act), other than (a) persons or their family members or affiliates which have such voting power on the date of adoption of this Third Amended and Restated Stock Incentive Plan, or (b) any trustee or other fiduciary holding securities under any employee benefit plan of the Company, shall become the beneficial owner (within the meaning of Rule 13d-3 under the Exchange Act) of 50% or more of the combined voting power of the voting securities of the Company other than pursuant to a plan or arrangement entered into by such person and the Company; or

(iv) during any period of two consecutive years, individuals who at the beginning of such period constitute the entire Board shall cease for any reason to constitute a majority of the Board unless the election or nomination for election by the Company's stockholders of each new director was approved by a vote of at least two-thirds of the directors then still in office who were directors at the beginning of the period.

(d) *Fractional Shares*. In the event of any adjustment in the number of shares covered by any Award pursuant to the provisions hereof, any fractional shares resulting from such adjustment shall be disregarded and each such Award shall cover only the number of full shares resulting from the adjustment.

(e) *Determination of Board to be Final*. All adjustments under this Section shall be made by the Board, and its determination as to what adjustments shall be made, and the extent thereof, shall be final, binding and conclusive.

10. *Tax Withholding*. As a condition to the exercise of any Award, the delivery of any shares of Common Stock pursuant to any Award or the settlement of any Award, or in connection with any other event that gives rise to a federal or other governmental tax withholding obligation on the part of the Company or an affiliate relating to an Award, the Company and/or the affiliate may (a) deduct or withhold (or cause to be deducted or withheld) the amount of such tax withholding from any payment or distribution to an Award recipient whether or not pursuant to the Plan or (b) require the recipient to remit cash (through payroll deduction or otherwise), in each case in an amount sufficient in the opinion of the Company to satisfy such withholding obligation. If the event giving rise to the withholding obligation involves a transfer of shares of Common Stock, then, at the sole discretion of the Committee, the recipient may satisfy the withholding obligation described under this Section by electing to have the Company withhold shares of Common Stock or by tendering previously-owned shares of Common Stock, in each case having a Fair Market Value equal to the minimum required amount of tax to be withheld (or by any other mechanism as may be required or appropriate to conform with local tax and other rules).

11. *Amendment and Termination*. The Board may amend or terminate the Plan provided, however, that no such action may adversely affect a holder's rights under an outstanding Award without his written consent. Any amendment which would (a) increase the maximum number of shares of Common Stock issuable under the Plan or the maximum number of shares with respect to which options or SARs may be granted to any employee in any calendar year, (b) modify the class of persons eligible to receive Awards under the Plan or (c) otherwise require stockholder approval under applicable law or exchange or market requirements, shall, to the extent required by applicable law or exchange or market requirements, be subject to the approval of the Company's stockholders.

12. *Claw Back Conditions*. Notwithstanding anything to the contrary contained herein or in an Award agreement, each Award shall be subject to any incentive compensation claw back policies that may be adopted by the Company (whether or not adopted prior to the date of such Award) as in effect at any time and from time to time, and, as applicable, to the claw back requirements of Section 954 of the Dodd-Frank Act.

13. *General Provisions*.

(a) *Documentation of Awards*. Each Award made under the Plan shall be evidenced by a written agreement or other instrument the terms of which shall be established by the Committee. To the extent not inconsistent with the provisions of the Plan, the written agreement or other instrument evidencing an Award shall govern the rights and obligations of the Award recipient (and any person claiming through the recipient) with respect to the Award.

(b) *Shares Issued under Plan*. Shares of Common Stock available for issuance under the Plan may be authorized and unissued, held by the Company in its treasury or otherwise acquired for purposes of the Plan. No fractional shares of Common Stock shall be issued under the Plan.

(c) *Compliance with Law*. The Company shall not be obligated to issue or deliver shares of Common Stock pursuant to the Plan unless the issuance and delivery of such shares complies with applicable law, including, without limitation, the Securities Act of 1933, as amended, the Exchange Act and the requirements of any stock exchange or market upon which the Common Stock may then be listed, and shall be further subject to the approval of counsel for the Company with respect to such compliance.

