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 September 30, 2022

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

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

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Class B Common Stock, $0.01 par value	UHS	New York Stock Exchange

Indicate by check mark whether the registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (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 every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

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

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

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

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 October 31, 2022:

Class A	6,577,100
Class B	64,157,474
Class C	661,688
Class D	14,170

UNIVERSAL HEALTH SERVICES, INC.

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This Quarterly Report on Form 10-Q is for the quarter ended September 30, 2022. 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 September 30,		Nine months ended September 30,	
	2022	2021	2022	2021
Net revenues	$ 3,336,027	$ 3,155,999	$ 9,952,390	$ 9,366,866
Operating charges:				
Salaries, wages and benefits	1,677,431	1,556,448	5,061,173	4,542,156
Other operating expenses	837,241	754,072	2,526,060	2,233,590
Supplies expense	366,337	367,834	1,092,403	1,052,977
Depreciation and amortization	145,874	134,462	433,508	399,850
Lease and rental expense	33,264	28,375	97,075	88,848
	3,060,147	2,841,191	9,210,219	8,317,421
Income from operations	275,880	314,808	742,171	1,049,445
Interest expense, net	35,653	21,199	83,002	64,455
Other (income) expense, net	6,015	6,719	15,244	(1,575)
Income before income taxes	234,212	286,890	643,925	986,565
Provision for income taxes	57,401	67,515	157,312	232,844
Net income	176,811	219,375	486,613	753,721
Less: Net income (loss) attributable to noncontrolling interests	(6,003)	1,024	(14,176)	1,255
Net income attributable to UHS	$ 182,814	$ 218,351	$ 500,789	$ 752,466
Basic earnings per share attributable to UHS	$ 2.52	$ 2.65	$ 6.78	$ 8.96
Diluted earnings per share attributable to UHS	$ 2.50	$ 2.60	$ 6.71	$ 8.83
Weighted average number of common shares - basic	72,595	82,262	73,769	83,756
Add: Other share equivalents	465	1,411	743	1,275
Weighted average number of common shares and equivalents - diluted	73,060	83,673	74,512	85,031

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

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

	Three months ended September 30,		Nine months ended September 30,	
	2022	2021	2022	2021
Net income	$ 176,811	$ 219,375	$ 486,613	$ 753,721
Other comprehensive income (loss):				
Foreign currency translation adjustment	24,242	(9,121)	(22,460)	(23,184)
Other comprehensive income (loss) before tax	24,242	(9,121)	(22,460)	(23,184)
Income tax expense (benefit) related to items of other comprehensive income (loss)	6,685	109	5,809	(1,958)
Total other comprehensive income (loss), net of tax	17,557	(9,230)	(28,269)	(21,226)
Comprehensive income	194,368	210,145	458,344	732,495
Less: Comprehensive income (loss) attributable to noncontrolling interests	(6,003)	1,024	(14,176)	1,255
Comprehensive income attributable to UHS	$ 200,371	$ 209,121	$ 472,520	$ 731,240

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

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

	September 30, 2022	December 31, 2021
Assets		
Current assets:		
Cash and cash equivalents	$ 74,571	$ 115,301
Accounts receivable, net	1,902,472	1,746,635
Supplies	217,818	206,839
Other current assets	261,698	194,781
Total current assets	2,456,559	2,263,556
Property and equipment	11,103,596	10,770,702
Less: accumulated depreciation	(5,167,198)	(4,896,427)
	5,936,398	5,874,275
Other assets:		
Goodwill	3,874,021	3,962,624
Deferred income taxes	55,789	45,707
Right of use assets-operating leases	457,209	367,477
Deferred charges	6,336	6,525
Other	592,588	573,379
Total Assets	$ 13,378,900	$ 13,093,543
Liabilities and Stockholders' Equity		
Current liabilities:		
Current maturities of long-term debt	$ 66,307	$ 48,409
Accounts payable and other liabilities	1,795,004	1,860,496
Operating lease liabilities	70,146	64,484
Federal and state taxes	7,743	10,720
Total current liabilities	1,939,200	1,984,109
Other noncurrent liabilities	500,119	464,759
Operating lease liabilities noncurrent	392,582	304,624
Long-term debt	4,638,356	4,141,879
Redeemable noncontrolling interests	4,563	5,119
Equity:		
UHS common stockholders' equity	5,855,353	6,089,664
Noncontrolling interest	48,727	103,389
Total equity	5,904,080	6,193,053
Total Liabilities and Stockholders' Equity	$ 13,378,900	$ 13,093,543

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY
For the Three and Nine Months ended September 30, 2022
(amounts in thousands, unaudited)

	Redeemable Noncontrolling Interest	Class A Common	Class B Common	Class C Common	Class D Common	Cumulative Dividends	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	UHS Common Stockholders' Equity	Noncontrolling Interest	Total
Balance, July 1, 2022	$ 4,449	$ 66	$ 660	$ 7	$ 0	$ (575,198)	$ 6,404,660	$ (15,535)	$ 5,814,660	$ 89,256	$ 5,903,916
Common Stock											
Issued/(converted)	—	—	1	—	—	—	3,738	—	3,739	—	3,739
Repurchased	—	—	(16)	—	—	—	(158,186)	—	(158,202)	—	(158,202)
Restricted share-based compensation expense	—	—	—	—	—	—	4,869	—	4,869	—	4,869
Dividends paid and accrued	—	—	—	—	—	(14,607)	—	—	(14,607)	—	(14,607)
Stock option expense	—	—	—	—	—	—	15,797	—	15,797	—	15,797
Acquisition of noncontrolling interest in majority owned business	—	—	—	—	—	—	(11,274)	—	(11,274)	(37,608)	(48,882)
Distributions to noncontrolling interests	—	—	—	—	—	—	—	—	—	(103)	(103)
Purchase (sale) of ownership interests by (from) minority members	—	—	—	—	—	—	—	—	—	3,299	3,299
Comprehensive income:											
Net income to UHS / noncontrolling interests	114	—	—	—	—	—	182,814	—	182,814	(6,117)	176,697
Foreign currency translation adjustments, net of income tax	—	—	—	—	—	—	—	17,557	17,557	—	17,557
Subtotal - comprehensive income	114	—	—	—	—	—	182,814	17,557	200,371	(6,117)	194,254
Balance, September 30, 2022	$ 4,563	$ 66	$ 645	$ 7	$ 0	$ (589,805)	$ 6,442,418	$ 2,022	$ 5,855,353	$ 48,727	$ 5,904,080

	Redeemable Noncontrolling Interest	Class A Common	Class B Common	Class C Common	Class D Common	Cumulative Dividends	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	UHS Common Stockholders' Equity	Noncontrolling Interest	Total
Balance, January 1, 2022	$ 5,119	$ 66	$ 698	$ 7	$ 0	$ (545,487)	$ 6,604,089	$ 30,291	$ 6,089,664	$ 103,389	$ 6,193,053
Common Stock											
Issued/(converted)	—	—	7	—	—	—	10,527	—	10,534	—	10,534
Repurchased	—	—	(60)	—	—	—	(723,324)	—	(723,384)	—	(723,384)
Restricted share-based compensation expense	—	—	—	—	—	—	12,972	—	12,972	—	12,972
Dividends paid and accrued	—	—	—	—	—	(44,318)	—	—	(44,318)	—	(44,318)
Stock option expense	—	—	—	—	—	—	48,639	—	48,639	—	48,639
Acquisition of noncontrolling interest in majority owned business	—	—	—	—	—	—	(11,274)	—	(11,274)	(37,608)	(48,882)
Distributions to noncontrolling interests	(650)	—	—	—	—	—	—	—	—	(4,776)	(4,776)
Purchase (sale) of ownership interests by (from) minority members	—	—	—	—	—	—	—	—	—	1,992	1,992
Comprehensive income:											
Net income (loss) to UHS / noncontrolling interests	94	—	—	—	—	—	500,789	—	500,789	(14,270)	486,519
Foreign currency translation adjustments, net of income tax	—	—	—	—	—	—	—	(28,269)	(28,269)	—	(28,269)
Subtotal - comprehensive income	94	—	—	—	—	—	500,789	(28,269)	472,520	(14,270)	458,250
Balance, September 30, 2022	$ 4,563	$ 66	$ 645	$ 7	$ 0	$ (589,805)	$ 6,442,418	$ 2,022	$ 5,855,353	$ 48,727	$ 5,904,080

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY
For the Three and Nine Months ended September 30, 2021
(amounts in thousands, unaudited)

	Redeemable Noncontrolling Interest	Class A Common	Class B Common	Class C Common	Class D Common	Cumulative Dividends	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	UHS Common Stockholders' Equity	Noncontrolling Interest	Total
Balance, July 1, 2021	$ 4,693	$ 66	$ 760	$ 7	$ 0	$ (513,377)	$ 6,956,520	$ 36,124	$ 6,480,100	$ 91,980	$ 6,572,080
Common Stock											
Issued/(converted)	—	—	—	—	—	—	3,665	—	3,665	—	3,665
Repurchased	—	—	(28)	—	—	—	(420,431)	—	(420,459)	—	(420,459)
Restricted share-based compensation expense	—	—	—	—	—	—	3,481	—	3,481	—	3,481
Dividends paid and accrued	—	—	—	—	—	(16,469)	—	—	(16,469)	—	(16,469)
Stock option expense	—	—	—	—	—	—	14,582	—	14,582	—	14,582
Distributions to noncontrolling interests	—	—	—	—	—	—	—	—	—	(127)	(127)
Purchase of ownership interests by minority members	—	—	—	—	—	—	—	—	—	1,093	1,093
Comprehensive income:											
Net income to UHS / noncontrolling interests	193	—	—	—	—	—	218,351	—	218,351	831	219,182
Foreign currency translation adjustments	—	—	—	—	—	—	—	(9,230)	(9,230)	—	(9,230)
Subtotal - comprehensive income	193	—	—	—	—	—	218,351	(9,230)	209,121	831	209,952
Balance, September 30, 2021	$ 4,886	$ 66	$ 732	$ 7	$ 0	$ (529,846)	$ 6,776,168	$ 26,894	$ 6,274,021	$ 93,777	$ 6,367,798

	Redeemable Noncontrolling Interest	Class A Common	Class B Common	Class C Common	Class D Common	Cumulative Dividends	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	UHS Common Stockholders' Equity	Noncontrolling Interest	Total
Balance, January 1, 2021	$ 4,569	$ 66	$ 778	$ 7	$ 0	$ (479,503)	$ 6,747,678	$ 48,120	$ 6,317,146	$ 84,821	$ 6,401,967
Common Stock											
Issued/(converted)	—	—	5	—	—	—	10,104	—	10,109	—	10,109
Repurchased	—	—	(51)	—	—	—	(788,488)	—	(788,539)	—	(788,539)
Restricted share-based compensation expense	—	—	—	—	—	—	9,583	—	9,583	—	9,583
Dividends paid and accrued	—	—	—	—	—	(50,343)	—	—	(50,343)	—	(50,343)
Stock option expense	—	—	—	—	—	—	44,825	—	44,825	—	44,825
Distributions to noncontrolling interests	(203)	—	—	—	—	—	—	—	—	(5,541)	(5,541)
Purchase of ownership interests by minority members	—	—	—	—	—	—	—	—	—	13,762	13,762
Comprehensive income:											
Net income (loss) to UHS / noncontrolling interests	520	—	—	—	—	—	752,466	—	752,466	735	753,201
Foreign currency translation adjustments	—	—	—	—	—	—	—	(21,226)	(21,226)	—	(21,226)
Subtotal - comprehensive income	520	—	—	—	—	—	752,466	(21,226)	731,240	735	731,975
Balance, September 30, 2021	$ 4,886	$ 66	$ 732	$ 7	$ 0	$ (529,846)	$ 6,776,168	$ 26,894	$ 6,274,021	$ 93,777	$ 6,367,798

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

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

	Nine months ended September 30,	
	2022	2021
Cash Flows from Operating Activities:		
Net income	$ 486,613	$ 753,721
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation & amortization	433,508	399,850
(Gain) loss on sale of assets and businesses	584	(4,803)
Costs related to extinguishment of debt	-	16,831
Stock-based compensation expense	62,741	55,548
Provision for asset impairment	-	7,195
Changes in assets & liabilities, net of effects from acquisitions and dispositions:		
Accounts receivable	(155,142)	(29,079)
Accrued interest	529	3,714
Accrued and deferred income taxes	(4,900)	(52,727)
Other working capital accounts	(173,903)	52,616
Medicare accelerated payments and deferred CARES Act and other grants	2,921	(697,393)
Other assets and deferred charges	22,219	(34,038)
Other	(23,358)	9,607
Accrued insurance expense, net of commercial premiums paid	134,908	140,702
Payments made in settlement of self-insurance claims	(88,001)	(60,069)
Net cash provided by operating activities	698,719	561,675
Cash Flows from Investing Activities:		
Property and equipment additions	(569,555)	(666,025)
Proceeds received from sales of assets and businesses	12,001	21,143
Acquisition of businesses and property	(18,666)	(39,391)
Inflows from foreign exchange contracts that hedge our net U.K. investment	177,214	4,261
Decrease in capital reserves of commercial insurance subsidiary	100	100
Costs incurred for purchase of information technology applications, net of refunds	-	20,202
Net cash used in investing activities	(398,906)	(659,710)
Cash Flows from Financing Activities:		
Repayments of long-term debt	(194,115)	(3,026,888)
Additional borrowings, net	705,321	2,912,374
Financing costs	(2,541)	(17,967)
Repurchase of common shares	(723,384)	(770,665)
Dividends paid	(44,192)	(50,284)
Issuance of common stock	10,399	10,108
Profit distributions to noncontrolling interests	(5,426)	(5,744)
Purchase (sale) of ownership interests by (from) minority members	(49,089)	13,046
Net cash used in financing activities	(303,027)	(936,020)
Effect of exchange rate changes on cash, cash equivalents and restricted cash	(10,339)	(682)
Decrease in cash, cash equivalents and restricted cash	(13,553)	(1,034,737)
Cash, cash equivalents and restricted cash, beginning of period	178,934	1,279,154
Cash, cash equivalents and restricted cash, end of period	$ 165,381	$ 244,417
Supplemental Disclosures of Cash Flow Information:		
Interest paid	$ 78,992	$ 58,719
Income taxes paid, net of refunds	$ 182,091	$ 286,376
Noncash purchases of property and equipment	$ 97,264	$ 73,428

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

(1) General

This Quarterly Report on Form 10-Q is for the quarterly period ended September 30, 2022. In this Quarterly Report, "we," "us," "our" "UHS" and the "Company" refer to Universal Health Services, Inc. and its subsidiaries.

The condensed consolidated interim 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 interim 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 audited consolidated 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 interim financial statements should be read in conjunction with the audited 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, 2021.

The impact of the COVID-19 pandemic, which began during the second half of March, 2020, has had a material effect on our operations and financial results since that time. The length and extent of the disruptions caused by the COVID-19 pandemic are currently unknown.

We believe that the adverse impact that COVID-19 will have on our future operations and financial results will depend upon many factors, most of which are beyond our capability to control or predict. Our future operations and financial results may be materially impacted by developments related to COVID-19 including, but not limited to, the potential impact on future COVID-19 patient volumes resulting from new variants of the virus, the length of time and severity of the spread of the pandemic; the volume of cancelled or rescheduled elective procedures and the volume of COVID-19 patients treated at our hospitals and other healthcare facilities; measures we are taking to respond to the COVID-19 pandemic; the impact of government and administrative regulation and stimulus on the hospital industry and potential retrospective adjustment in future periods of CARES Act and other grant income revenues recorded as revenues in prior periods; the requirements that federal healthcare program participation is conditional upon facility employees being vaccinated; declining patient volumes and unfavorable changes in payer mix caused by deteriorating macroeconomic conditions (including increases in uninsured and underinsured patients as the result of business closings and layoffs); potential disruptions to our clinical staffing and shortages and disruptions related to supplies required for our employees and patients; and potential increases to expenses related to staffing, supply chain or other expenditures; the impact of our substantial indebtedness and the ability to refinance such indebtedness on acceptable terms, as well as risks associated with disruptions in the financial markets and the business of financial institutions as the result of the COVID-19 pandemic which could impact us from a financing perspective; and changes in general economic conditions nationally and regionally in our markets resulting from the COVID-19 pandemic. Because of these and other uncertainties, we cannot estimate the length or severity of the impact of COVID-19 on our business. Decreases in cash flows and results of operations may have an impact on the inputs and assumptions used in significant accounting estimates, including estimated implicit price concessions related to uninsured patient accounts, professional and general liability reserves, and potential impairments of goodwill and long-lived assets.

The nationwide shortage of nurses and other clinical staff and support personnel has been a significant operating issue facing us and other healthcare providers. Like others in the healthcare industry, we continue to experience a shortage of nurses and other clinical staff and support personnel at our acute care and behavioral health care hospitals in many geographic areas. In some areas, the labor scarcity is putting a strain on our resources and staff, which has required us to utilize higher-cost temporary labor and pay premiums above standard compensation for essential workers. This staffing shortage has required us to hire expensive temporary personnel and/or enhance wages and benefits to recruit and retain nurses and other clinical staff and support personnel. At certain facilities, particularly within our behavioral health care segment, we have been unable to fill all vacant positions and, consequently, have been required to limit patient volumes. These factors had a material unfavorable impact on our results of operations during the first nine months of 2022.