(d) *Transfer Orders; Placement of Legends*. All certificates for shares of Common Stock delivered under the Plan shall be subject to such stock transfer orders and other restrictions as the Company may deem advisable under the rules, regulations and other requirements of the Securities and Exchange Commission, any stock exchange or market upon which the Common Stock may then be listed, and any applicable federal or state securities law. The Company may cause a legend or legends to be placed on any such certificates to make appropriate reference to such restrictions.

(e) *No Employment or other Rights*. Nothing contained in the Plan or in any Award agreement shall confer upon any recipient of an Award any right with respect to the continuation of his or her employment or other service with the Company or an affiliate or interfere in any way with the right of the Company and its affiliates at any time to terminate such employment or other service or to increase or decrease, or otherwise adjust, the other terms and conditions of the recipient's employment or other service.

(f) *Decisions and Determinations Final*. Except to the extent rights or powers under the Plan are reserved specifically to the discretion of the Board, the Committee shall have full power and authority to interpret the Plan and any Award agreement made under the Plan and to determine all issues which arise thereunder or in connection therewith, and the decision of the Board or the Committee, as the case may be, shall be binding and conclusive on all interested persons.

(g) *Nonexclusivity of the Plan*. No provision of the Plan, and neither its adoption by the Board or submission to the stockholders for approval, shall be construed as creating any limitations on the power of the Board or a committee thereof to adopt (subject to stockholder approval if such approval is required in order to comply with applicable law or exchange listing requirements) such equity-based or other incentive arrangements, apart from the Plan, as it may deem desirable, including incentive arrangements and awards which do not qualify as "performance-based compensation" under Section 162(m) of the Code.

14. *Governing Law*. All rights and obligations under the Plan and each Award agreement or instrument shall be governed by and construed in accordance with the laws of the State of Delaware, without regard to its principles of conflict of laws.

15. *Term of the Plan*. This Third Amended and Restated Stock Incentive Plan shall become effective on the date it is approved by the Company's stockholders (the "Effective Date"). Unless sooner terminated by the Board, the Plan shall terminate on the tenth anniversary of the Effective Date. The rights of any person with respect to an Award made under the Plan that is outstanding at the time of the termination of the Plan shall not be affected solely by reason of the termination of the Plan and shall continue in accordance with the terms of the Award and of the Plan, as each is then in effect or is thereafter amended.

Exhibit 10.2

AMENDED AND RESTATED
UNIVERSAL HEALTH SERVICES, INC.
2010 EMPLOYEES' RESTRICTED STOCK PURCHASE PLAN

1. *Purpose*. The purpose of this 2010 Employees' Restricted Stock Purchase Plan (the "Plan"), is to secure for Universal Health Services, Inc. (the "Company") the benefits of the additional incentive resulting from the ownership of its Shares of Class B Common Stock, par value $.01 per share (the "Shares"), by selected employees of, and consultants to, the Company or its subsidiaries (for convenience such persons are hereinafter collectively referred to as "employees") who are important to the success and the growth of the business of the Company and its subsidiaries, and to help the Company and its subsidiaries secure and retain the services of such persons.

2. *Restricted Stock Committee*. The Plan will be administered by the compensation committee of the Company's Board of Directors (the "Board"), or such other committee of directors designated by the Board (the "Committee"), provided that all of said designated directors qualify as "non-employee directors" (within the meaning of Rule 16b-3(b)(3) under the Securities Exchange Act of 1934, as amended) and as "outside directors" (within the meaning of Treas. Reg. Section 1.162-27(e)(3)).

3. *Shares Subject to Plan*. Subject to the adjustment provisions of paragraph 12, the number of shares of Class B Common Stock which may be issued or sold under the Plan shall not exceed 600,000. Shares sold under the Plan may be authorized and unissued Shares of Class B Common Stock, issued Shares of Class B Common Stock held in the Company's treasury, or both. Should any Shares sold pursuant to the Plan be forfeited or repurchased by the Company, such Shares shall again become available for sale hereunder. Any Shares surrendered to the Company for the satisfaction of applicable tax withholding will not be so available. All awards of restricted stock under the Plan are deemed issued and outstanding for all purposes. Subject to adjustment under paragraph 12, the number of shares of Class B Common Stock which may be issued or sold under the Plan to any employee during any calendar year shall not exceed 100,000.

4. *Employees Eligible*. Shares may be sold pursuant to the Plan to all employees and consultants of the Company and its subsidiaries (including officers of the Company or any of its subsidiaries whether or not they are also directors of the Company or any of its subsidiaries). For purposes of the Plan, "subsidiary" shall mean a "subsidiary corporation" as defined in Section 424(f) of the Internal Revenue Code of 1986, as amended (the "Code"). In making determinations as to whom Shares should be sold, the Committee shall take into consideration an employee's present and potential contribution to the success of the Company and its subsidiaries and such other factors as the Committee may deem proper and relevant.

5. *Purchase of Shares, Price and Delivery of Payment*. Subsequent to a determination by the Committee that Shares shall be sold pursuant to the Plan, the Company or a subsidiary shall deliver to the employee a letter advising him of such determination. Within 30 days of the date of such letter (or such later time as may be determined by the Committee), the employee must complete the Restricted Stock Purchase Agreement enclosed therewith and return it to the Company along with payment in full by cash or check. The price of each Share sold pursuant to the Plan shall be the par value thereof at the time of sale. Prior to delivery by an employee to the Company of a completed Restricted Stock Purchase Agreement and payment in full for the Shares, the Committee may, at its discretion, revoke its decision to sell Shares to an employee.

6. *Restrictions*. All Shares sold pursuant to the Plan shall be sold subject to a Restricted Stock Purchase Agreement which gives the Company the right to repurchase all or a portion of such Shares, for an amount equal to the price paid by the employee, in the event that the employee's employment terminates for any reason (subject to any exceptions as the Committee may specify) before such restrictions lapse pursuant to the vesting conditions set forth in such Restricted Stock Purchase Agreement. Each employee shall also be required to agree that all Shares purchased by the employee pursuant to the Plan are purchased for investment purposes and not for the purpose of resale or other distribution thereof. Restricted stock awards made under the Plan must provide for a vesting period of at least one year from the date of grant.

Notwithstanding the foregoing, in the event that an employee of the Company or one of its subsidiaries who has purchased Shares under the plan terminates his employment with such employer and immediately commences employment with the Company or a different subsidiary thereof, such event shall not be treated as a termination of employment under the Plan, and the Company's repurchase rights with respect to such Shares shall not be triggered by such event. Upon the termination of employment in such cases, the Restricted Stock Purchase Agreement entered into between such employee and his employer may be assumed by the new employer or cancelled and replaced by a new Restricted Stock Purchase Agreement between the transferring employee and the employer.

7. *Performance-Based Awards*. The provisions of this paragraph 7 will apply to awards under the Plan that are intended to generate "qualified performance-based compensation" within the meaning of Section 162(m) of the Internal Revenue Code of the Code). Awards made under this paragraph will be interpreted and construed accordingly.