During 2021, we received approximately $189 million of additional funds from the federal government in connection with the CARES Act, substantially all of which was received during the first quarter of 2021. During the second quarter of 2021, we returned the $189 million to the appropriate government agencies utilizing a portion of our cash and cash equivalents held on deposit. Therefore, our results of operations for the three and nine-month periods ended September 30, 2021 include no impact from the receipt of those funds.

Also, in March of 2021, we made an early repayment of $695 million of funds received during 2020 pursuant to the Medicare Accelerated and Advance Payment Program. These funds were returned to the government utilizing a portion of our cash and cash equivalents held on deposit.

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

Relationship with Universal Health Realty Income Trust:

At September 30, 2022, we held approximately 5.7% of the outstanding shares of Universal Health Realty Income Trust (the "Trust"). We serve as Advisor to the Trust under an annually renewable advisory agreement, which is scheduled to expire on December 31st of each year, pursuant to the terms of which we conduct the Trust's day-to-day affairs, provide administrative services and present investment opportunities. The advisory agreement was renewed by the Trust for 2022 at the same rate as the prior three years, providing for an advisory fee computation at 0.70% of the Trust's average invested real estate assets. We earned an advisory fee from the Trust, which is included in net revenues in the accompanying consolidated statements of income, of approximately $1.3 million and $1.1 million during the three-month periods ended September 30, 2022 and 2021, respectively, and approximately $3.8 million and $3.3 million during the nine-month periods ended September 30, 2022 and 2021, respectively.

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.

Our pre-tax share of income from the Trust, which is included in other income, net, on the accompanying consolidated statements of income for each period was approximately $275,000 and $276,000 during the three-month periods ended September 30, 2022 and 2021, respectively, and approximately $882,000 and $977,000 during the nine-month periods ended September 30, 2022 and 2021, respectively. Included in our share of the Trust's income for the nine-month period ended September 30, 2021 was a gain realized by the Trust in connection with a divestiture of property that was completed during the second quarter of 2021. We received dividends from the Trust amounting to $559,000 and $552,000 during the three-month periods ended September 30, 2022 and 2021, respectively, and $1.7 million during each of the nine-month periods ended September 30, 2022 and 2021. The carrying value of our investment in the Trust was approximately $8.6 million and $9.4 million at September 30, 2022 and December 31, 2021, respectively, and is included in other assets in the accompanying consolidated balance sheets. The market value of our investment in the Trust was $34.0 million at September 30, 2022 and $46.8 million at December 31, 2021, based on the closing price of the Trust's stock on the respective dates.

The Trust commenced operations in 1986 by purchasing certain properties from us and immediately leasing the properties back to our respective subsidiaries. The base rents are paid monthly and the bonus rents, which as of January 1, 2022 are applicable to only McAllen Medical Center, 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 those subsidiaries are unconditionally guaranteed by us and are cross-defaulted with one another.

On December 31, 2021, we entered into an asset purchase and sale agreement with the Trust. Pursuant to the terms of the asset purchase and sale agreement, which was amended during the first quarter of 2022, a wholly-owned subsidiary of ours purchased from the Trust the real estate assets of the Inland Valley Campus of Southwest Healthcare System (at its fair market value of $79.6 million). Additionally, two wholly-owned subsidiaries of ours transferred to the Trust the real estate assets of Aiken Regional Medical Center (at its fair market value of $57.7 million) and Canyon Creek Behavioral Health (at its fair market value of $26.0 million). In connection with this transaction, since the $83.7 million aggregate fair market value of Aiken Regional Medical Center ("Aiken") and Canyon Creek Behavioral Health ("Canyon Creek") exceeded the $79.6 million fair market value of the Inland Valley Campus of Southwest Healthcare System, we received approximately $4.1 million in cash from the Trust.

Pursuant to the leases, as amended, the aggregate annual rental during 2022 for Aiken and Canyon Creek aggregates to approximately $5.7 million ($3.9 million related to Aiken and $1.8 million related to Canyon Creek). There is no bonus rental component applicable to the leases for these two facilities.

The asset purchase and sale transaction was accounted for as a financing arrangement and, since we did not derecognize the real property related to Aiken and Canyon Creek, we will continue to depreciate the assets. Our consolidated balance sheet as of September 30, 2022 reflects a financial liability of $81.7 million, which is included in debt, related to this transaction. Our monthly lease payments payable to the Trust will be recorded to interest expense and as a reduction to the outstanding financial liability.

The aggregate rental for the leases on the four wholly-owned hospital facilities with the Trust was approximately $5 million and $15 million during the three and nine months ended September 30, 2022, respectively. The aggregate rental for the leases on the three wholly-owned hospital facilities with the Trust was approximately $4 million and $13 million during the three and nine months ended September 30, 2021, respectively.

Pursuant to the Master Leases by certain subsidiaries of ours and the Trust as described in the table below, dated 1986 and 2021 ("the Master Leases") which govern the leases of McAllen Medical Center and Wellington Regional Medical Center (each of which is governed by the Master Lease dated 1986), and Aiken Regional Medical Center and Canyon Creek Behavioral Health (each of which is governed by the Master Lease dated 2021), we have the option to renew the leases at the lease terms described above and below 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 their appraised fair market value upon any of the following: (i) at the end of the lease terms or any

renewal terms; (ii) upon one month's notice should a change of control of the Trust occur, or; (iii) within the time period as specified in the lease in the event that we provide notice to the Trust of our intent to offer a substitution property/properties in exchange for one (or more) of the hospital properties leased from the Trust should we be unable to reach an agreement with the Trust on the properties to be substituted. 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.

In addition, we are the managing, majority member in a joint venture with an unrelated third-party that operates Clive Behavioral Health, a 100-bed behavioral health care facility located in Clive, Iowa. The real property of this newly constructed facility, which was completed and opened in late 2020, is also leased from the Trust pursuant to the lease terms as provided in the table below. The rental on this facility was approximately $657,000 and $631,000 for the three months ended September 30, 2022 and 2021, respectively, and approximately $2.0 million and $1.8 million for the nine months ended September 30, 2022 and 2021, respectively. In connection with the lease on this facility, the joint venture has the right to purchase the leased facility from the Trust at its appraised fair market value upon either of the following: (i) by providing notice at least 270 days prior to the end of the lease terms or any renewal terms, or; (ii) upon 30 days' notice anytime within 12 months of a change of control of the Trust. Additionally, the joint venture has rights of first offer to purchase the facility prior to any third-party sale.

The table below provides certain details for each of the hospitals leased from the Trust as of September 30, 2022:

Hospital Name	Annual Minimum Rent	End of Lease Term	Renewal Term (years)	
McAllen Medical Center	$ 5,485,000	December, 2026	5	(a)
Wellington Regional Medical Center	$ 6,319,000	December, 2026	5	(b)
Aiken Regional Medical Center/Aurora Pavilion Behavioral Health Services	$ 3,895,000	December, 2033	35	(c)
Canyon Creek Behavioral Health	$ 1,670,000	December, 2033	35	(c)
Clive Behavioral Health Hospital	$ 2,628,000	December, 2040	50	(d)

(a) We have one 5-year renewal option at existing lease rates (through 2031).

(b) We have one 5-year renewal options at fair market value lease rates (through 2031). Upon the December 31, 2021 expiration of the lease on Wellington Regional Medical Center, a wholly-owned subsidiary of ours exercised its fair market value renewal option and renewed the lease for a 5-year term scheduled to expire on December 31, 2026. Effective January 1, 2022, the annual fair market value lease rate for this hospital is $6.3 million (there is no longer a bonus rental component of the lease payment). Beginning on January 1, 2023, and thereafter on each January 1st through 2026, the annual rent will increase by 2.50% on a cumulative and compounded basis.

(c) We have seven 5-year renewal options at fair market value lease rates (2034 through 2068).

(d) This facility is operated by a joint venture in which we are the managing, majority member and an unrelated third-party holds a minority ownership interest. The joint venture has three, 10-year renewal options at computed lease rates as stipulated in the lease (2041 through 2070) and two additional, 10-year renewal options at fair market values lease rates (2071 through 2090). Beginning in January, 2022, and thereafter in each January through 2040 (and potentially through 2070 if three, 10-year renewal options are exercised), the annual rental will increase by 2.75% on a cumulative and compounded basis.

In addition, certain of our subsidiaries are tenants in several medical office buildings ("MOBs") and two free-standing emergency departments owned by the Trust or by limited liability companies in which the Trust holds 95% to 100% of the ownership interest.

In January, 2022, the Trust commenced construction on a new 86,000 rentable square feet multi-tenant MOB that is located on the campus of Northern Nevada Sierra Medical Center in Reno, Nevada. Northern Nevada Sierra Medical Center, a 170-bed newly constructed acute care hospital owned and operated by a wholly-owned subsidiary of ours, was completed and opened in April, 2022. In connection with this MOB, which is expected to be completed and opened during the first quarter of 2023, a ground lease and a master flex lease was executed between a wholly-owned subsidiary of ours and the Trust, pursuant to the terms of which our subsidiary will master lease approximately 68% of the rentable square feet of the MOB at an initial minimum rent of $1.3 million annually. The master flex lease could be reduced during the term if certain conditions are met.

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 Alan B. Miller (our Executive Chairman of the Board) and his wife. As a result of these agreements, as amended in October, 2016, based on actuarial tables and other assumptions, during the life expectancies of the insureds, we would pay approximately $28 million in premiums, and certain trusts owned by our Executive Chairman of the Board, would pay approximately $9 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 approximately $37 million representing the $28 million of aggregate premiums paid by us as well as the $9 million of aggregate premiums paid by the trusts. In connection with these

policies, we will pay/we paid approximately $1.0 million, net, in premium payments during each of the 2022 and 2021 years, respectively.

In August, 2015, Marc D. Miller, our President and Chief Executive Officer and member of our Board of Directors, was appointed to the Board of Directors of Premier, Inc. ("Premier"), a healthcare performance improvement alliance. During 2013, we entered into a new group purchasing organization agreement ("GPO") with Premier. In conjunction with the GPO agreement, we acquired a minority interest in Premier for a nominal amount. During the fourth quarter of 2013, in connection with the completion of an initial public offering of the stock of Premier, we received cash proceeds for the sale of a portion of our ownership interest in the GPO. Also in connection with this GPO agreement, we received shares of restricted stock of Premier which vested ratably over a seven-year period (2014 through 2020), contingent upon our continued participation and minority ownership interest in the GPO. During the third quarter of 2020, we entered into an agreement with Premier pursuant to the terms of which, among other things, our ownership interest in Premier was converted into shares of Class A Common Stock of Premier. We have elected to retain a portion of the previously vested shares of Premier, the market value of which is included in other assets on our consolidated balance sheet. Based upon the closing price of Premier's stock on each respective date, the market value of our shares of Premier was approximately $76 million and $92 million as of September 30, 2022 and December 31, 2021, respectively. Any change in market value of our Premier shares since December 31, 2021 was recorded as an unrealized gain/loss and included in "Other (income) expense, net" in our condensed consolidated statements of income for the three and nine-month periods ended September 30, 2022. Additionally, Premier declared and paid quarterly cash dividends during each of the first three quarters of 2022 and 2021. Our share of the cash dividends amounted to approximately $470,000 and $400,000 for the three-month periods ended September 30, 2022 and 2021, respectively, and approximately $1.4 million and $1.3 million for the nine-month periods ended September 30, 2022 and 2021, respectively. The dividends are included in "Other (income) expense, net" in our condensed consolidated statements of income.

A member of our Board of Directors and member of the Executive Committee and Finance Committee is a partner in Norton Rose Fulbright US LLP, a law firm engaged by us for a variety of legal services. The Board member and his law firm also provide personal legal services to our Executive Chairman and he acts as trustee of certain trusts for the benefit of our Executive Chairman and his family.

(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 liabilities incurred in connection with split-dollar life insurance agreements on the lives of our chief executive officer and his wife.

As of September 30, 2022, outside owners held noncontrolling, minority ownership interests of: (i) approximately 7% in an acute care facility located in Texas; (ii) 49%, 20%, 30%, 20%, 25%, 48% and 26% in seven behavioral health care facilities located in Arizona, Pennsylvania, Ohio, Washington, Missouri, Iowa and Michigan, respectively, and; (iii) approximately 5% in an acute care facility located in Nevada. The noncontrolling interest and redeemable noncontrolling interest balances of $49 million and $5 million, respectively, as of September 30, 2022, consist primarily of the third-party ownership interests in these hospitals.

In August 2022, we purchased the 20% noncontrolling ownership interest in a hospital majority owned by us, located in Washington D.C. for $51 million. We now have 100% ownership interest in the hospital. The noncontrolling interest balance was reclassified to retained earnings as of September 30, 2022 and is included in common stockholders' equity in the accompanying condensed consolidated balance sheet and in retained earnings in the accompanying condensed consolidated statements of changes in equity.

In connection with the two behavioral health care facilities located in Pennsylvania and Ohio, the minority ownership interests of which are reflected as redeemable noncontrolling interests on our Condensed Consolidated Balance Sheet, the outside owners have "put options" to put their 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. Accordingly, the amounts recorded as redeemable noncontrolling interests on our Condensed Consolidated Balance Sheet reflects the estimated fair market value of these ownership interests.

(4) Treasury

Credit Facilities and Outstanding Debt Securities:

In June, 2022 we entered into a ninth amendment to our credit agreement dated as of November 15, 2010, as amended and restated as of September, 2012, August, 2014, October, 2018, August, 2021, and September, 2021, among UHS, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders, and JPMorgan Chase Bank, N.A., as administrative agent, (the "Credit Agreement"). The ninth amendment provided for, among other things, the following: (i) a new incremental tranche A term loan facility in the aggregate principal amount of $700 million which is scheduled to mature on August 24, 2026, and; (ii) replaces the option to make Eurodollar borrowings (which bear interest by reference to the LIBOR Rate) with Term Benchmark Loans, which will bear interest by reference to the Secured Overnight Financing Rate ("SOFR"). The net proceeds generated from the incremental tranche A term loan facility were used to repay a portion of the borrowings that were previously outstanding under our revolving credit facility.

In September, 2021 we entered into an eighth amendment to our Credit Agreement which modified the definition of "Adjusted LIBO Rate".

In August, 2021 we entered into a seventh amendment to our Credit Agreement which, among other things, provided for the following:

- a $1.2 billion aggregate amount revolving credit facility, which is scheduled to mature on August 24, 2026, representing an increase of $200 million over the $1.0 billion previous commitment. As of September 30, 2022, this facility had $189 million of borrowings outstanding and $1.007 billion of available borrowing capacity, net of $4 million of outstanding letters of credit;
- a $1.7 billion initial tranche A term loan facility which was subsequently increased by $700 million in June, 2022 by the above-mentioned ninth amendment. The seventh amendment also provided for repayment of $150 million of borrowings outstanding pursuant to the previous tranche A term loan facility, and;
- repayment of approximately $488 million of outstanding borrowings and termination of the previous tranche B term loan facility.

The terms of the tranche A term loan facility, as amended, which had $2.353 billion of outstanding borrowings as of September 30, 2022, provides for installment payments of $15.0 million per quarter during the period of September, 2022 through September, 2023, and $30.0 million per quarter during the period of December, 2023 through June, 2026. The unpaid principal balance at June 30, 2026 is payable on the August 24, 2026 scheduled maturity date of the Credit Agreement.

Revolving credit and tranche A term loan borrowings under the Credit Agreement bear interest at our election at either (1) the ABR rate which is defined as the rate per annum equal to 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 SOFR rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.25% to 0.625%, or (2) the one, three or six month SOFR rate plus 0.1% (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.25% to 1.625%. As of September 30, 2022, the applicable margins were 0.50% for ABR-based loans and 1.50% for SOFR-based loans under the revolving credit and term loan A facilities. 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 (which generally excludes asset classes such as substantially all of the patient-related accounts receivable of our acute care hospitals, and certain real estate assets and assets held in joint-ventures with third parties) and is guaranteed by our material subsidiaries.

The Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement also contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens, indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage. We were in compliance with all required covenants as of September 30, 2022 and December 31, 2021.

On August 24, 2021, we completed the following via private offerings 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:

- Issued $700 million of aggregate principal amount of 1.65% senior secured notes due on September 1, 2026, and;
- Issued $500 million of aggregate principal amount of 2.65% senior secured notes due on January 15, 2032.

In April, 2021 our accounts receivable securitization program ("Securitization") was amended (the eighth amendment) to: (i) reduce the aggregate borrowing commitments to $20 million (from $450 million previously); (ii) slightly reduce the borrowing rates and commitment fee, and; (iii) extend the maturity date to April 25, 2022. In April, 2022, the Securitization was amended (the ninth amendment) to extend the maturity date to July 22, 2022. In July, 2022, the Securitization was amended (the tenth amendment) to extend the maturity date to September 20, 2022. In September, 2022, the Securitization was amended (the eleventh amendment) to extend the maturity date to December 20, 2022. Substantially all other material terms and conditions remained unchanged. There were no borrowings outstanding pursuant to the Securitization as of September 30, 2022.

On September 13, 2021, we redeemed $400 million of aggregate principal amount of 5.00% senior secured notes, that were scheduled to mature on June 1, 2026, at 102.50% of the aggregate principal, or $410 million.

As of September 30, 2022, we had combined aggregate principal of $2.0 billion from the following senior secured notes:

- $700 million aggregate principal amount of 1.65% senior secured notes due in September, 2026 ("2026 Notes") which were issued on August 24, 2021.
- $800 million aggregate principal amount of 2.65% senior secured notes due in October, 2030 ("2030 Notes") which were issued on September 21, 2020.
- $500 million of aggregate principal amount of 2.65% senior secured notes due in January, 2032 ("2032 Notes") which were issued on August 24, 2021.

Interest on the 2026 Notes is payable on March 1st and September 1st until the maturity date of September 1, 2026. Interest on the 2030 Notes payable on April 15th and October 15th, until the maturity date of October 15, 2030. Interest on the 2032 Notes is payable on January 15th and July 15th until the maturity date of January 15, 2032.

The 2026 Notes, 2030 Notes and 2032 Notes (collectively "The 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 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.

The Notes are guaranteed (the "*Guarantees*") on a senior secured basis by all of our existing and future direct and indirect subsidiaries (the "*Subsidiary Guarantors*") that guarantee our Credit Agreement, or other first lien obligations or any junior lien obligations. The Notes and the Guarantees are secured by first-priority liens, subject to permitted liens, on certain of the Company's and the Subsidiary Guarantors' assets now owned or acquired in the future by the Company or the Subsidiary Guarantors (other than real property, accounts receivable sold pursuant to the Company's Existing Receivables Facility (as defined in the Indenture pursuant to which The Notes were issued (the "Indenture")), and certain other excluded assets). The Company's obligations with respect to The Notes, the obligations of the Subsidiary Guarantors under the Guarantees, and the performance of all of the Company's and the Subsidiary Guarantors' other obligations under the Indenture, are secured equally and ratably with the Company's and the Subsidiary Guarantors' obligations under the Credit Agreement and The Notes by a perfected first-priority security interest, subject to permitted liens, in the collateral owned by the Company and its Subsidiary Guarantors, whether now owned or hereafter acquired. However, the liens on the collateral securing The Notes and the Guarantees will be released if: (i) The Notes have investment grade ratings; (ii) no default has occurred and is continuing, and; (iii) the liens on the collateral securing all first lien obligations (including the Credit Agreement and The Notes) and any junior lien obligations are released or the collateral under the Credit Agreement, any other first lien obligations and any junior lien obligations is released or no longer required to be pledged. The liens on any collateral securing The Notes and the Guarantees will also be released if the liens on that collateral securing the Credit Agreement, other first lien obligations and any junior lien obligations are released.

In connection with the issuance of The Notes, the Company, the Subsidiary Guarantors and the representatives of the several initial purchasers, entered into Registration Rights Agreements (the "*Registration Rights Agreements*"), whereby the Company and the Subsidiary Guarantors have agreed, at their expense, to use commercially reasonable best efforts to: (i) cause to be filed a registration statement enabling the holders to exchange The Notes and the Guarantees for registered senior secured notes issued by the Company and guaranteed by the then Subsidiary Guarantors under the Indenture (the "*Exchange Securities*"), containing terms identical to those of The Notes (except that the Exchange Securities will not be subject to restrictions on transfer or to any increase in annual interest rate for failure to comply with the Registration Rights Agreements); (ii) cause the registration statement to become effective; (iii) complete the exchange offer not later than 60 days after such effective date and in any event on or prior to a target registration date of March 21, 2023 in the case of the 2030 Notes and February 24, 2024 in the case of the 2026 and 2032 Notes, and; (iv) file a shelf registration statement for the resale of The Notes if the exchange offers cannot be effected within the time periods listed above. The interest rate on The Notes will increase and additional interest thereon will be payable if the Company does not comply with its obligations under the Registration Rights Agreements.

As discussed in *Note 2 to the Consolidated Financial Statements-Relationship with Universal Health Realty Income Trust and Other Related Party Transactions*, on December 31, 2021, we (through wholly-owned subsidiaries of ours) entered into an asset purchase and sale agreement with Universal Health Realty Income Trust (the "Trust"). Pursuant to the terms of the agreement, which was amended during the first quarter of 2022, we, among other things, transferred to the Trust, the real estate assets of Aiken Regional Medical Center ("Aiken") and Canyon Creek Behavioral Health ("Canyon Creek"). In connection with this transaction, Aiken and Canyon Creek (as lessees), entered into a master lease and individual property leases, as amended, (with the Trust as lessor), for initial lease terms on each property of approximately twelve years, ending on December 31, 2033. As a result of our purchase option within the Aiken and Canyon Creek lease agreements, this asset purchase and sale transaction is accounted for as a failed sale leaseback in accordance with U.S. GAAP and we have accounted for the transaction as a financing arrangement. Our lease payments payable to the Trust are recorded to interest expense and as a reduction of the outstanding financial liability, and the amount allocated to interest expense is determined based upon our incremental borrowing rate and the outstanding financial liability. In connection with this transaction, our Consolidated Balance Sheets at September 30, 2022 and December 31, 2021 reflect financial liabilities, which are included in debt, of approximately $82 million as of each date.

At September 30, 2022, the carrying value and fair value of our debt were approximately $4.7 billion and $4.3 billion, respectively. At December 31, 2021, the carrying value and fair value of our debt were each approximately $4.2 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.

Foreign Currency Forward Exchange Contracts:

We use forward exchange contracts to hedge our net investment in foreign operations against movements in exchange rates. The effective portion of the unrealized gains or losses on these contracts is recorded in foreign currency translation adjustment within accumulated other comprehensive income and remains there until either the sale or liquidation of the subsidiary. In connection with

these forward exchange contracts, we recorded net cash inflows of $177 million and $4 million during the nine-month periods ended September 30, 2022 and 2021, respectively.

Derivatives Hedging Relationships:

The following table presents the effects of our foreign currency foreign exchange contracts on our results of operations for the three and nine-month periods ended September 30, 2022 and 2021 (in thousands):

	Gain/(Loss) recognized in AOCI			
	Three months ended		Nine months ended	
	September 30, 2022	September 30, 2021	September 30, 2022	September 30, 2021
Net Investment Hedge relationships				
Foreign currency foreign exchange contracts	$ 120,043	$ 26,152	$ 201,619	$ (4,879)

No other gains or losses were recognized in income related to derivatives in Subtopic 815-20.

Cash, Cash Equivalents and Restricted Cash:

Cash, cash equivalents, and restricted cash as reported in the condensed consolidated statements of cash flows are presented separately on our condensed consolidated balance sheets as follows (in thousands):

	September 30, 2022	September 30, 2021	December 31, 2021
Cash and cash equivalents	$ 74,571	$ 189,743	$ 115,301
Restricted cash (a)	90,810	54,674	63,633
Total cash, cash equivalents and restricted cash	$ 165,381	$ 244,417	$ 178,934

(a) Restricted cash is included in other assets on the accompanying consolidated balance sheet.

(5) Fair Value Measurement

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. The following fair value hierarchy classifies the inputs to valuation techniques used to measure fair value into one of three levels:

- Level 1: Unadjusted quoted prices in active markets for identical assets or liabilities.
- Level 2: Inputs other than quoted prices that are observable for the asset or liability, either directly or indirectly. These included quoted prices for similar assets or liabilities in active markets and quoted prices for identical or similar assets or liabilities in markets that are not active.
- Level 3: Unobservable inputs that reflect the reporting entity’s own assumptions.

The following tables present the assets and liabilities recorded at fair value on a recurring basis:

(in thousands)	Balance at September 30, 2022	Balance Sheet Location	Basis of Fair Value Measurement Level 1	Level 2	Level 3
Assets:					
Money market mutual funds	106,360	Other assets	106,360		
Certificates of deposit	2,200	Other assets		2,200	
Equity securities	75,777	Other assets	75,777		
Deferred compensation assets	36,343	Other assets	36,343		
Foreign currency exchange contracts	25,762	Other current assets		25,762	
	$ 246,442		$ 218,480	$ 27,962	-
Liabilities:					
Deferred compensation liability	36,343	Other noncurrent liabilities	36,343		
	$ 36,343		$ 36,343	-	-

(in thousands)	Balance at December 31, 2021	Balance Sheet Location	Basis of Fair Value Measurement Level 1	Level 2	Level 3
Assets:					
Money market mutual funds	79,900	Other assets	79,900		
Certificates of deposit	2,300	Other assets		2,300	
Equity securities	91,919	Other assets	91,919		
Deferred compensation assets	45,759	Other assets	45,759		
Foreign currency exchange contracts	1,357	Other current assets		1,357	
	$ 221,235		$ 217,578	$ 3,657	-
Liabilities:					
Deferred compensation liability	45,759	Other noncurrent liabilities	$ 45,759		
	$ 45,759		$ 45,759	-	-

The fair value of our money market mutual funds, certificates of deposit and equity securities with a readily determinable fair value are computed based upon quoted market prices in an active market. The fair value of deferred compensation assets and offsetting liability are computed based on market prices in an active market held in a rabbi trust. The fair value of our interest rate swaps are based on quotes from our counter parties. The fair value of our foreign currency exchange contracts is valued using quoted forward exchange rates and spot rates at the reporting date.

(6) Commitments and Contingencies

Professional and General Liability, Workers' Compensation Liability

The vast majority of our subsidiaries are self-insured for professional and general liability exposure up to: (i) $20 million for professional liability and $3 million for general liability per occurrence in 2022 and 2021; (ii) $10 million and $3 million per occurrence in 2020 (professional liability claims are also subject to an additional annual aggregate self-insured retention of $2.5 million for claims in excess of $10 million for 2020); (iii) $5 million and $3 million per occurrence, respectively, during 2019, 2018 and 2017, and; (iv) $10 million and $3 million per occurrence, respectively, prior to 2017.

These subsidiaries are provided with several excess policies through commercial insurance carriers which provide for coverage in excess of the applicable per occurrence and aggregate self-insured retention or underlying policy limits up to $162.5 million in 2022; $155 million in 2021 and $250 million during each of 2014 through 2020. In addition, from time to time based upon marketplace conditions, we may elect to purchase additional commercial coverage for certain of our facilities or businesses. Our behavioral health care facilities located in the U.K. have policies through a commercial insurance carrier located in the U.K. that provides for £16 million of professional liability coverage, and £25 million of general liability coverage.

As of September 30, 2022, the total net accrual for our professional and general liability claims was $388 million, of which $74 million was included in current liabilities. As of December 31, 2021, the total net accrual for our professional and general liability claims was $349 million, of which $74 million was included in current liabilities.

As a result of unfavorable trends experienced during 2022 and 2021, our results of operations included pre-tax increases to our reserves for self-insured professional and general liability claims amounting to approximately $16 million during the nine-month

period ended September 30, 2022 (recorded during the second quarter of 2022) and $41 million during the nine-month period ended September 30, 2021 ($36 million and $5 million recorded during the second and third quarters of 2021, respectively). 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 September 30, 2022, the total accrual for our workers' compensation liability claims was $123 million, $55 million of which was included in current liabilities. As of December 31, 2021, the total accrual for our workers' compensation liability claims was $115 million, $55 million of which was included in current liabilities.

Although we are unable to predict whether or not our future financial statements will require updates to estimates for our prior year reserves for self-insured general and professional and workers' compensation claims, given the relatively unpredictable nature of these potential liabilities and the factors impacting these reserves, as discussed above, it is reasonably likely that our future financial results may include material adjustments to prior period reserves.

Property Insurance

We have commercial property insurance policies for our properties covering catastrophic losses, including windstorm damage, up to a $1 billion policy limit, subject to a per occurrence/per location deductible of $2.5 million as of June 1, 2020. Losses resulting from named windstorms are subject to deductibles between 3% and 5% of the 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). Commercially insured earthquake coverage for our facilities is subject to various deductibles and limitations including: (i) $150 million limitation for our facilities located in California; (ii) $100 million limitation for our facilities located in fault zones within the United States; (iii) $40 million limitation for our facilities located in Puerto Rico, and; (iv) $250 million limitation for many of our facilities located in other states. Our commercially insured flood coverage has a limit of $100 million annually. There is also a $10 million sublimit for one of our facilities located in Houston, Texas, and a $1 million sublimit for our facilities located in Puerto Rico. Property insurance for our behavioral health facilities located in the U.K. are provided on an all risk basis up to a £1.5 billion policy limit, with coverage caps per location, that includes coverage for real and personal property as well as business interruption losses.

Although we are unable to predict whether or not our future financial statements will require updates to estimates for our reserves for self-insured general and professional and workers' compensation claims, given the relatively unpredictable nature of these potential liabilities and the factors impacting these reserves, as discussed above, it is reasonably likely that our future financial results may include material adjustments to prior period reserves.

Legal Proceedings

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 Claims 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 Claims Act matter. In September 2014, the Criminal Division of the Department of Justice ("DOJ") announced that all qui tam cases will be shared with their Division to determine if a parallel criminal investigation should be opened. The DOJ has also announced an intention to pursue civil and criminal actions against individuals within a company as well as the corporate entity or entities. 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 Legislation 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.

Certain legal matters are described below:

Litigation:

Knight v. Miller, et. al.

In July 2021, a shareholder derivative lawsuit was filed by plaintiff, Robin Knight, in the Chancery Court in Delaware against the members of the Board of Directors of the Company as well as certain officers (C.A. No.: 2021-0581-SG). The Company was named as a nominal defendant. The lawsuit alleges that in March 2020 stock options were awarded with exercise prices that did not reflect the Company's fundamentals and business prospects, and in anticipation of future market rebound resulting in excessive gains. The lawsuit makes claims of breaches of fiduciary duties, waste of corporate assets, and unjust enrichment. The lawsuit seeks monetary damages allegedly incurred by the Company, disgorgement of the March 2020 stock awards as well as any proceeds derived therefrom and unspecified equitable relief. Defendants deny the allegations. We filed a motion to dismiss the complaint and the court granted part and denied part of our motion. During the third quarter of 2022, we have reached a preliminary settlement, which will not have a material impact on our consolidated financial statements, pending finalization of certain outstanding items, preparation of settlement documentation and court approval. We are uncertain as to potential liability or financial exposure, if any, which may be associated with this matter in the event the settlement is not finalized and approved by the court.

The George Washington University v. Universal Health Services, Inc., et. al.

In December 2019, The George Washington University ("University") filed a lawsuit in the Superior Court for the District of Columbia against Universal Health Services, Inc. as well as certain subsidiaries and individuals associated with the ownership and management of The George Washington University Hospital ("GW Hospital") in Washington, D.C. (case No. 2019 CA 008019 B). The lawsuit claimed that UHS failed to provide sufficient financial compensation to the University under the terms of various agreements entered into in 1997 between the University and UHS for the joint venture ownership of GW Hospital. The lawsuit included claims for breach of contract, breach of fiduciary duty, and unjust enrichment. We denied liability and defended this matter vigorously. We filed a motion to dismiss the complaint. In June 2020, the Court granted the motion in part dismissing the majority of the claims against UHS.

During the second quarter of 2022 the parties reached a settlement which was subject to regulatory approval from the District of Columbia's State Health Planning and Development Agency. Regulatory approval was granted during the third quarter of 2022 at which time the settlement was finalized and the litigation was dismissed. The settlement, which did not have a material impact on our consolidated financial statements, provided for, among other things: (i) the purchase by us of the University's 20% minority ownership interest in GW Hospital; (ii) a new ground lease related to GW Hospital, and; (iii) annual payments from us to the University for academic mission support and trademark royalties.

Disproportionate Share Hospital Payment Matter:

In late September, 2015, many hospitals in Pennsylvania, including certain of our behavioral health care hospitals located in the state, received letters from the Pennsylvania Department of Human Services (the "Department") demanding repayment of allegedly excess Medicaid Disproportionate Share Hospital payments ("DSH"), primarily consisting of managed care payments characterized as DSH payments, for the federal fiscal year ("FFY") 2011 amounting to approximately $4 million in the aggregate. Since that time, certain of our behavioral health care hospitals in Pennsylvania have received similar requests for repayment for alleged DSH overpayments for FFYs 2012 through 2015. For FFY 2012, the claimed overpayment amounts to approximately $4 million. For FY 2013, FY 2014 and FY 2015 the initial claimed overpayments and attempted recoupment by the Department were approximately $7 million, $8 million and $7 million, respectively. The Department has agreed to a change in methodology which, upon confirmation of the underlying data being accepted by the Department, could reduce the initial claimed overpayments for FY 2013, FY 2014 and FY 2015 to approximately $2 million, $2 million and $3 million, respectively. We filed administrative appeals for all of our facilities contesting the recoupment efforts for FFYs 2011 through 2015 as we believe the Department's calculation methodology is inaccurate and

conflicts with applicable federal and state laws and regulations. The Department has agreed to postpone the recoupment of the state's share for FY 2011 to 2013 until all hospital appeals are resolved but started recoupment of the federal share. For FY 2014 and FY 2015, the Department has initiated the recoupment of the alleged overpayments. Starting in FY 2016, the first full fiscal year after the January 1, 2015 effective date of Medicaid expansion in Pennsylvania, the Department no longer characterized managed care payments received by the hospitals as DSH payments. We can provide no assurance that we will ultimately be successful in our legal and administrative appeals related to the Department's repayment demands. If our legal and administrative appeals are unsuccessful, our future consolidated results of operations and financial condition could be adversely impacted by these repayments.

Boley, et al. v. UHS, et al.