(a) Shares issued or sold pursuant to this paragraph 7 shall be subject to such performance-based conditions as the Committee deems appropriate, consistent with the requirements of this paragraph and Section 162(m) of the Code. A performance condition established by the Committee in connection with a sale or issuance of Shares pursuant to this paragraph must be (1) objective, so that a third party having knowledge of the relevant facts could determine whether the condition is met, (2) prescribed in writing by the Committee before the beginning of the applicable performance period or at such later date (when fulfillment is substantially uncertain) as may be permitted under Section 162(m) of the Code, and (3) based on one or more of the following performance criteria:

(i) attainment of certain target levels of, or a specified percentage increase in, revenues, income before income taxes and extraordinary items, net income, earnings before income tax, earnings before interest, taxes, depreciation and amortization or a combination of any or all of the foregoing;

(ii) attainment of certain target levels of, or a percentage increase in, after-tax or pre-tax profits;

(iii) attainment of certain target levels of, or a specified increase in, operational cash flow;

(iv) achievement of a certain level of, reduction of, or other specified objectives with regard to limiting the level of increase in, all or a portion of, the Company's bank debt or other long-term or short-term public or private debt or other similar financial obligations of the Company, which may be calculated net of such cash balances and/or other offsets and adjustments as may be established by the Committee;

(v) attainment of a specified percentage increase in earnings per share or earnings per share from continuing operations;

(vi) attainment of certain target levels of, or a specified increase in return on capital employed or return on invested capital;

(vii) attainment of certain target levels of, or a percentage increase in, after-tax return on stockholders' equity;

(viii) attainment of certain target levels of, or a specified increase in, economic value added targets based on a cash flow return on investment formula;

(ix) attainment of certain target levels in the fair market value of the shares of the Company's Common Stock; and

(x) growth in the value of an investment in the Company's Common Stock assuming the reinvestment of dividends.

In setting performance goals, the Committee may express such factors in absolute or relative terms and may apply such factors with respect to performance by the Company, any subsidiary, any division and/or any other business unit as the Committee may determine. If and to the extent permitted under Section 162(m) of the Code, performance conditions may be determined without regard to (or adjusted for) changes in accounting methods, corporate transactions (including, without limitation, dispositions and acquisitions) and other similar types of events or circumstances occurring during the applicable performance period. The Committee may not delegate any responsibility with respect to the establishment or certification of the achievement of performance conditions to which awards covered by this paragraph are subject.

(b) Upon the expiration of the performance period applicable to a performance-based award, the Committee will certify in writing the extent to which the performance conditions applicable to the award and any other material terms were in fact achieved and the percentage of such award that has been earned.

(c) The Board of Directors may re-submit the performance goals contained in this Section 7 for shareholder approval from time to time in order to satisfy the shareholder approval conditions relating to the for exemption of Plan compensation from the deduction limitations of Section 162(m) of the Code, it being understood that, under current law, such re-submission would first be required to be made at the first meeting of stockholders of the Company (or any adjournment or postponement thereof) in 2015.

8. *Change in Control.*

(a) *Effect of a Change in Control*. If a "Change in Control" (as defined below) occurs, the parties to the Change in Control may agree that outstanding restricted Share awards shall be assumed by, or converted into an award with respect to shares of common stock of, the successor or acquiring company (or a parent company thereof). In the event that the successor company does not assume or substitute any such outstanding award, the vested Shares covered by such award will be entitled to participate in the Change in Control transaction on the same basis as any other stockholder or the award may be cancelled immediately prior to the Change in Control in exchange for the right to receive an amount equal to the per Share consideration received by the holders of outstanding Shares in the Change in Control transaction. The Board may in its sole discretion accelerate, in whole or in part, the vesting of any outstanding Award upon the occurrence of a Change in Control, whether or not the vesting requirements set forth in the applicable Award agreement have been satisfied and whether or not the Award is otherwise assumed or substituted by the successor company.