Former UHS subsidiary facility employees Mary K. Boley, Kandie Sutter, and Phyllis Johnson, individually and on behalf of a putative class of participants in the UHS Retirement Savings Plan (the "Plan"), filed a complaint in the U.S. District Court for the Eastern District of Pennsylvania against UHS, the Board of Directors of UHS, and the "Plan Committee" of UHS (Case No. 2:20-cv-02644). In subsequent amended complaints, Plaintiffs have dropped the Board of Directors and the "Plan Committee" as defendants and added the UHS Retirement Plans Investment Committee as a new defendant. Plaintiffs allege that UHS breached its fiduciary duties under the Employee Retirement Income Security Act ("ERISA") by offering to participants in the Plan overly expensive investment options when less expensive investment options were available in the marketplace; caused participants to pay excessive recordkeeping fees associated with the Plan; breached its duty to monitor appointed fiduciaries and: in the alternative, engaged in a "knowing breach of trust" separate from the alleged violations under ERISA. UHS disputes Plaintiffs' allegations and is actively defending against Plaintiffs' claims. UHS' motion for partial dismissal of Plaintiffs' claims was denied by the Court. In March 2021, the Court granted Plaintiffs' motion for class certification. Although the Third Circuit Court of Appeal agreed to hear an appeal of the trial court's order granting class certification, the appeal was denied and the class certification was affirmed. As a result, the stay of the case in the trial court pending conclusion of the appellate proceedings has been lifted. We maintain commercial insurance coverage for claims of this nature, subject to specified deductibles and limitations. During the third quarter of 2022, the parties have reached a preliminary settlement, within the policy limitations of our commercial insurance coverage after satisfaction of specified deductibles, pending preparation, execution and finalization of settlement documents as well as court approval of the settlement. We are uncertain as to potential liability or financial exposure, if any, which may be associated with this matter in the event the preliminary settlement is not finalized and approved by the court.

Other Matters:

Various other suits, claims and investigations, including government subpoenas, arising against, or issued to, us are pending and additional such matters may arise in the future. Management will consider additional disclosure from time to time to the extent it believes such matters may be or become material. 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 described above or that are otherwise pending 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 matter 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.

(7) 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, but not limited to, information technology, purchasing, reimbursement, accounting and finance, taxation, legal, advertising and design and construction. The chief operating decision making group for our acute care services and behavioral health care services is comprised of our President and Chief Executive Officer and the Presidents of each operating segment. The Presidents for 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, 2021. The corporate overhead allocations, as reflected below, are utilized for internal reporting purposes and are comprised of each period's projected corporate-level operating expenses (excluding interest expense). The overhead expenses are captured and allocated directly to each segment to the extent possible, and overhead expenses incurred on behalf of both segments are captured and allocated to each segment based upon each segment's respective percentage of total operating expenses.

	Three months ended September 30, 2022			
	Acute Care Hospital Services	Behavioral Health Services (a)	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 9,875,794	$ 2,582,448	$ -	$ 12,458,242
Gross outpatient revenues	$ 6,379,324	$ 248,167	$ -	$ 6,627,491
Total net revenues	$ 1,919,678	$ 1,434,828	$ (18,479)	$ 3,336,027
Income/(loss) before allocation of corporate overhead and income taxes	$ 129,241	$ 237,949	$ (132,978)	$ 234,212
Allocation of corporate overhead	$ (63,242)	$ (44,882)	$ 108,124	$ 0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 65,999	$ 193,067	$ (24,854)	$ 234,212
Total assets as of September 30, 2022	$ 6,039,787	$ 7,336,437	$ 2,676	$ 13,378,900

	Nine months ended September 30, 2022			
	Acute Care Hospital Services	Behavioral Health Services (a)	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 29,821,756	$ 7,580,475		$ 37,402,231
Gross outpatient revenues	$ 18,360,902	$ 773,769		$ 19,134,671
Total net revenues	$ 5,707,510	$ 4,235,215	$ 9,665	$ 9,952,390
Income/(loss) before allocation of corporate overhead and income taxes	$ 372,981	$ 693,694	$ (422,750)	$ 643,925
Allocation of corporate overhead	$ (188,739)	$ (134,946)	$ 323,685	$ 0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 184,242	$ 558,748	$ (99,065)	$ 643,925
Total assets as of September 30, 2022	$ 6,039,787	$ 7,336,437	$ 2,676	$ 13,378,900

	Three months ended September 30, 2021			
	Acute Care Hospital Services	Behavioral Health Services (a)	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 9,497,975	$ 2,470,401	$ 0	$ 11,968,376
Gross outpatient revenues	$ 5,343,246	$ 242,976	$ 0	$ 5,586,222
Total net revenues	$ 1,822,027	$ 1,328,293	$ 5,679	$ 3,155,999
Income/(loss) before allocation of corporate overhead and income taxes	$ 208,638	$ 197,779	$ (119,527)	$ 286,890
Allocation of corporate overhead	$ (58,452)	$ (43,120)	$ 101,572	$ 0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 150,186	$ 154,659	$ (17,955)	$ 286,890
Total assets as of September 30, 2021	$ 5,295,533	$ 7,106,832	$ 444,488	$ 12,846,853

	Nine months ended September 30, 2021			
	Acute Care Hospital Services	Behavioral Health Services (a)	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 27,279,494	$ 7,471,742	$ 0	$ 34,751,236
Gross outpatient revenues	$ 15,281,854	$ 756,068	$ 0	$ 16,037,922
Total net revenues	$ 5,271,000	$ 4,075,127	$ 20,739	$ 9,366,866
Income/(loss) before allocation of corporate overhead and income taxes	$ 600,419	$ 753,681	$ (367,535)	$ 986,565
Allocation of corporate overhead	$ (174,786)	$ (129,169)	$ 303,955	$ 0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 425,633	$ 624,512	$ (63,580)	$ 986,565
Total assets as of September 30, 2021	$ 5,295,533	$ 7,106,832	$ 444,488	$ 12,846,853

(a) Includes net revenues generated from our behavioral health care facilities located in the U.K. amounting to approximately $167 million and $174 million for the three-month periods ended September 30, 2022 and 2021, respectively, and approximately $516 million and $511 million for the nine-month periods ended September 30, 2022 and 2021, respectively. Total assets at our U.K. behavioral health care facilities were approximately $1.119 billion and $1.338 billion as of September 30, 2022 and 2021, respectively.

(8) 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 September 30,		Nine months ended September 30,	
	2022	2021	2022	2021
Basic and Diluted:				
Net income attributable to UHS	$ 182,814	$ 218,351	$ 500,789	$ 752,466
Less: Net income attributable to unvested restricted share grants	(179)	(396)	(592)	(1,609)
Net income attributable to UHS – basic and diluted	$ 182,635	$ 217,955	$ 500,197	$ 750,857
Weighted average number of common shares - basic	72,595	82,262	73,769	83,756
Net effect of dilutive stock options and grants based on the treasury stock method	465	1,411	743	1,275
Weighted average number of common shares and equivalents - diluted	73,060	83,673	74,512	85,031
Earnings per basic share attributable to UHS:	$ 2.52	$ 2.65	$ 6.78	$ 8.96
Earnings per diluted share attributable to UHS:	$ 2.50	$ 2.60	$ 6.71	$ 8.83

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. The excluded weighted-average stock options totaled 6.7 million for the three months ended September 30, 2022 and 6.0 million for the nine months ended September 30, 2022. The excluded weighted-average stock options totaled 4.1 million for the three months ended September 30, 2021 and 4.3 million for the nine months ended September 30, 2021. All classes of our common stock have the same dividend rights.

Stock-Based Compensation:

During the three-month periods ended September 30, 2022 and 2021, pre-tax compensation costs of $15.8 million and $14.6 million, respectively, was recognized related to outstanding stock options. During the nine-month periods ended September 30, 2022 and 2021, pre-tax compensation costs of $48.6 million and $44.8 million, respectively, was recognized related to outstanding stock options. In addition, during the three-month periods ended September 30, 2022 and 2021, pre-tax compensation cost of approximately $4.9 million and $3.5 million, respectively, was recognized related to restricted stock awards, restricted stock units and performance based restricted stock units. During the nine-month periods ended September 30, 2022 and 2021, pre-tax compensation cost of approximately $13.0 million and $9.6 million, respectively, was recognized related to restricted stock awards, restricted stock units and performance based restricted stock units. As of September 30, 2022 there was approximately $170.0 million of unrecognized compensation cost related to unvested options, restricted stock awards, restricted stock units and performance based restricted stock units which is expected to be recognized over the remaining weighted average vesting period of 2.8 years. There were 1,828,573 stock options granted during the first nine months of 2022 with a weighted-average grant date fair value of $45.63 per option. There were an aggregate of 250,089 restricted units granted during the first nine months of 2022, including 73,782 performance based restricted stock units, with a weighted-average grant date fair value of $142.70 per share.

The expense associated with stock-based compensation arrangements is a non-cash charge. In the Condensed Consolidated Statements of Cash Flows, stock-based compensation expense is an adjustment to reconcile net income to cash provided by operating activities and aggregated to $62.7 million and $55.5 million during the nine-month periods ended September 30, 2022 and 2021.

(9) Dispositions and acquisitions

Nine-month period ended September 30, 2022:

Acquisitions:

During the first nine months of 2022, we spent $19 million on the acquisition of businesses and property. In addition, in August, we spent $51 million to acquire the 20% noncontrolling ownership interest in a hospital majority owned by us, located in Washington D.C.

Divestitures:

During the first nine months of 2022, we received $12 million from the sales of assets and businesses.

Nine-month period ended September 30, 2021:

Acquisitions:

During the first nine months of 2021, we spent $39 million to acquire a 22-bed micro hospital located in Las Vegas, Nevada.

Divestitures:

During the first nine months of 2021, we received $21 million from the sale of our equity interest in a business.

(10) Dividends

We declared and paid dividends of $14.6 million, or $.20 per share, during the third quarter of 2022 and $16.4 million, or $.20 per share, during the third quarter of 2021. We declared and paid dividends of $44.2 million, or $.60 per share during the nine-month period ended September 30, 2022 and $50.3 million, or $.60 per share, during the nine-month period ended September 30, 2021. Included in the amounts above were dividend equivalents applicable to unvested restricted stock units which were accrued during 2022 and 2021 and will be, or were, paid upon vesting of the restricted stock unit.

(11) Income Taxes

Our effective income tax rates were 24.5% and 23.5% during the three-month periods ended September 30, 2022, and 2021, respectively, and 24.4% and 23.6% during the nine-month periods ended September 30, 2022, and 2021, respectively. The increase in the effective tax rates during the three and nine-month periods ended September 30, 2022, as compared to the comparable periods of 2021, was primarily due to the decreases in net income attributable to noncontrolling interests during the three and nine-month periods ended September 30, 2022, as compared to the comparable periods of 2021.

The global intangible low-taxed income ("GILTI") provisions from the TCJA-17 require the inclusion of the earnings of certain foreign subsidiaries in excess of an acceptable rate of return on certain assets of the respective subsidiaries in our U.S. tax return for tax years beginning after December 31, 2017. An accounting policy election was made during 2018 to treat taxes related to GILTI as a period cost when the tax is incurred. We recorded a GILTI tax provision of zero for the nine months ended September 30, 2022 and 2021.

On August 16, 2022, the U.S. federal government enacted the Inflation Reduction Act of 2022 ("the Act"). The Act includes tax provisions, among other things, which implements (i) a 15 percent minimum tax on book income of certain large corporations; (ii) a one percent excise tax on net stock repurchases, and; (iii) several tax incentives to promote clean energy. We do not expect the Act to have a material impact on our income tax provision.

As of January 1, 2022, our unrecognized tax benefits were approximately $2 million. The amount, if recognized, that would favorably affect the effective tax rate is approximately $2 million. During the nine months ended September 30, 2022, 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 September 30, 2022, we have less than $1 million of accrued interest and penalties. The U.S. federal statute of limitations remains open for 2018 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.

(12) Revenue

We recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which we expect to be entitled in exchange for those goods or services. Our estimate for amounts not expected to be collected based on historical experience will continue to be recognized as a reduction to net revenue. However, subsequent changes in estimate of collectability due to a change in the financial status of a payer, for example a bankruptcy, will be recognized as bad debt expense in operating charges.

The performance obligation is separately identifiable from other promises in the customer contract. As the performance obligations are met (i.e.: room, board, ancillary services, level of care), revenue is recognized based upon allocated transaction price. The transaction price is allocated to separate performance obligations based upon the relative standalone selling price. In instances where we determine there are multiple performance obligations across multiple months, the transaction price will be allocated by applying an estimated implicit and explicit rate to gross charges based on the separate performance obligations.

In assessing collectability, we have elected the portfolio approach. This portfolio approach is being used as we have large volume of similar contracts with similar classes of customers. We reasonably expect that the effect of applying a portfolio approach to a group of contracts would not differ materially from considering each contract separately. Management’s judgment to group the contracts by portfolio is based on the payment behavior expected in each portfolio category. As a result, aggregating all of the contracts (which are at the patient level) by the particular payer or group of payers, will result in the recognition of the same amount of revenue as applying the analysis at the individual patient level.

We group our revenues into categories based on payment behaviors. Each component has its own reimbursement structure which allows us to disaggregate the revenue into categories that share the nature and timing of payments. The other patient revenue consists primarily of self-pay, government-funded non-Medicaid, and other.

The following table disaggregates our revenue by major source for the three and nine-month periods ended September 30, 2022 and 2021 (in thousands):

	For the three months ended September 30, 2022					
	Acute Care		Behavioral Health		Other	Total	
Medicare	$ 314,785	16%	$ 86,125	6%		$ 400,910	12%
Managed Medicare	305,239	16%	78,554	5%		383,793	12%
Medicaid	200,656	10%	195,656	14%		396,312	12%
Managed Medicaid	213,723	11%	373,456	26%		587,179	18%
Managed Care (HMO and PPOs)	631,670	33%	363,442	25%		995,112	30%
UK Revenue	0	0%	166,843	12%		166,843	5%
Other patient revenue and adjustments, net	38,427	2%	115,969	8%		154,396	5%
Other non-patient revenue	215,178	11%	54,783	4%	(18,479)	251,482	8%
Total Net Revenue	$ 1,919,678	100%	$ 1,434,828	100%	$ (18,479)	3,336,027	100%

	For the nine months ended September 30, 2022					
	Acute Care		Behavioral Health		Other	Total	
Medicare	$ 970,060	17%	$ 248,987	6%		$ 1,219,047	12%
Managed Medicare	944,072	17%	213,281	5%		1,157,353	12%
Medicaid	540,590	9%	554,970	13%		1,095,560	11%
Managed Medicaid	547,452	10%	1,071,792	25%		1,619,244	16%
Managed Care (HMO and PPOs)	1,898,040	33%	1,104,658	26%		3,002,698	30%
UK Revenue	0	0%	516,166	12%		516,166	5%
Other patient revenue and adjustments, net	204,660	4%	362,697	9%		567,357	6%
Other non-patient revenue	602,636	11%	162,664	4%	9,665	774,965	8%
Total Net Revenue	$ 5,707,510	100%	$ 4,235,215	100%	$ 9,665	$ 9,952,390	100%

	For the three months ended September 30, 2021					
	Acute Care		Behavioral Health		Other	Total	
Medicare	$ 310,483	17%	$ 96,219	7%		$ 406,702	13%
Managed Medicare	280,674	15%	66,249	5%		346,923	11%
Medicaid	136,989	8%	146,281	11%		283,270	9%
Managed Medicaid	176,497	10%	326,789	25%		503,286	16%
Managed Care (HMO and PPOs)	674,396	37%	349,275	26%		1,023,671	32%
UK Revenue	0	0%	173,728	13%		173,728	6%
Other patient revenue and adjustments, net	69,935	4%	117,442	9%		187,377	6%
Other non-patient revenue	173,053	9%	52,310	4%	5,679	231,042	7%
Total Net Revenue	$ 1,822,027	100%	$ 1,328,293	100%	$ 5,679	$ 3,155,999	100%

	For the nine months ended September 30, 2021					
	Acute Care		Behavioral Health		Other	Total	
Medicare	$ 954,207	18%	$ 277,438	7%		$ 1,231,645	13%
Managed Medicare	830,627	16%	185,323	5%		1,015,950	11%
Medicaid	418,335	8%	526,945	13%		945,280	10%
Managed Medicaid	473,256	9%	995,749	24%		1,469,005	16%
Managed Care (HMO and PPOs)	1,862,012	35%	1,070,165	26%		2,932,177	31%
UK Revenue	0	0%	510,614	13%		510,614	5%
Other patient revenue and adjustments, net	248,342	5%	366,669	9%		615,011	7%
Other non-patient revenue	484,221	9%	142,224	3%	20,739	647,184	7%
Total Net Revenue	$ 5,271,000	100%	$ 4,075,127	100%	$ 20,739	$ 9,366,866	100%

(13) Lease Accounting

Our operating leases are primarily for real estate, including certain acute care facilities, off-campus outpatient facilities, medical office buildings, and corporate and other administrative offices. Our real estate lease agreements typically have initial terms of five to ten years. These real estate leases may include one or more options to renew, with renewals that can extend the lease term from five to ten years. The exercise of lease renewal options is at our sole discretion. When determining the lease term, we included options to extend or terminate the lease when it is reasonably certain that we will exercise that option.

Five of our hospital facilities are held under operating leases with Universal Health Realty Income Trust with two leases expiring in 2026, two expiring in 2033 and one expiring in 2040 (see Note 2 for additional disclosure). We are also the lessee of the real property of certain facilities from unrelated third parties.

Supplemental cash flow information related to leases for the nine-month periods ended September 30, 2022 and 2021 are as follows (in thousands):

	Nine months ended September 30,	
	2022	2021
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from operating leases	$ 93,153	$ 88,113
Operating cash flows from finance leases	$ 2,986	$ 3,507
Financing cash flows from finance leases	$ 2,621	$ 2,315
Right-of-use assets obtained in exchange for lease obligations:		
Operating leases	$ 145,446	$ 20,292
Finance leases	$ 1,066	$ 7,690

(14) Recent Accounting Standards

In November 2021, the Financial Accounting Standards Board (the "FASB") issued Accounting Standards Update ("ASU") 2021-10, "Government Assistance (Topic 832)" ("ASU 2021-10"). ASU 2021-10 provides guidance to increase the transparency of government assistance including the disclosure of (1) the types of assistance, (2) an entity's accounting for the assistance, and (3) the effect of the assistance on an entity's financial statements. ASU 2021-10 applies to all business entities that account for a transaction with a government by applying a grant or contribution accounting model by analogy to other accounting guidance (for example, a grant model within IAS 20, Accounting for Government Grants and Disclosure of Government Assistance, or Subtopic 958-605, Not-For-Profit Entities—Revenue Recognition). ASU 2021-10 is effective for fiscal years beginning after December 15, 2021. Early adoption is permitted. The adoption of this standard is not expected to have a material impact on our results of operations, cash flows or financial position.

In March 2020, the FASB issued ASU 2020-04, "Facilitation of the Effects of Reference Rate Reform on Financial Reporting." The ASU is intended to provide temporary optional expedients and exceptions to the US GAAP guidance on contract modifications and hedge accounting to ease the financial reporting burdens related to the expected market transition from LIBOR and other interbank offered rates to alternative reference rates. The pronouncement is effective immediately and can be applied to contract modifications through December 31, 2022. To the extent that, prior to December 31, 2022, the Company enters into any contract modifications for which the optional expedients are applied, the adoption of this standard is not expected to have a material impact on our results of operations, cash flows or financial position.

From time to time, new accounting guidance is issued by the FASB or other standard setting bodies that is adopted by the Company as of the effective date or, in some cases where early adoption is permitted, in advance of the effective date. The Company has assessed the recently issued guidance that is not yet effective and, unless otherwise indicated above, believes the new guidance will not have a material impact on our results of operations, cash flows or financial position.

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 and outpatient facilities and behavioral health care facilities.

As of September 30, 2022, we owned and/or operated 359 inpatient facilities and 41 outpatient and other facilities including the following located in 39 U.S states, Washington, D.C., the United Kingdom and Puerto Rico:

Acute care facilities located in the U.S.:

- 28 inpatient acute care hospitals;
- 21 free-standing emergency departments, and;
- 7 outpatient centers & 1 surgical hospital.

Behavioral health care facilities (331 inpatient facilities and 12 outpatient facilities):

Located in the U.S.:

- 185 inpatient behavioral health care facilities, and;
- 10 outpatient behavioral health care facilities.

Located in the U.K.:

- 143 inpatient behavioral health care facilities, and;
- 2 outpatient behavioral health care facilities.

Located in Puerto Rico:

- 3 inpatient behavioral health care facilities.

As a percentage of our consolidated net revenues, net revenues from our acute care hospitals, outpatient facilities and commercial health insurer accounted for 58% during each of the three-month periods ended September 30, 2022 and 2021, and 57% and 56% during the nine-month periods ended September 30, 2022 and 2021, respectively. Net revenues from our behavioral health care facilities and commercial health insurer accounted for 43% and 42% of our consolidated net revenues during the three-month period ended September 30, 2022 and 2021, respectively, and 43% and 44% during the nine-month periods ended September 30, 2022 and 2021, respectively.

Our behavioral health care facilities located in the U.K. generated net revenues of approximately $167 million and $174 million during the three-month periods ended September 30, 2022 and 2021, respectively, and $516 million and $511 million during the nine-month periods ended September 30, 2022 and 2021, respectively. Total assets at our U.K. behavioral health care facilities were approximately $1.119 billion as of September 30, 2022 and $1.351 billion as of December 31, 2021.

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 our Annual Report on Form 10-K for the year ended December 31, 2021, 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 set forth herein in *Item 1A. Risk Factors* and *Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations-Forward Looking Statements and Risk Factors* in our Annual Report on Form 10-K for the year ended December 31, 2021 and in *Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations-*

Forward Looking Statements and Risk Factors, as included herein. 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:

- we are subject to risks associated with public health threats and epidemics, including the health concerns relating to the COVID-19 pandemic. In January 2020, the Centers for Disease Control and Prevention ("CDC") confirmed the spread of the disease to the United States. In March 2020, the World Health Organization declared the COVID-19 outbreak a pandemic. The federal government has declared COVID-19 a national emergency, as many federal and state authorities have implemented aggressive measures to "flatten the curve" of confirmed individuals diagnosed with COVID-19 in an attempt to curtail the spread of the virus and to avoid overwhelming the health care system;
- the impact of the COVID-19 pandemic, which began during the second half of March, 2020, has had a material effect on our operations and financial results since that time. The length and extent of the disruptions caused by the COVID-19 pandemic are currently unknown; however, we expect such disruptions to continue into the future. Since the future volumes and severity of COVID-19 patients remain highly uncertain and subject to change, including potential increases in future COVID-19 patient volumes caused by new variants of the virus, as well as related pressures on staffing and wage rates, we are not able to fully quantify the impact that these factors will have on our future financial results. However, developments related to the COVID-19 pandemic could continue to materially affect our financial performance. Even after the COVID-19 pandemic has subsided, we may continue to experience materially adverse impacts on our financial condition and our results of operations as a result of its macroeconomic impact, and many of our known risks described in the *Risk Factors* sections of our Annual Report on Form 10-K for the year ended December 31, 2021;
- the nationwide shortage of nurses and other clinical staff and support personnel has been a significant operating issue facing us and other healthcare providers. Like others in the healthcare industry, we continue to experience a shortage of nurses and other clinical staff and support personnel at our acute care and behavioral health care hospitals in many geographic areas. In some areas, the labor scarcity is putting a strain on our resources and staff, which has required us to utilize higher-cost temporary labor and pay premiums above standard compensation for essential workers. This staffing shortage has required us to hire expensive temporary personnel and/or enhance wages and benefits to recruit and retain nurses and other clinical staff and support personnel. At certain facilities, particularly within our behavioral health care segment, we have been unable to fill all vacant positions and, consequently, have been required to limit patient volumes. These factors, which had a material unfavorable impact on our results of operations during the first nine months of 2022, are expected to continue to have an unfavorable material impact on our results of operations for the foreseeable future;
- the Centers for Medicare and Medicaid Services ("CMS") issued an Interim Final Rule ("IFR") effective November 5, 2021 mandating COVID-19 vaccinations for all applicable staff at all Medicare and Medicaid certified facilities. Under the IFR, facilities covered by this regulation must establish a policy ensuring all eligible staff have received the COVID-19 vaccine prior to providing any care, treatment, or other services. All eligible staff must have received the necessary shots to be fully vaccinated. The regulation also provides for exemptions based on recognized medical conditions or religious beliefs, observances, or practices. Under the IFR, facilities must develop a similar process or plan for permitting exemptions in alignment with federal law. If facilities fail to comply with the IFR by the deadlines established, they are subject to potential termination from the Medicare and Medicaid program for non-compliance. We cannot predict at this time the potential viability or impact of any additional vaccination requirements. Implementation of these rules could have an impact on staffing at our facilities for those employees that are not vaccinated in accordance with IFR requirements, and associated loss of revenues and increased costs resulting from staffing issues could have a material adverse effect on our financial results;
- the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"), a stimulus package signed into law on March 27, 2020, authorizes $100 billion in grant funding to hospitals and other healthcare providers to be distributed through the Public Health and Social Services Emergency Fund (the "PHSSEF"). These funds are not required to be repaid provided the recipients attest to and comply with certain terms and conditions, including limitations on balance billing and not using PHSSEF funds to reimburse expenses or losses that other sources are obligated to reimburse. However, since the expenses and losses will be ultimately measured over the life of the COVID-19 pandemic, potential retrospective unfavorable adjustments in future periods, of funds recorded as revenues in prior periods, could occur. The U.S. Department of Health and Human Services ("HHS") initially distributed $30 billion of this funding based on each provider's share of total Medicare fee-for-service reimbursement in 2019. Subsequently, HHS determined that CARES Act funding (including the $30 billion already distributed) would be allocated proportional to providers' share of 2018 net patient revenue. We have received payments from these initial distributions of the PHSSEF as disclosed herein. HHS has indicated that distributions of the remaining $50 billion will be targeted primarily to hospitals in COVID-19 high impact

areas, to rural providers, safety net hospitals and certain Medicaid providers and to reimburse providers for COVID-19 related treatment of uninsured patients. We have received payments from these targeted distributions of the PHSSEF, as disclosed herein. The CARES Act also makes other forms of financial assistance available to healthcare providers, including through Medicare and Medicaid payment adjustments and an expansion of the Medicare Accelerated and Advance Payment Program, which made available accelerated payments of Medicare funds in order to increase cash flow to providers. On April 26, 2020, CMS announced it was reevaluating and temporarily suspending the Medicare Accelerated and Advance Payment Program in light of the availability of the PHSSEF and the significant funds available through other programs. We have received accelerated payments under this program during 2020, and returned early all of those funds during the first quarter of 2021, as disclosed herein. The Paycheck Protection Program and Health Care Enhancement Act (the "PPPHCE Act"), a stimulus package signed into law on April 24, 2020, includes additional emergency appropriations for COVID-19 response, including $75 billion to be distributed to eligible providers through the PHSSEF. A third phase of PHSSEF allocations made $24.5 billion available for providers who previously received, rejected or accepted PHSSEF payments. Applicants that had not yet received PHSSEF payments of 2 percent of patient revenue were to receive a payment that, when combined with prior payments (if any), equals 2 percent of patient care revenue. Providers that have already received payments of approximately 2 percent of annual revenue from patient care were potentially eligible for an additional payment. Recipients will not be required to repay the government for PHSSEF funds received, provided they comply with HHS defined terms and conditions. On December 27, 2020, the Consolidated Appropriations Act, 2021 ("CAA") was signed into law. The CAA appropriated an additional $3 billion to the PHSSEF, codified flexibility for providers to calculate lost revenues, and permitted parent organizations to allocate PHSSEF targeted distributions to subsidiary organizations. The CAA also provides that not less than 85 percent of the unobligated PHSSEF amounts and any future funds recovered from health care providers should be used for additional distributions that consider financial losses and changes in operating expenses in the third or fourth quarters of 2020 and the first quarter of 2021 that are attributable to the coronavirus. The CAA provided additional funding for testing, contact tracing and vaccine administration. Providers receiving payments were required to sign terms and conditions regarding utilization of the payments. Any provider receiving funds in excess of $10,000 in the aggregate will be required to report data elements to HHS detailing utilization of the payments, and we will be required to file such reports. We, and other providers, will report healthcare related expenses attributable to COVID-19 that have not been reimbursed by another source, which may include general and administrative or healthcare related operating expenses. Funds may also be applied to lost revenues, represented as a negative change in year-over-year net patient care operating income. The deadline for using all Provider Relief Fund payments depends on the date of the payment received period; payments received in the first period of April 10, 2020 to June 30, 2020 were to have been expended by June 30, 2021 and payments received in the fourth period of July 1, 2021 to December 31, 2021 must be expended by December 31, 2022. The American Rescue Plan Act of 2021 ("ARPA"), enacted on March 11, 2021, included funding directed at detecting, diagnosing, tracing, and monitoring COVID-19 infections; establishing community vaccination centers and mobile vaccine units; promoting, distributing, and tracking COVID-19 vaccines; and reimbursing rural hospitals and facilities for healthcare-related expenses and lost revenues attributable to COVID-19. ARPA increased the eligibility for, and amount of, premium tax credits to purchase health coverage through Patient Protection and Affordable Care Act, as amended by the Health and Education Reconciliation Act (collectively, the "Legislation"). Further, ARPA set the Medicaid program's federal medical assistance percentage ("FMAP") at 100 percent for amounts expended for COVID-19 vaccines and vaccine administration. ARPA also increases the FMAP by 5 percent for eight calendar quarters to incentivize states to expand their Medicaid programs. Finally, ARPA provides subsidies to cover 100 percent of health insurance premiums under the Consolidated Omnibus Budget Reconciliation Act through September 30, 2021. There is a high degree of uncertainty surrounding the implementation of the CARES Act, the PPPHCE Act, the CAA and ARPA, and the federal government may consider additional stimulus and relief efforts, but we are unable to predict whether additional stimulus measures will be enacted or their impact. There can be no assurance as to the total amount of financial and other types of assistance we will receive under the CARES Act, the PPPHCE Act, the CAA and the ARPA, and it is difficult to predict the impact of such legislation on our operations or how they will affect operations of our competitors. Moreover, we are unable to assess the extent to which anticipated negative impacts on us arising from the COVID-19 pandemic will be offset by amounts or benefits received or to be received under the CARES Act, the PPPHCE Act, the CAA and the ARPA;

- 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. For example, Congress has reduced to $0 the penalty for failing to maintain health coverage that was part of the original Legislation as part of the Tax Cuts and Jobs Act. President Biden has undertaken and is expected to undertake additional executive actions that will strengthen the Legislation and reverse the policies of the prior administration. To date, the Biden administration has issued executive orders implementing a special enrollment period permitting individuals to enroll in health plans outside of the annual open enrollment period and reexamining policies that may undermine the Legislation or the Medicaid program. The Inflation Reduction Act of 2022 ("IRA") was passed on August 16, 2022, which among other things, allows for CMS to negotiate prices for certain single-

source drugs reimbursed under Medicare Part B and Part D. The ARPA's expansion of subsidies to purchase coverage through a Legislation exchange, which the IRA continued through 2025, is anticipated to increase exchange enrollment. The Trump Administration had directed the issuance of final rules (i) enabling the formation of association health plans that would be exempt from certain Legislation requirements such as the provision of essential health benefits, (ii) expanding the availability of short-term, limited duration health insurance, (iii) eliminating cost-sharing reduction payments to insurers that would otherwise offset deductibles and other out-of-pocket expenses for health plan enrollees at or below 250 percent of the federal poverty level, (iv) relaxing requirements for state innovation waivers that could reduce enrollment in the individual and small group markets and lead to additional enrollment in short-term, limited duration insurance and association health plans and (v) incentivizing the use of health reimbursement arrangements by employers to permit employees to purchase health insurance in the individual market. The uncertainty resulting from these Executive Branch policies may have led to reduced Exchange enrollment in 2018, 2019 and 2020. It is also anticipated that these policies, to the extent that they remain as implemented, may create additional cost and reimbursement pressures on hospitals, including ours. In addition, there have been numerous political and legal efforts to expand, repeal, replace or modify the Legislation since its enactment, some of which have been successful, in part, in modifying the Legislation, as well as court challenges to the constitutionality of the Legislation. The U.S. Supreme Court rejected the latest such case on June 17, 2021, when the Court held in *California v. Texas* that the plaintiffs lacked standing to challenge the Legislation's requirement to obtain minimum essential health insurance coverage, or the individual mandate. The Court dismissed the case without specifically ruling on the constitutionality of the Legislation. As a result, the Legislation will continue to remain law, in its entirety, likely for the foreseeable future. On September 7, 2022, the Legislation faced its most recent challenge when a Texas Federal District Court judge, in the case of *Braidwood Management v. Becerra*, ruled that a requirement that certain health plans cover services without cost sharing violates the Appointments Clause of the U.S. Constitution and that the coverage of certain HIV prevention medication violates the Religious Freedom Restoration Act. Any future efforts to challenge, replace or replace the Legislation or expand or substantially amend its provision is unknown. See below in *Sources of Revenue and Health Care Reform* for additional disclosure;

- under the Legislation, hospitals are required to make public a list of their standard charges, and effective January 1, 2019, CMS has required that this disclosure be in machine-readable format and include charges for all hospital items and services and average charges for diagnosis-related groups. On November 27, 2019, CMS published a final rule on "Price Transparency Requirements for Hospitals to Make Standard Charges Public." This rule took effect on January 1, 2021 and requires all hospitals to also make public their payor-specific negotiated rates, minimum negotiated rates, maximum negotiated rates, and cash for all items and services, including individual items and services and service packages, that could be provided by a hospital to a patient. Failure to comply with these requirements may result in daily monetary penalties. On November 2, 2021, CMS released a final rule amending several hospital price transparency policies and increasing the amount of penalties for noncompliance through the use of a scaling factor based on hospital bed count;
- as part of the CAA, Congress passed legislation aimed at preventing or limiting patient balance billing in certain circumstances. The CAA addresses surprise medical bills stemming from emergency services, out-of-network ancillary providers at in-network facilities, and air ambulance carriers. The legislation prohibits surprise billing when out-of-network emergency services or out-of-network services at an in-network facility are provided, unless informed consent is received. In these circumstances providers are prohibited from billing the patient for any amounts that exceed in-network cost-sharing requirements. HHS, the Department of Labor and the Department of the Treasury have issued interim final rules, which begin to implement the legislation. The rules are expected to limit our ability to receive payment for services at usually higher out-of-network rates in certain circumstances and prohibit out-of-network payments in other circumstances. On February 28, 2022, a district judge in the Eastern District of Texas invalidated portions of the rule governing aspects of the Independent Dispute Resolution ("IDR") process. In light of this decision, the government issued a final rule on August 19, 2022 eliminating the rebuttable presumption in favor of the qualifying payment amount ("QPA") by the IDR entity and providing additional factors the IDR entity should consider when choosing between two competing offers. On September 22, 2022, the Texas Medical Association filed a lawsuit challenging the IDR process provided in the updated final rule and alleging that the final rule unlawfully elevates the QPA above other factors the IDR entity must consider. The American Hospital Association and American Medical Association have announced their intent to join this case as amici supporting the Texas Medical Association;
- possible unfavorable changes in the levels and terms of reimbursement for our charges by third party payers or government based payers, including Medicare or Medicaid in the United States, and government based payers 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;
- the outcome of known and unknown litigation, government investigations, false claims act allegations, and liabilities and other claims asserted against us and other matters as disclosed in *Note 6 to the Consolidated Financial Statements - Commitments and Contingencies* and the effects of adverse publicity relating to such matters*;*