(b) *Definition of Change in Control*. For purposes hereof, a "Change in Control" of the Company shall be deemed to occur upon the occurrence of any of the following events:

(i) completion of a consolidation or merger in which the Company is not the continuing or surviving entity or pursuant to which each class of the Company's common stock would be converted into cash, securities or other property, other than (a) a consolidation or merger of the Company in which the holders of each class of common stock immediately prior to the consolidation or merger have the same proportionate ownership and voting power with respect to the common stock of the surviving corporation immediately after the consolidation or merger, or (b) a consolidation or merger which would result in the voting securities of the Company outstanding immediately prior thereto continuing to represent (by being converted into voting securities of the continuing or surviving entity) more than 50% of the combined voting power of the voting securities of the surviving or continuing entity immediately after such consolidation or merger and which would result in the members of the Board immediately prior to such consolidation or merger (including, for this purpose, any individuals whose election or nomination for election was approved by a vote of at least two-thirds of such members), constituting a majority of the board of directors (or equivalent governing body) of the surviving or continuing entity immediately after such consolidation or merger;

(ii) consummation of a plan of complete liquidation or dissolution of the Company or of a sale or disposition by the Company of all or substantially all of the Company's assets, in one transaction or a series of related transactions, other than a sale or disposition by the Company of all or substantially all of the Company's assets to an entity, more than 50% of the combined voting power of the voting securities of which is owned by stockholders of the Company in substantially the same proportion as their ownership of the Company immediately prior to such sale;

(iii) any person (as such term is used in Sections 13(d) and 14(d)(2) of the Exchange Act), other than (1) persons or their family members or affiliates which have such voting power on the date of adoption of this Third Amended and Restated Stock Incentive Plan, or (2) any trustee or other fiduciary holding securities under any employee benefit plan of the Company, shall become the beneficial owner (within the meaning of Rule 13d-3 under the Exchange Act) of 50% or more of the combined voting power of the voting securities of the Company other than pursuant to a plan or arrangement entered into by such person and the Company; or

(iv) during any period of two consecutive years, individuals who at the beginning of such period constitute the entire Board shall cease for any reason to constitute a majority of the Board unless the election or nomination for election by the Company's stockholders of each new director was approved by a vote of at least two-thirds of the directors then still in office who were directors at the beginning of the period.

9. *Transferability*. No Shares subject to repurchase by the Company may be sold, assigned, transferred, disposed of, pledged or otherwise hypothecated, by the purchase of such Shares. Any attempt to do any of the foregoing shall be null and void and may cause the immediate forfeiture of such Shares.

10. *Right to Terminate Employment or Service*. Nothing in the Plan or in any Restricted Stock Purchase Agreement shall confer upon any employee the right to continue in the employment or other service of the Company or affect the right of the Company to terminate the employee's employment or other service at any time, subject, however, to the provisions of any agreement between the Company and the employee.

11. *Withholding*. Notwithstanding anything to the contrary contained herein, the vesting or lapse of the Company's repurchase right with respect to Shares issued hereunder shall be subject to and conditioned upon the satisfaction by the employee of applicable tax withholding obligations. The Company and its subsidiaries may require the employee to remit an amount sufficient to satisfy applicable withholding taxes and/or deduct or withhold all or part of such amount from any payments otherwise payable to the employee (whether or not under this Plan). The Committee, acting in its sole and absolute discretion, may permit an employee to satisfy the employee's tax withholding obligation arising with respect to the vesting of Shares by surrendering (or having the Company retain) Shares that would otherwise become unrestricted, provided, however, that the fair market value of the Shares so surrendered or retained (on the date the applicable tax withholding is satisfied) for the satisfaction of applicable tax withholding shall not be greater than the minimum amount required to be withheld pursuant to applicable law.

12. *Adjustment Upon Changes in Capitalization, etc.* In the event of one or more stock splits, reverse stock splits, stock dividends, reclassifications, recapitalizations or any other change in the character or amount of the Company's Shares, the number, kind and purchase price of Shares which may thereafter be sold under the Plan and the number of Shares that may be issued or sold to any individual employee during any calendar year shall be adjusted as determined by the Board, in its sole discretion, to give effect thereto, and all new, substituted or additional securities to which any employee may become entitled by reason of the employee's ownership of Shares previously purchased or issued pursuant to the Plan shall be subject to the terms of the Plan and the Restricted Stock Purchase Agreement under which such Shares were purchased or issued.

13. *Claw Back Conditions*. Notwithstanding anything to the contrary contained herein or in an Award agreement, each Award shall be subject to any incentive compensation claw back policies that may be adopted by the Company (whether or not adopted prior to the date of such Award) as in effect at any time and from time to time, and, as applicable, to the claw back requirements of Section 954 of the Dodd-Frank Act.

14. *Amendment or Termination of Plan*. The Board of Directors shall have the authority to amend or terminate the Plan at any time; provided, however, that no such amendment or termination shall adversely affect the rights of any employee with respect to Shares previously sold hereunder. Notwithstanding the above, no amendment to the Plan will become effective without the approval of the Company's stockholders if such amendment would increase the number of shares which may be issued under the Plan or if such approval is necessary or desirable to comply with applicable law or exchange requirements.

15. *Expiration of the Plan*. Unless sooner terminated by the Board of Directors, shares may be sold under this Amended and Restated Plan at any time and from time to time, prior to the tenth anniversary of the date such amendment and restatement is adopted. Any Shares sold under the Plan that remain outstanding on or after such expiration date shall remain subject to the terms of the applicable Restricted Stock Purchase Agreement and the Plan until any restrictions thereon have lapsed or they have been repurchased by the Company.

16. *Effective Date of Amended and Restated Plan*. This amended and restated Plan was adopted by the Board of Directors on March 18, 2015, subject nevertheless to approval by the Company's stockholders at the 2015 Annual Meeting of Stockholders.

Exhibit 10.3

UNIVERSAL HEALTH SERVICES, INC.
2010 EXECUTIVE INCENTIVE PLAN

1. *Purpose*. The purpose of the 2010 Executive Incentive Plan (the "Plan") is to foster the ability of Universal Health Services, Inc., a Delaware corporation (the "Company"), and its affiliates to attract, retain and motivate highly qualified senior management and other executive officers of the Company and its affiliates through the payment of performance-based incentive compensation.

2. *Administration*. The Plan will be administered by the Compensation Committee of the Company's Board of Directors (the "Board"), or such other committee of directors designated by the Board (the "Committee"), provided that all of said designated directors qualify as "outside directors" (within the meaning of Treas. Reg. Section 1.162-27(e)(3) under Section 162(m) of the Internal Revenue Code of 1986, as amended (the "Code")). Subject to the provisions of the Plan, the Committee, acting in its sole and absolute discretion, will have full power and authority to interpret, construe and apply the provisions of the Plan and to take such action as may be necessary or desirable in order to carry out the provisions of the Plan. A majority of the members of the Committee will constitute a quorum. The Committee may act by the vote of a majority of its members present at a meeting at which there is a quorum or by unanimous written consent. The Committee will keep a record of its proceedings and acts and will keep or cause to be kept such books and records as may be necessary in connection with the proper administration of the Plan. The Company shall indemnify and hold harmless each member of the Committee and any employee or director of the Company or an affiliate to whom any duty or power relating to the administration or interpretation of the Plan is delegated from and against any loss, cost, liability (including any sum paid in settlement of a claim with the approval of the Board), damage and expense (including reasonable legal fees and other expenses incident thereto and, to the extent permitted by applicable law, advancement of such fees and expenses) arising out of or incurred in connection with the Plan, unless and except to the extent attributable to such person's fraud or willful misconduct.

3. *Eligibility*. Annual incentive compensation may be awarded under the Plan to any person who is a member of the senior management of the Company and to other executive officers of the Company or an affiliate. Subject to the provisions hereof, the Committee will select the persons to whom incentive compensation may be awarded for any calendar year and will fix the terms and conditions of each such award.

4. *Annual Performance Bonus*. The amount of a participant's incentive award for a calendar year will be based upon the participant's target bonus amount and the extent to which the performance goal(s) applicable to the participant are achieved, all as described in (a) through (c) below, subject to the limitation in (e) below.