- the unfavorable impact on our business of a continued or worsening deterioration in economic, business and credit market conditions, including a continuation or worsening of inflationary pressures on our operating expenses (most particularly labor and supply costs) since our ability, to pass on to payers, the increased costs associated with providing healthcare services to our patients (most particularly Medicare and Medicaid patients) is limited;
- 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;
- there is a heightened risk of future cybersecurity threats, including ransomware attacks targeting healthcare providers. If successful, future cyberattacks could have a material adverse effect on our business. Any costs that we incur as a result of a data security incident or breach, including costs to update our security protocols to mitigate such an incident or breach could be significant. Any breach or failure in our operational security systems can result in loss of data or an unauthorized disclosure of or access to sensitive or confidential member or protected personal or health information and could result in significant penalties or fines, litigation, loss of customers, significant damage to our reputation and business, and other losses. Previously, we had experienced a cyberattack in September, 2020 that had an adverse effect on our operating results during the fourth quarter of 2020, before giving effect to partial recovery of the loss through receipt of commercial insurance proceeds and collection of previously reserved patient accounts;
- the availability of suitable acquisition and divestiture opportunities and our ability to successfully integrate and improve our acquisitions since failure to achieve expected acquisition benefits from certain of our prior or future acquisitions could result in impairment charges for goodwill and purchased intangibles;
- the impact of severe weather conditions, including the effects of hurricanes and climate change;
- 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 annual Medicaid revenues of approximately $100 million, or greater, from each of Texas, California, Nevada, Illinois, Pennsylvania, Washington, D.C., Kentucky, Florida and Massachusetts. We also receive 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, and the effect of the COVID-19 pandemic on state budgets, 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;
- our inpatient acute care and behavioral health care facilities may experience decreasing admission and length of stay trends;
- our financial statements reflect large amounts due from various commercial and private payers and there can be no assurance that failure of the payers to remit amounts due to us will not have a material adverse effect on our future results of operations;

- the Budget Control Act of 2011 (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 with a uniform percentage reduction across all Medicare programs. The Bipartisan Budget Act of 2015, enacted on November 2, 2015, continued the 2% reductions to Medicare reimbursement imposed under the 2011 Act. Recent legislation has suspended payment reductions through December 31, 2021 in exchange for extended cuts through 2030. Subsequent legislation extended the payment reduction suspension through March 31, 2022, with a 1% payment reduction from then until June 30, 2022 and the full 2% payment reduction thereafter. 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 going forward. See below in *2019 Novel Coronavirus Disease Medicare and Medicaid Payment Related Legislation – Medicare Sequestration Relief*, for additional disclosure related to the favorable effect the legislative extensions have had on our results of operations during 2020 and 2021;
- 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;
- changes in our business strategies or development plans;
- in June, 2016, the United Kingdom affirmatively voted in a non-binding referendum in favor of the exit of the United Kingdom ("U.K.") from the European Union (the "Brexit") and it was approved by vote of the British legislature. On March 29, 2017, the United Kingdom triggered Article 50 of the Lisbon Treaty, formally starting negotiations regarding its exit from the European Union. On January 31, 2020, the U.K. formally exited the European Union. On December 24, 2020, the United Kingdom and the European Union reached a post-Brexit trade and cooperation agreement that created new business and security requirements and preserved the United Kingdom's tariff- and quota-free access to the European Union member states. The trade and cooperation agreement was provisionally applied as of January 1, 2021 and entered into force on May 1, 2021, following ratification by the European Union. We do not know to what extent Brexit will ultimately impact the business and regulatory environment in the U.K., the European Union, or other countries. Any of these effects of Brexit, and others we cannot anticipate, could harm our business, financial condition and results of operations;
- in 2021, the rate of inflation in the United States began to increase and has since risen to levels not experienced in over 40 years. We are experiencing inflationary pressures, primarily in personnel costs, and we anticipate impacts on other cost areas within the next twelve months. The extent of any future impacts from inflation on our business and our results of operations will be dependent upon how long the elevated inflation levels persist and the extent to which the rate of inflation further increases, if at all, neither of which we are able to predict. If elevated levels of inflation were to persist or if the rate of inflation were to accelerate, our expenses could increase faster than anticipated and we may utilize our capital resources sooner than expected. Further, given the complexities of the reimbursement landscape in which we operate, our payors may be unwilling or unable to increase reimbursement rates to compensate for inflationary impacts. Although we have hedged some of our floating rate indebtedness, the rapid increase in interest rates have increased our interest expense significantly increasing our expenses and reducing our free cash flow. As such, the effects of inflation may adversely impact our results of operations, financial condition and cash flows;
- we have exposure to fluctuations in foreign currency exchange rates, primarily the pound sterling. We have international subsidiaries that operate in the United Kingdom. We routinely hedge our exposures to foreign currencies with certain financial institutions in an effort to minimize the impact of certain currency exchange rate fluctuations, but these hedges may be inadequate to protect us from currency exchange rate fluctuations. To the extent that these hedges are inadequate, our reported financial results or the way we conduct our business could be adversely affected. Furthermore, if a financial counterparty to our hedges experiences financial difficulties or is otherwise unable to honor the terms of the foreign currency hedge, we may experience material financial losses, 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

There have been no significant changes to our critical accounting policies or estimates from those disclosed in our 2021 Annual Report on Form 10-K.

Recent Accounting Standards: For a summary of accounting standards, please see *Note 14 to the Condensed Consolidated Financial Statements*, as included herein.

Results of Operations

COVID-19, Clinical Staffing Shortage and Effects of Inflation:

The impact of the COVID-19 pandemic, which began during the second half of March, 2020, has had a material effect on our operations and financial results since that time. The length and extent of the disruptions caused by the COVID-19 pandemic are currently unknown; however, we expect such disruptions to continue into the future. Since the future volumes and severity of COVID-19 patients remain highly uncertain and subject to change, including potential increases in future COVID-19 patient volumes caused by new variants of the virus, as well as related pressures on staffing and wage rates, we are not able to fully quantify the impact that these factors will have on our future financial results. However, developments related to the COVID-19 pandemic could continue to materially affect our financial performance.

The healthcare industry is labor intensive and salaries, wages and benefits are subject to inflationary pressures, as are supplies expense and other operating expenses. In addition, the nationwide shortage of nurses and other clinical staff and support personnel has been a significant operating issue facing us and other healthcare providers. Like others in the healthcare industry, we continue to experience a shortage of nurses and other clinical staff and support personnel at our acute care and behavioral health care hospitals in many geographic areas. In some areas, the labor scarcity is putting a strain on our resources and staff, which has required us to utilize higher-cost temporary labor and pay premiums above standard compensation for essential workers. This staffing shortage has required us to hire expensive temporary personnel and/or enhance wages and benefits to recruit and retain nurses and other clinical staff and support personnel. At certain facilities, particularly within our behavioral health care segment, we have been unable to fill all vacant positions and, consequently, have been required to limit patient volumes. These factors, which had a material unfavorable impact on our results of operations during the first nine months of 2022, are expected to continue to have an unfavorable material impact on our results of operations for the foreseeable future.

Although our ability to pass on increased costs associated with providing healthcare to Medicare and Medicaid patients is limited due to various federal, state and local laws which, in certain circumstances, limit our ability to increase prices, we have begun negotiating increased rates from commercial insurers to defray our increased cost of providing patient care. In addition, we have implemented various productivity enhancement programs and cost reduction initiatives including, but not limited to, the following: team-based patient care initiatives designed to optimize the level of patient care services provided by our licensed nurses/clinicians; efforts to reduce utilization of, and rates paid for, premium pay labor; consolidation of medical supply vendors to increase purchasing discounts; review and reduction of clinical variation in connection with the utilization of medical supplies, and; various other efforts to increase productivity and/or reduce costs including investments in new information technology applications.

Financial results for the three-month periods ended September 30, 2022 and 2021:

The following table summarizes our results of operations and is used in the discussion below for the three-month periods ended September 30, 2022 and 2021 (dollar amounts in thousands):

	Three months ended September 30, 2022		Three months ended September 30, 2021	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 3,336,027	100.0%	$ 3,155,999	100.0%
Operating charges:				
Salaries, wages and benefits	1,677,431	50.3%	1,556,448	49.3%
Other operating expenses	837,241	25.1%	754,072	23.9%
Supplies expense	366,337	11.0%	367,834	11.7%
Depreciation and amortization	145,874	4.4%	134,462	4.3%
Lease and rental expense	33,264	1.0%	28,375	0.9%
Subtotal-operating expenses	3,060,147	91.7%	2,841,191	90.0%
Income from operations	275,880	8.3%	314,808	10.0%
Interest expense, net	35,653	1.1%	21,199	0.7%
Other (income) expense, net	6,015	0.2%	6,719	0.2%
Income before income taxes	234,212	7.0%	286,890	9.1%
Provision for income taxes	57,401	1.7%	67,515	2.1%
Net income	176,811	5.3%	219,375	7.0%
Less: Income (loss) attributable to noncontrolling interests	(6,003)	(0.2)%	1,024	0.0%
Net income attributable to UHS	$ 182,814	5.5%	$ 218,351	6.9%

Net revenues increased by 5.7%, or $180 million, to $3.34 billion during the three-month period ended September 30, 2022, as compared to $3.16 billion during the third quarter of 2021. The net increase was primarily attributable to: (i) a $126 million or 4.1% 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"), and; (ii) $54 million of other combined net increases.

Income before income taxes (before income attributable to noncontrolling interests) decreased by $53 million, or 18%, to $234 million during the three-month period ended September 30, 2022 as compared to $287 million during the third quarter of 2021. The $53 million net decrease was due to:

- a decrease of $79 million at our acute care facilities, as discussed below in *Acute Care Hospital Services*;
- an increase of $40 million at our behavioral health care facilities, as discussed below in *Behavioral Health Services*, and;
- a decrease of $14 million due to an increase in interest expense due to an increase in our aggregate average outstanding borrowings as well as an increase in our weighted average cost of borrowings, as discussed below in *Other Operating Results-Interest Expense*.

Net income attributable to UHS decreased by $36 million, or 16%, to $183 million during the three-month period ended September 30, 2022 as compared to $218 million during the third quarter of 2021. This decrease was attributable to:

- a $53 million decrease in income before income taxes, as discussed above;
- an increase of $7 million due to a decrease in income (loss) attributable to noncontrolling interests, and;
- an increase of $10 million resulting from a decrease in the provision for income taxes due primarily to the income tax benefit recorded in connection with the $46 million decrease in pre-tax income.

Financial results for the nine-month periods ended September 30, 2022 and 2021:

The following table summarizes our results of operations and is used in the discussion below for the nine-month periods ended September 30, 2022 and 2021 (dollar amounts in thousands):

	Nine months ended September 30, 2022		Nine months ended September 30, 2021	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 9,952,390	100.0%	$ 9,366,866	100.0%
Operating charges:				
Salaries, wages and benefits	5,061,173	50.9%	4,542,156	48.5%
Other operating expenses	2,526,060	25.4%	2,233,590	23.8%
Supplies expense	1,092,403	11.0%	1,052,977	11.2%
Depreciation and amortization	433,508	4.4%	399,850	4.3%
Lease and rental expense	97,075	1.0%	88,848	0.9%
Subtotal-operating expenses	9,210,219	92.5%	8,317,421	88.8%
Income from operations	742,171	7.5%	1,049,445	11.2%
Interest expense, net	83,002	0.8%	64,455	0.7%
Other (income) expense, net	15,244	0.2%	(1,575)	(0.0)%
Income before income taxes	643,925	6.5%	986,565	10.5%
Provision for income taxes	157,312	1.6%	232,844	2.5%
Net income	486,613	4.9%	753,721	8.0%
Less: Income attributable to noncontrolling interests	(14,176)	(0.1)%	1,255	0.0%
Net income attributable to UHS	$ 500,789	5.0%	$ 752,466	8.0%

Net revenues increased by 6.3%, or $586 million, to $9.95 billion during the nine-month period ended September 30, 2022, as compared to $9.37 billion during the comparable period of 2021. The net increase was primarily attributable to: (i) a $400 million, or 4.4%, increase in net revenues generated from our acute care hospital services and behavioral health services, on a Same Facility basis, and; (ii) $186 million of other combined net increases.

Income before income taxes (before income attributable to noncontrolling interests) decreased by $343 million, or 35%, to $644 million during the nine-month period ended September 30, 2022, as compared to $987 million during the comparable period of 2021. The $343 million net decrease was due to:

- a decrease of $227 million at our acute care facilities, as discussed below in *Acute Care Hospital Services*;
- a decrease of $60 million at our behavioral health care facilities, as discussed below in *Behavioral Health Services*;
- a decrease of $19 million due to an increase in interest expense due to an increase in our aggregate average outstanding borrowings as well as an increase in our weighted average cost of borrowings, as discussed below in *Other Operating Results-Interest Expense*, and;
- $37 million of other combined net decreases.

Net income attributable to UHS decreased by $252 million, or 33%, to $501 million during the nine-month period ended September 30, 2022, as compared to $752 million during the first nine months of 2021. This decrease was attributable to:

- a $343 million decrease in income before income taxes, as discussed above;
- an increase of $15 million due to a decrease in income (loss) attributable to noncontrolling interests, and;
- an increase of $76 million resulting from a decrease in the provision for income taxes due primarily to the income tax benefit recorded in connection with the $328 million decrease in pre-tax income.

Increase to self-insured professional and general liability reserves:

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.

As a result of unfavorable trends experienced during 2022 and 2021, our results of operations during the nine-month periods ended September 30, 2022 and 2021 included increases to our reserves for self-insured professional and general liability claims amounting to approximately $16 million and $41 million, respectively.

During the nine-month period ended September 30, 2022, approximately $10 million of the increase to our reserves for self-insured professional and general liability claims is included in our Same Facility basis acute care hospitals services' results, and approximately $6 million is included in our behavioral health services' results. During the nine-month period ended September 30, 2021, approximately $31 million of the increase to our reserves for self-insured professional and general liability claims is included in our

Same Facility basis acute care hospitals services' results, and approximately $10 million is included in our behavioral health services' results.

Acute Care Hospital Services

Same Facility Basis Acute Care Hospital Services

We believe that providing our results on a "Same Facility" basis (which is a non-GAAP measure), 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 (if applicable) the effect of items that are non-operational in nature including items such as, but not limited to, gains/losses on sales of assets and businesses, impacts of settlements, legal judgments and lawsuits, impairments of long-lived and intangible assets 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.* However, these provider tax assessments are included in net revenues and other operating expenses as reflected in the table below under *All Acute Care Hospital Services*. The provider tax assessments had no impact on the income before income taxes as reflected on the tables below since the amounts offset between net revenues and other operating expenses. To obtain a complete understanding of our financial performance, the Same Facility results should be examined in connection with our net income as determined in accordance with U.S. GAAP and as presented in the condensed consolidated financial statements and notes thereto as contained in this Quarterly Report on Form 10-Q.

The following table summarizes the results of operations for our acute care facilities on a Same Facility basis and is used in the discussion below for the three and nine-month periods ended September 30, 2022 and 2021 (dollar amounts in thousands):

	Three months ended September 30, 2022		Three months ended September 30, 2021		Nine months ended September 30, 2022		Nine months ended September 30, 2021	
	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,813,899	100.0%	$ 1,797,161	100.0%	$ 5,419,224	100.0%	$ 5,182,893	100.0%
Operating charges:								
Salaries, wages and benefits	791,902	43.7%	756,524	42.1%	2,405,034	44.4%	2,154,354	41.6%
Other operating expenses	474,086	26.1%	411,348	22.9%	1,380,670	25.5%	1,216,665	23.5%
Supplies expense	299,888	16.5%	316,890	17.6%	903,092	16.7%	902,479	17.4%
Depreciation and amortization	88,931	4.9%	82,811	4.6%	269,506	5.0%	246,954	4.8%
Lease and rental expense	18,738	1.0%	17,508	1.0%	53,804	1.0%	55,666	1.1%
Subtotal-operating expenses	1,673,545	92.3%	1,585,081	88.2%	5,012,106	92.5%	4,576,118	88.3%
Income from operations	140,354	7.7%	212,080	11.8%	407,118	7.5%	606,775	11.7%
Interest expense, net	234	0.0%	255	0.0%	1,350	0.0%	749	0.0%
Other (income) expense, net	384	0.0%	436	0.0%	806	0.0%	436	0.0%
Income before income taxes	$ 139,736	7.7%	$ 211,389	11.8%	$ 404,962	7.5%	$ 605,590	11.7%

Three-month periods ended September 30, 2022 and 2021:

During the three-month period ended September 30, 2022, as compared to the comparable prior year quarter, net revenues from our acute care hospital services, on a Same Facility basis, increased by $17 million or 0.9%. Income before income taxes (and before income attributable to noncontrolling interests) decreased by $72 million, or 34%, amounting to $140 million, or 7.7% of net revenues during the third quarter of 2022, as compared to $211 million, or 11.8% of net revenues during the third quarter of 2021.