(a) *Target Bonus Amount*. For each calendar year, a participant's target bonus amount will be equal to a fixed percentage of the participant's annual base salary. The applicable percentage will be determined by the Committee on a participant-by-participant and year-by-year basis.

(b) *Performance Goals*. For each calendar year, the Committee shall establish performance goals for each participant, using such business criteria and other measures of performance as it may deem appropriate; provided that, in the case of incentive awards intended to qualify as "performance-based compensation" under Section 162(m) of the Code, the Committee shall establish objective performance goals based upon one or more of the following business criteria: (i) attainment of certain target levels of, or a specified increase in, revenues, income before income taxes and extraordinary items, net income, earnings before income tax, earnings before interest, taxes, depreciation and amortization or a combination of any or all of the foregoing; (ii) attainment of certain target levels of, or a specified increase in, after-tax or pre-tax profits; (iii) attainment of certain target levels of, or a specified increase in, operational cash flow; (iv) attainment of a certain level of, reduction of, or other specified objectives with regard to limiting the level of increase in, all or a portion of, the Company's bank debt or other long-term or short-term public or private debt or other similar financial obligations of the Company, which may be calculated net of such cash balances and/or other offsets and adjustments as may be established by the Committee; (v) attainment of certain target levels of, or a specified increase in, earnings per share or earnings per share from continuing operations; (vi) attainment of certain target levels of, or a specified increase in return on capital or return on invested capital; (vii) attainment of certain target levels of, or a specified increase in, after-tax return on stockholders' equity; (viii) attainment of certain target levels of, or a specified increase in, economic value added targets based on a cash flow return on investment formula; and/or (ix) attainment of certain target levels in the fair market value of the shares of the Company's Class B Common Stock, par value $.01 (the "Common Stock") or growth in the value of an investment in the Common Stock assuming the reinvestment of dividends. As to any participant or class of participants, the performance goals may be based upon one or more of such permissible criteria and may be based upon the performance of the Company, on a consolidated basis, the individual participant or class of participants, a regional, local or divisional unit of the Company, one or more subsidiaries or other affiliates of the Company or a combination thereof, either on an absolute basis or relative to an index or peer-group. Performance goals may be determined without regard to, or adjusted to reflect, items that are nonrecurring or non-operational in nature including items such as, but not limited to, gains on sales of assets and businesses, reserves for settlements, legal judgments and lawsuits and other amounts that may be reflected in the current or prior year financial statements that relate to prior periods, provided that, in the case of an award intended to qualify as "performance-based compensation" under Section 162(m) of the Code, such determination or adjustment is permitted under Section 162(m) of the Code.

(c) *Performance Factor*. For each calendar year, the Committee will establish a performance factor or a range of performance factors ("performance factors") for each participant, based on varying levels of attainment of the performance goals for the year. The performance factor(s) will be used to determine the portion, if any, of the participant's target bonus amount that is earned for the year. The performance factors may be expressed in a performance matrix established by the Committee. If the target level performance goals for a year are achieved (but not exceeded), the participant will be entitled to in incentive bonus for the year equal to 100% of the participant's target bonus amount. The Committee may establish higher or lower percentage factors for levels of performance that are more or less than the target levels. If the minimum level of performance for a year is not achieved, then the participant's performance factor will be zero and no incentive compensation will be payable to participant for the year.

(d) *Preestablished Goals*. In the case of an award intended to qualify as "performance-based compensation" under Section 162(m) of the Code, except as otherwise permitted under Section 162(m) of the Code, the applicable target bonus amount, performance goals and performance factors with respect to any calendar year will be established in writing by the Committee no later than 90 days after the commencement of that year.

(e) *Limitation on Amount of Incentive Awards*. Notwithstanding anything to the contrary contained herein, the maximum incentive award which any participant may earn hereunder for any calendar year shall not exceed $5 million.