During the three-month period ended September 30, 2022, net revenue per adjusted admission decreased by 2.5% while net revenue per adjusted patient day increased 4.5%, as compared to the comparable quarter of 2021. During the three-month period ended September 30, 2022, as compared to the comparable prior year quarter, inpatient admissions to our acute care hospitals decreased by 2.4% while adjusted admissions (adjusted for outpatient activity) increased by 1.9%. Patient days at these facilities decreased by 9.0% and adjusted patient days decreased by 5.0% during the three-month period ended September 30, 2022, as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities was 4.9 days and 5.3 days during the three-month periods ended September 30, 2022 and 2021, respectively. The occupancy rate, based on the average available beds at these facilities, was 62% and 71% during the three-month periods ended September 30, 2022 and 2021, respectively.

On a Same Facility basis during the three-month period ended September 30, 2022, as compared to the comparable quarter of 2021, salaries, wages and benefits expense increased $35 million or 4.7%. The increase during the third quarter of 2022, as compared to the third quarter of 2021, was due primarily to higher labor costs due, in part, to the healthcare labor shortage, partially offset by a reduction in higher-cost temporary labor and pay premiums above standard compensation for nurses and other clinicians.

Other operating expenses increased $63 million, or 15.3%, during the third quarter of 2022, as compared to the comparable quarter of 2021. Operating expenses, consisting primarily of medical costs incurred in connection with our commercial health insurer, increased approximately $31 million during the third quarter of 2022 as compared to the comparable quarter of 2021. Excluding the operating expenses incurred in connection with our commercial health insurer, other operating expenses increased $32 million, or 9.6%.

Supplies expense decreased $17 million, or 5.4%, during the third quarter of 2022, as compared to the third quarter of 2021. The decrease was due primarily to a decrease in the number of patients with a COVID-19 diagnosis treated at our hospitals, who generally require more intensive medical resources and supplies.

During the third quarter of 2022, we experienced a decrease in the number of patients with a COVID-19 diagnosis treated in our acute care hospitals, as compared to the comparable quarter in the prior year. As a percentage of total admissions, patients diagnosed with COVID-19 comprised 14% of our inpatient admissions during the third quarter of 2021, but only 6% of our inpatient admissions during the third quarter of 2022. This decline in COVID-19 patients unfavorably impacted our net revenues due to lower acuity and less incremental government reimbursement associated with COVID-19 patients. While overall surgical volumes tended to recover to pre-pandemic levels during the third quarter of 2022, there was a measurable shift from inpatient surgeries to outpatient surgeries, which further contributed to the lower than expected revenues. Although we were able to continue to reduce the amount of higher-cost temporary labor and pay premiums above standard compensation for nurses and other clinicians at our acute care hospitals, there was insufficient revenue growth to offset the accelerated rate of wage increases and other inflationary pressures.

Nine-month periods ended September 30, 2022 and 2021:

During the nine-month period ended September 30, 2022, as compared to the comparable prior year period, net revenues from our acute care hospital services, on a Same Facility basis, increased by $236 million or 4.6%. Income before income taxes (and before income attributable to noncontrolling interests) decreased by $201 million, or 33%, amounting to $405 million, or 7.5% of net revenues during the first nine months of 2022, as compared to $606 million, or 11.7% of net revenues during the comparable period of 2021.

During the nine-month period ended September 30, 2022, net revenue per adjusted admission increased by 1.0% while net revenue per adjusted patient day increased by 2.6%, as compared to the comparable period of 2021. During the nine-month period ended September 30, 2022, as compared to the comparable period of 2021, inpatient admissions to our acute care hospitals decreased by 0.3% and adjusted admissions (adjusted for outpatient activity) increased by 2.2%. Patient days at these facilities decreased by 1.8% and adjusted patient days increased by 0.6% during the nine-month period ended September 30, 2022, as compared to the comparable period of 2021. The average length of inpatient stay at these facilities was 5.1 days during each of the nine-month periods ended September 30, 2022 and 2021. The occupancy rate, based on the average available beds at these facilities, was 64% during the nine-month period ended September 30, 2022, as compared to 67% during the comparable period of 2021.

On a Same Facility basis during the three-month period ended September 30, 2022, as compared to the comparable quarter of 2021, salaries, wages and benefits expense increased $251 million or 11.6%. The increase during the first nine months of 2022, as compared to the comparable period of 2021, was due primarily to higher labor costs due, in part, to the healthcare labor shortage as well as an increase in patients with COVID-19 treated earlier in 2022 at our hospitals which increased the demand for care and pressured our staffing resources requiring us to utilize higher-cost temporary labor and pay premiums above standard compensation for essential workers. During the second and third quarters of 2022, we experienced a decrease in patients with COVID-19 which resulted in reductions in higher-cost temporary labor and pay premiums, as compared to the first quarter of 2022.

Other operating expenses increased $164 million, or 13.5%, during the first nine months of 2022, as compared to the comparable period of 2021. Operating expenses, consisting primarily of medical costs incurred in connection with our commercial health insurer, increased approximately $95 million during the first nine months of 2022, as compared to the comparable period of 2021. Excluding the operating expenses incurred in connection with our commercial health insurer, other operating expenses increased $69 million, or 6.9%.

Supplies expense increased only slightly during the first nine months of 2022, as compared to the comparable period of 2021. Offsetting increased cost of supplies experienced during the first nine months of 2022, as compared to the comparable period of 2021, was a decrease in the number of patients with a COVID-19 diagnosis treated at our hospitals, who generally require more intensive medical resources and supplies.

All Acute Care Hospitals

The following table summarizes the results of operations for all our acute care operations during the three and nine-month periods ended September 30, 2022 and 2021. These amounts include: (i) our acute care results on a same facility basis, as indicated above; (ii) the impact of provider tax assessments which increased net revenues and other operating expenses but had no impact on income before income taxes, and; (iii) certain other amounts including, if applicable, the results of recently acquired/opened ancillary facilities and businesses. Dollar amounts below are reflected in thousands.

	Three months ended September 30, 2022		Three months ended September 30, 2021		Nine months ended September 30, 2022		Nine months ended September 30, 2021	
	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,919,678	100.0%	$ 1,822,027	100.0%	$ 5,707,510	100.0%	$ 5,271,000	100.0%
Operating charges:								
Salaries, wages and benefits	824,942	43.0%	757,962	41.6%	2,497,888	43.8%	2,157,060	40.9%
Other operating expenses	535,463	27.9%	436,475	24.0%	1,550,044	27.2%	1,305,544	24.8%
Supplies expense	311,404	16.2%	316,950	17.4%	935,559	16.4%	902,654	17.1%
Depreciation and amortization	96,020	5.0%	83,794	4.6%	285,558	5.0%	248,462	4.7%
Lease and rental expense	21,990	1.1%	17,518	1.0%	63,324	1.1%	55,676	1.1%
Subtotal-operating expenses	1,789,819	93.2%	1,612,699	88.5%	5,332,373	93.4%	4,669,396	88.6%
Income from operations	129,859	6.8%	209,328	11.5%	375,137	6.6%	601,604	11.4%
Interest expense, net	234	0.0%	255	0.0%	1,350	0.0%	749	0.0%
Other (income) expense, net	384	0.0%	436	0.0%	806	0.0%	436	0.0%
Income before income taxes	$ 129,241	6.7%	$ 208,637	11.5%	$ 372,981	6.5%	$ 600,419	11.4%

Three-month periods ended September 30, 2022 and 2021:

During the three-month period ended September 30, 2022, as compared to the comparable prior year quarter, net revenues from our acute care hospital services increased by $98 million, or 5.4%, due to: (i) the $17 million, or 0.9% increase in Same Facility revenues, as discussed above, and; (ii) $81 million of other combined increases due to facilities and businesses acquired during the past year, the revenues generated at a newly constructed, 170-bed acute care hospital located in Reno, Nevada, that opened in early April, 2022 and an increase in provider tax assessments.

Income before income taxes decreased by $79 million, or 38%, to $129 million, or 6.7% of net revenues during the third quarter of 2022, as compared to $209 million, or 11.5% of net revenues during the third quarter of 2021. The $79 million decrease in income before income taxes from our acute care hospital services resulted from the $72 million, or 34%, decrease in income before income taxes at our hospitals, on a Same Facility basis, as discussed above, and $7 million of other combined net decreases related primarily to the start-up losses incurred at the newly constructed hospital located in Reno, Nevada, that opened in early April, 2022.

During the three-month period ended September 30, 2022, as compared to the comparable quarter of 2021, salaries, wages and benefits expense increased $67 million or 8.8%. The increase was due to the $35 million, or 4.7%, above-mentioned increase related to our acute care hospital services, on a Same Facility basis, as well as a combined increase of $32 million due to the facilities and businesses acquired/opened during the past year.

Other operating expenses increased $99 million, or 22.7%, during the third quarter of 2022, as compared to the comparable quarter of 2021. The increase was due to the $63 million, or 15.3%, above-mentioned increase related to our acute care hospital services, on a Same Facility basis, and a combined increase of $36 million due to the facilities and businesses acquired/opened during the past year as well as an increase in provider tax assessments.

Supplies expense decreased $6 million, or 1.7%, during the third quarter of 2022, as compared to the third quarter of 2021. The decrease was due primarily to the $17 million, or 5.4%, above-mentioned decrease related to our acute care hospital services, on a Same Facility basis, partially offset by a combined increase of $11 million due to the facilities and businesses acquired/opened during the past year.

Nine-month periods ended September 30, 2022 and 2021:

During the nine-month period ended September 30, 2022, as compared to the comparable prior year period, net revenues from our acute care hospital services increased by $437 million, or 8.3%, due to: (i) the $236 million, or 4.6% increase in Same Facility revenues, as discussed above, and; (ii) $201 million of other combined increases due to facilities and businesses acquired during the past year, the revenues generated at the newly constructed and recently opened hospital located in Reno, Nevada, and an increase in provider tax assessments.

Income before income taxes decreased by $227 million, or 38%, to $373 million, or 6.5% of net revenues during the first nine months of 2022, as compared to $600 million, or 11.4% of net revenues during the first nine months of 2021. The $227 million decrease in income before income taxes from our acute care hospital services resulted from the $201 million, or 33%, decrease in income before income taxes at our hospitals, on a Same Facility basis, as discussed above, and $26 million of other combined net decreases related primarily to the start-up losses incurred at the recently opened hospital located in Reno, Nevada.

During the nine-month period ended September 30, 2022, as compared to the comparable period of 2021, salaries, wages and benefits expense increased $341 million or 15.8%. The increase was due to the $251 million, or 11.6%, above-mentioned increase related to our acute care hospital services, on a Same Facility basis, as well as a combined increase of $90 million due to the facilities and businesses acquired/opened during the past year.

Other operating expenses increased $245 million, or 18.7%, during the first nine months of 2022, as compared to the comparable period of 2021. The increase was due to the $164 million, or 13.5%, above-mentioned increase related to our acute care hospital services, on a Same Facility basis, and a combined increase of $81 million due to the facilities and businesses acquired/opened during the past year as well as an increase in provider tax assessments.

Supplies expense increased $33 million, or 3.6%, during the first nine months of 2022, as compared to the comparable period of 2021. Since supplies expense was relatively unchanged for our acute care hospital services, on a Same Facility basis, the increase was due to the expense incurred at the facilities and businesses acquired/opened during the past year.

Please see *Results of Operations - COVID-19, Clinical Staffing Shortage and Effects of Inflation* above for additional disclosure regarding the factors impacting our operating costs.

Charity Care and Uninsured Discounts:

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 nine-month periods ended September 30, 2022 and 2021:

Uncompensated care:

Amounts in millions	Three Months Ended				Nine Months Ended			
	September 30, 2022	%	September 30, 2021	%	September 30, 2022	%	September 30, 2021	%
Charity care	$ 192	31%	$ 189	33%	$ 612	36%	$ 535	35%
Uninsured discounts	429	69%	378	67%	1,103	64%	987	65%
Total uncompensated care	$ 621	100%	$ 567	100%	$ 1,715	100%	$ 1,522	100%

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. 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.

Amounts in millions	Three Months Ended		Nine Months Ended	
	September 30, 2022	September 30, 2021	September 30, 2022	September 30, 2021
Estimated cost of providing charity care	$ 21	$ 20	$ 66	$ 57
Estimated cost of providing uninsured discounts related care	46	41	119	107
Estimated cost of providing uncompensated care	$ 67	$ 61	$ 185	$ 164

Behavioral Health 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 (if applicable) the effect of items that are non-operational in nature including items such as, but not limited to, gains/losses on sales of assets and businesses, impacts of settlements, legal judgments and lawsuits, impairments of long-lived and intangible assets 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 excludes 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.* 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 Services.* The provider tax assessments had no impact on the income before income taxes as reflected on the tables below since the amounts offset between net revenues and other operating expenses. To obtain a complete understanding of our financial performance, the Same Facility results should be examined in connection with our net income as determined in accordance with U.S. GAAP and as presented in the condensed consolidated financial statements and notes thereto as contained in this Quarterly Report on Form 10-Q.

The following table summarizes the results of operations for our behavioral health care facilities, on a Same Facility basis, and is used in the discussions below for the three and nine-month periods ended September 30, 2022 and 2021 (dollar amounts in thousands):

Same Facility—Behavioral Health

	Three months ended September 30, 2022		Three months ended September 30, 2021		Nine months ended September 30, 2022		Nine months ended September 30, 2021	
	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,403,013	100.0%	$ 1,294,141	100.0%	$ 4,148,344	100.0%	$ 3,984,260	100.0%
Operating charges:								
Salaries, wages and benefits	774,406	55.2%	717,807	55.5%	2,288,386	55.2%	2,125,205	53.3%
Other operating expenses	271,295	19.3%	267,083	20.6%	811,223	19.6%	774,583	19.4%
Supplies expense	55,036	3.9%	51,111	3.9%	156,976	3.8%	150,902	3.8%
Depreciation and amortization	44,566	3.2%	46,004	3.6%	134,451	3.2%	137,417	3.4%
Lease and rental expense	10,617	0.8%	10,012	0.8%	32,026	0.8%	30,999	0.8%
Subtotal-operating expenses	1,155,920	82.4%	1,092,017	84.4%	3,423,062	82.5%	3,219,106	80.8%
Income from operations	247,093	17.6%	202,124	15.6%	725,282	17.5%	765,154	19.2%
Interest expense, net	1,151	0.1%	994	0.1%	2,757	0.1%	2,321	0.1%
Other (income) expense, net	(664)	(0.0)%	27	0.0%	(1,422)	(0.0)%	435	0.0%
Income before income taxes	$ 246,606	17.6%	$ 201,103	15.5%	$ 723,947	17.5%	$ 762,398	19.1%

Three-month periods ended September 30, 2022 and 2021:

During the three-month period ended September 30, 2022, as compared to the comparable prior year quarter, net revenues from our behavioral health services, on a Same Facility basis, increased by $109 million or 8.4%. Income before income taxes (and before income attributable to noncontrolling interests) increased by $46 million, or 23%, amounting to $247 million or 17.6% of net revenues during the third quarter of 2022, as compared to $201 million or 15.5% of net revenues during the third quarter of 2021.

During the three-month period ended September 30, 2022, net revenue per adjusted admission increased by 4.2% while net revenue per adjusted patient day increased by 5.0%, as compared to the comparable quarter of 2021. During the three-month period ended September 30, 2022, as compared to the comparable prior year quarter, inpatient admissions to our behavioral health care hospitals increased by 4.3% and adjusted admissions increased by 4.0%. Patient days at these facilities increased by 3.6% and adjusted patient days increased by 3.3% during the three-month period ended September 30, 2022, as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities was 13.5 days and 13.6 days during the three-month periods ended September 30, 2022 and 2021, respectively. The occupancy rate, based on the average available beds at these facilities, was 72% and 70% during the three-month periods ended September 30, 2022 and 2021, respectively.

On a Same Facility basis during the three-month period ended September 30, 2022, as compared to the comparable quarter of 2021, salaries, wages and benefits expense increased $57 million or 7.9%. The increase during the third quarter of 2022, as compared to the third quarter of 2021, was due, in part, to increased staffing levels related to the increased patient volumes. As a percentage of net revenues during each quarter, salaries, wages and benefits expense decreased to 55.2% during the third quarter of 2022 as compared to 55.5% during the third quarter of 2021.

Other operating expenses increased $4 million, or 1.6%, during the third quarter of 2022, as compared to the comparable quarter of 2021. Supplies expense increased $4 million, or 7.7%, during the third quarter of 2022, as compared to the third quarter of 2021 due, in part, to increased patient volumes.

Nine-month periods ended September 30, 2022 and 2021:

During the nine-month period ended September 30, 2022, as compared to the comparable prior year period, net revenues from our behavioral health services, on a Same Facility basis, increased by $164 million or 4.1%. Income before income taxes (and before income attributable to noncontrolling interests) decreased by $38 million, or 5%, amounting to $724 million or 17.5% of net revenues during the first nine months of 2022 as compared to $762 million or 19.1% of net revenues during the first nine months of 2021.