5. *Calculation and Payment of Performance Bonus*. Promptly after the date on which the necessary financial or other information for a particular year becomes available, the Committee shall determine the amount, if any, of the incentive compensation payable to each participant for that calendar year and shall certify in writing prior to payment that the performance goals for the year were in fact satisfied. A participant's incentive award for a calendar year will be paid to the participant promptly after the Committee determines, the amount earned by the participant pursuant to such award, provided that such payment will in all events be made by the last day of the calendar year following the applicable bonus year. Notwithstanding the preceding sentence, the Committee may establish an arrangement, separate and apart from the Plan, pursuant to which payment of all or a portion of a participant's incentive award for a calendar year will or must be deferred. It is intended that any such arrangement will comply with the requirements of Section 409A of the Code. Unless the Committee determines otherwise, no incentive award will be payable to a participant with respect to a calendar year if the participant's employment with the Company and its affiliates terminates at any time prior to the payment thereof.

6. *Amendment or Termination*. The Board may amend or terminate the Plan at any time.

7. *Effective Date of Plan; Stockholder Approval Conditions*. The Plan will become effective as of the date of the 2010 annual meeting of the Company's stockholders, subject to approval by the stockholders at such meeting. The Board may re-submit the performance goals contained in this Section 4 for shareholder approval from time to time in order to satisfy the shareholder approval conditions of Section 162(m) of the Code, it being understood that, under current law, such re-submission would first be required to be made at the first meeting of stockholders of the Company (or any adjournment or postponement thereof) in 2015.

8. *Governing Law*. The Plan and each award made under the Plan shall be governed by the laws of the State of Delaware, without regard to its principles of conflicts of law. In the case of an annual incentive compensation award that is intended constitute "performance-based compensation" under Section 162(m) of the Code, the terms and conditions of the Plan and of such award shall be interpreted and construed accordingly. The Plan is not intended to be a "nonqualified deferred compensation plan" within the meaning of Section 409A of the Code and will be interpreted and construed accordingly.

9. *No Rights Conferred*. Nothing contained herein will be deemed to give any person any right to receive an incentive compensation award under the Plan or to be retained in the employ or service of the Company or any affiliate or interfere with the right of the Company or any affiliate to terminate the employment or other service of any person for any reason.

10. *Decisions of the Committee to be Final*. Any decision or determination made by the Committee shall be final, binding and conclusive on all persons.

Exhibit 31.1

CERTIFICATION—Chief Executive Officer

I, Alan B. Miller, certify that:

1. I have reviewed this quarterly report on Form 10-Q of Universal Health Services, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report, based on such evaluation; and

d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting.

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: August 7, 2015

/s/ Alan B. Miller
Chief Executive Officer

Exhibit 31.2

CERTIFICATION—Chief Financial Officer

I, Steve Filton, certify that:

1. I have reviewed this quarterly report on Form 10-Q of Universal Health Services, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report, based on such evaluation; and

d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting.

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: August 7, 2015

/s/ Steve Filton
Senior Vice President and Chief Financial Officer

Exhibit 32.1

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report of Universal Health Services, Inc. (the "Company") on Form 10-Q for the quarter ended June 30, 2015, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Alan B. Miller, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, and to the best of my knowledge, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company at the end of, and for the period covered by, the Report.

/s/ Alan B. Miller
Chief Executive Officer
August 7, 2015

A signed original of this written statement required by Section 906 has been provided to Universal Health Services, Inc. and will be retained and furnished to the Securities and Exchange Commission or its staff upon request.

Exhibit 32.2

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report of Universal Health Services, Inc. (the "Company") on Form 10-Q for the quarter ended June 30, 2015, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Steve Filton, Senior Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, and to the best of my knowledge, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company at the end of, and for the period covered by, the Report.

/s/ Steve Filton
Senior Vice President and Chief Financial Officer
August 7, 2015

A signed original of this written statement required by Section 906 has been provided to Universal Health Services, Inc. and will be retained and furnished to the Securities and Exchange Commission or its staff upon request.