During the nine-month period ended September 30, 2022, net revenue per adjusted admission increased by 4.2% while net revenue per adjusted patient day increased by 3.9%, as compared to the comparable period of 2021. During the nine-month period ended September 30, 2022, as compared to the comparable prior year period, inpatient admissions and adjusted admissions to our behavioral health care hospitals each increased by 0.6%. Patient days and adjusted patient days at these facilities each increased by 0.9% during the nine-month period ended September 30, 2022, as compared to the comparable prior year period. The average length of inpatient stay at these facilities was 13.5 days during each of the nine-month periods ended September 30, 2022 and 2021. The occupancy rate, based on the average available beds at these facilities, was 71% during each of the nine-month periods ended September 30, 2022 and 2021.

On a Same Facility basis during the nine-month period ended September 30, 2022, as compared to the comparable period of 2021, salaries, wages and benefits expense increased $163 million or 7.7%. The increase during the first nine months of 2022, as compared to the comparable period of 2021, was due, in part, to a nationwide shortage of nurses and other clinical staff and support personnel at

our behavioral health care hospitals which pressured our staffing resources and required us to utilize higher-cost temporary labor and pay premiums above standard compensation for essential workers.

Other operating expenses increased $37 million, or 4.7%, during the first nine months of 2022, as compared to the comparable period of 2021. Supplies expense increased $6 million, or 4.0%, during the first nine months of 2022, as compared to the comparable period of 2021.

All Behavioral Health Care Facilities

The following table summarizes the results of operations for all our behavioral health care services during the three and nine-month periods ended September 30, 2022 and 2021. These amounts include: (i) our behavioral health care results on a Same Facility basis, as indicated above; (ii) the impact of provider tax assessments which increased net revenues and other operating expenses but had no impact on income before income taxes, and; (iii) certain other amounts including the results of facilities acquired or opened during the past year (if applicable) as well as the results of certain facilities that were closed or restructured during the past year. Dollar amounts below are reflected in thousands.

	Three months ended September 30, 2022		Three months ended September 30, 2021		Nine months ended September 30, 2022		Nine months ended September 30, 2021	
	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,434,828	100.0%	$ 1,328,293	100.0%	$ 4,235,215	100.0%	$ 4,075,127	100.0%
Operating charges:								
Salaries, wages and benefits	782,909	54.6%	727,137	54.7%	2,310,761	54.6%	2,144,735	52.6%
Other operating expenses	300,406	20.9%	292,794	22.0%	898,655	21.2%	847,780	20.8%
Supplies expense	55,482	3.9%	51,712	3.9%	158,315	3.7%	152,273	3.7%
Depreciation and amortization	46,861	3.3%	47,205	3.6%	138,803	3.3%	140,870	3.5%
Lease and rental expense	11,010	0.8%	10,421	0.8%	32,803	0.8%	31,789	0.8%
Subtotal-operating expenses	1,196,668	83.4%	1,129,269	85.0%	3,539,337	83.6%	3,317,447	81.4%
Income from operations	238,160	16.6%	199,024	15.0%	695,878	16.4%	757,680	18.6%
Interest expense, net	1,375	0.1%	1,218	0.1%	4,106	0.1%	3,564	0.1%
Other (income) expense, net	(1,164)	(0.1)%	27	0.0%	(1,922)	(0.0)%	435	0.0%
Income before income taxes	$ 237,949	16.6%	$ 197,779	14.9%	$ 693,694	16.4%	$ 753,681	18.5%

Three-month periods ended September 30, 2022 and 2021:

During the three-month period ended September 30, 2022, as compared to the comparable prior year quarter, net revenues generated from our behavioral health services increased by $107 million, or 8.0%.

Income before income taxes increased by $40 million, or 20%, to $238 million or 16.6% of net revenues during the third quarter of 2022, as compared to $198 million or 14.9% of net revenues during the third quarter of 2021. The increase in income before income taxes at our behavioral health facilities during the third quarter of 2022, as compared to the third quarter of 2021, was primarily attributable to the $46 million, or 23% increase in income before income taxes experienced at our behavioral health facilities, on a same facility basis, as discussed above, as well as $5 million of other combined net decreases consisting primarily of the startup losses incurred at various facilities opened during the past year.

During the three-month period ended September 30, 2022, as compared to the comparable quarter of 2021, salaries, wages and benefits expense increased $56 million or 7.7%. The increase was due to our behavioral health services, on a Same Facility basis, as discussed above.

Other operating expenses increased $8 million, or 2.6%, during the third quarter of 2022, as compared to the comparable quarter of 2021. Supplies expense increased $4 million, or 7.3%, during the third quarter of 2022, as compared to the third quarter of 2021.

Nine-month periods ended September 30, 2022 and 2021:

During the nine-month period ended September 30, 2022, as compared to the comparable prior year period, net revenues generated from our behavioral health services increased by $160 million, or 3.9% due primarily to the above-mentioned $164 million, or 4.1% increase in net revenues on a Same Facility basis.

Income before income taxes decreased by $60 million, or 8%, to $694 million or 16.4% of net revenues during the first nine months of 2022, as compared to $754 million or 18.5% of net revenues during the first nine months of 2021. The decrease in income before income taxes at our behavioral health facilities during the first nine months of 2022, as compared to the compared period of 2021, was primarily attributable to the $38 million, or 5% decrease in income before income taxes experienced at our behavioral health facilities, on a Same Facility basis, as discussed above, as well as $22 million of other combined net decreases consisting primarily of the startup losses incurred at various facilities opened during the past year.

During the nine-month period ended September 30, 2022, as compared to the comparable period of 2021, salaries, wages and benefits expense increased $166 million or 7.7%. The increase was due to our behavioral health services, on a same facility basis, as discussed above.

Other operating expenses increased $51 million, or 6.0%, during the first nine months of 2022, as compared to the comparable period of 2021. The increase was due primarily to the $37 million, or 4.7%, above-mentioned increase related to our behavioral health services, on a Same Facility basis. Supplies expense increased $6 million, or 4.0%, during the first nine months of 2022, as compared to the comparable period of 2021.

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.

As described below in the section titled *2019 Novel Coronavirus Disease Medicare and Medicaid Payment Related Legislation*, the federal government has enacted multiple pieces of legislation to assist healthcare providers during the COVID-19 world-wide pandemic and U.S. National Emergency declaration. We have outlined those legislative changes related to Medicare and Medicaid payment and their estimated impact on our financial results, where estimates are possible.

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, impacts on state revenue and expenses resulting from the COVID-19 pandemic, economic recovery stimulus packages, responses to natural disasters, and the federal and state budget deficits in general may affect the availability of government funds to provide additional relief in the future. We are unable to predict the effect of future policy changes on our operations.

On March 23, 2010, President Obama signed into law the Legislation. Two primary goals of the Legislation are to provide for increased access to coverage for healthcare and to reduce healthcare-related expenses.

The Legislation revises reimbursement under the Medicare and Medicaid programs to emphasize the efficient delivery of high-quality care and contains a number of incentives and penalties under these programs to achieve these goals. The Legislation provides for decreases in the annual market basket update for federal fiscal years 2010 through 2019, a productivity offset to the market basket update beginning October 1, 2011 for Medicare Part B reimbursable items and services and beginning October 1, 2012 for Medicare inpatient hospital services. The Legislation and subsequent revisions provide for reductions to both Medicare DSH and Medicaid DSH payments. The Medicare DSH reductions began in October, 2013 while the Medicaid DSH reductions are scheduled to begin in 2024. The Legislation implemented a value-based purchasing program, which will reward the delivery of efficient care. Conversely, certain facilities will receive reduced reimbursement for failing to meet quality parameters; such hospitals will include those with excessive readmission or hospital-acquired condition rates.

A 2012 U.S. Supreme Court ruling limited the federal government’s ability to expand health insurance coverage by holding unconstitutional sections of the Legislation that sought to withdraw federal funding for state noncompliance with certain Medicaid coverage requirements. Pursuant to that decision, the federal government may not penalize states that choose not to participate in the Medicaid expansion by reducing their existing Medicaid funding. Therefore, states can choose to expand or not to expand their Medicaid program without risking the loss of federal Medicaid funding. As a result, many states, including Texas, have not expanded their Medicaid programs without the threat of loss of federal funding. CMS has previously granted section 1115 demonstration waivers providing for work and community engagement requirements for certain Medicaid eligible individuals. CMS has also released

guidance to states interested in receiving their Medicaid funding through a block grant mechanism. The Biden administration has signaled its intent to withdraw previously issued section 1115 demonstrations aligned with these policies. However, if implemented, the previously issued section 1115 demonstrations are anticipated to lead to reductions in coverage, and likely increases in uncompensated care, in states where these demonstration waivers are granted.

On December 14, 2018, a Texas Federal District Court deemed the Legislation to be unconstitutional in its entirety. The Court concluded that the Individual Mandate is no longer permissible under Congress's taxing power as a result of the Tax Cut and Jobs Act of 2017 ("TCJA") reducing the individual mandate's tax to $0 (i.e., it no longer produces revenue, which is an essential feature of a tax), rendering the Legislation unconstitutional. The Court also held that because the individual mandate is "essential" to the Legislation and is inseverable from the rest of the law, the entire Legislation is unconstitutional. That ruling was ultimately appealed to the United States Supreme Court, which decided in *California v. Texas* that the plaintiffs in the matter lacked standing to bring their constitutionality claims. The Court did not reach the plaintiffs' merits arguments, which specifically challenged the constitutionality of the Legislation's individual mandate and the entirety of the Legislation itself. As a result, the Legislation will continue to be law, and HHS and its respective agencies will continue to enforce regulations implementing the law. However, on September 7, 2022, the Legislation faced its most recent challenge when a Texas Federal District Court judge, in the case of *Braidwood Management v. Becerra*, ruled that a requirement that certain health plans cover services without cost sharing violates the Appointments Clause of the U.S. Constitution and that the coverage of certain HIV prevention medication violates the Religious Freedom Restoration Act.

The various provisions in the Legislation that directly or indirectly affect Medicare and Medicaid reimbursement took effect over a number of years. The impact of the Legislation on healthcare providers will be subject to implementing regulations, interpretive guidance and possible future legislation or legal challenges. Certain Legislation provisions, such as that creating the Medicare Shared Savings Program creates uncertainty in how healthcare may be reimbursed by federal programs in the future. Thus, we cannot predict the impact of the Legislation on our future reimbursement at this time and we can provide no assurance that the Legislation will not have a material adverse effect on our future results of operations.

The Legislation also contained provisions aimed at reducing fraud and abuse in healthcare. The Legislation amends several existing laws, including the federal Anti-Kickback Statute and the False Claims Act, making it easier for government agencies and private plaintiffs to prevail in lawsuits brought against healthcare providers. While Congress had previously revised the intent requirement of the Anti-Kickback Statute to provide that a person is not required to "have actual knowledge or specific intent to commit a violation of" the Anti-Kickback Statute in order to be found in violation of such law, the Legislation also provides that any claims for items or services that violate the Anti-Kickback Statute are also considered false claims for purposes of the federal civil False Claims Act. The Legislation provides that a healthcare provider that retains an overpayment in excess of 60 days is subject to the federal civil False Claims Act. The Legislation also expands the Recovery Audit Contractor program to Medicaid. These amendments also make it easier for severe fines and penalties to be imposed on healthcare providers that violate applicable laws and regulations.

We have partnered with local physicians in the ownership of certain of our facilities. These investments have been permitted under an exception to the physician self-referral law. The Legislation permits existing physician investments in a hospital to continue under a "grandfather" clause if the arrangement satisfies certain requirements and restrictions, but physicians are prohibited from increasing the aggregate percentage of their ownership in the hospital. The Legislation also imposes certain compliance and disclosure requirements upon existing physician-owned hospitals and restricts the ability of physician-owned hospitals to expand the capacity of their facilities. As discussed below, should the Legislation be repealed in its entirety, this aspect of the Legislation would also be repealed restoring physician ownership of hospitals and expansion right to its position and practice as it existed prior to the Legislation.

The impact of the Legislation on each of our hospitals may vary. Because Legislation provisions are effective at various times over the next several years, we anticipate that many of the provisions in the Legislation may be subject to further revision. Initiatives to repeal the Legislation, in whole or in part, to delay elements of implementation or funding, and to offer amendments or supplements to modify its provisions have been persistent. The ultimate outcomes of legislative attempts to repeal or amend the Legislation and legal challenges to the Legislation are unknown. Legislation has already been enacted that eliminated the individual mandate penalty, effective January 1, 2019, related to the obligation to obtain health insurance that was part of the original Legislation. In addition, Congress previously considered legislation that would, in material part: (i) eliminate the large employer mandate to offer health insurance coverage to full-time employees; (ii) permit insurers to impose a surcharge up to 30 percent on individuals who go uninsured for more than two months and then purchase coverage; (iii) provide tax credits towards the purchase of health insurance, with a phase-out of tax credits accordingly to income level; (iv) expand health savings accounts; (v) impose a per capita cap on federal funding of state Medicaid programs, or, if elected by a state, transition federal funding to block grants, and; (vi) permit states to seek a waiver of certain federal requirements that would allow such state to define essential health benefits differently from federal standards and that would allow certain commercial health plans to take health status, including pre-existing conditions, into account in setting premiums.

In addition to legislative changes, the Legislation can be significantly impacted by executive branch actions. President Biden is expected to undertake executive actions that will strengthen the Legislation and may reverse the policies of the prior administration. The Trump Administration had directed the issuance of final rules (i) enabling the formation of health plans that would be exempt from certain Legislation essential health benefits requirements; (ii) expanding the availability of short-term, limited duration health

insurance; (iii) eliminating cost-sharing reduction payments to insurers that would otherwise offset deductibles and other out-of-pocket expenses for health plan enrollees at or below 250 percent of the federal poverty level; (iv) relaxing requirements for state innovation waivers that could reduce enrollment in the individual and small group markets and lead to additional enrollment in short-term, limited duration insurance and association health plans; and (vi) incentivizing the use of health reimbursement arrangements by employers to permit employees to purchase health insurance in the individual market. The uncertainty resulting from these Executive Branch policies led to reduced Exchange enrollment in 2018, 2019 and 2020. To date, the Biden administration has issued executive orders implementing a special enrollment period permitting individuals to enroll in health plans outside of the annual open enrollment period and reexamining policies that may undermine the ACA or the Medicaid program. The ARPA's expansion of subsidies to purchase coverage through an exchange contributed to increased exchange enrollment in 2021. The IRA's extension of the subsidies through 2025 is expected to increase exchange enrollment in future years. The recent and on-going COVID-19 pandemic and related U.S. National Emergency declaration may significantly increase the number of uninsured patients treated at our facilities extending beyond the most recent CBO published estimates due to increased unemployment and loss of group health plan health insurance coverage. It is also anticipated that these policies may create additional cost and reimbursement pressures on hospitals.

It remains unclear what portions of the Legislation may remain, or whether any replacement or alternative programs may be created by any future legislation. Any such future repeal or replacement may have significant impact on the reimbursement for healthcare services generally, and may create reimbursement for services competing with the services offered by our hospitals. Accordingly, there can be no assurance that the adoption of any future federal or state healthcare reform legislation will not have a negative financial impact on our hospitals, including their ability to compete with alternative healthcare services funded by such potential legislation, or for our hospitals to receive payment for services.

For additional disclosure related to our revenues including a disaggregation of our consolidated net revenues by major source for each of the periods presented herein, please see *Note 12 to the Consolidated Financial Statements-Revenue*.

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 August, 2022, CMS published its IPPS 2023 final payment rule which provides for a 4.1% 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 adjustments mandated by the Legislation are considered, without consideration for the required Medicare DSH payments changes and increase to the Medicare Outlier threshold, the overall increase in IPPS payments is approximately 4.6.%. Including DSH payments, an increase to the Medicare Outlier threshold and certain other adjustments, we estimate our overall increase from the final IPPS 2023 rule (covering the period of October 1, 2022 through September 30, 2023) will approximate 4.4%. This projected impact from the IPPS 2023 final rule includes an increase of approximately 0.5% to partially restore cuts made as a result of the American Taxpayer Relief Act of 2012 ("ATRA"), as required by the 21st Century Cures Act, but excludes the impact of the sequestration reductions related to the 2011 Act, Bipartisan Budget Act of 2015, and Bipartisan Budget Act of 2018, as discussed below.

In August, 2021, CMS published its IPPS 2022 final payment rule which provides for a 2.7% 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 adjustments mandated by the Legislation are considered, without consideration for the required Medicare DSH payments changes and increase to the Medicare Outlier threshold, the overall final increase in IPPS payments is approximately 2.5%. Including DSH payments and certain other adjustments, we estimate our overall increase from the final IPPS 2022 rule (covering the period of October 1, 2021 through September 30, 2022) will approximate 1.5%. This projected impact from

the IPPS 2022 final rule includes an increase of approximately 0.5% to partially restore cuts made as a result of the ATRA, as required by the 21st Century Cures Act but excludes the impact of the sequestration reductions related to the 2011 Act, Bipartisan Budget Act of 2015, and Bipartisan Budget Act of 2018, as discussed below.

In June, 2019, the Supreme Court of the United States issued a decision favorable to hospitals impacting prior year Medicare DSH payments (*Azar v. Allina Health Services*, No. 17-1484 (U.S. Jun. 3, 2019)). In *Allina*, the hospitals challenged the Medicare DSH adjustments for federal fiscal year 2012, specifically challenging CMS's decision to include inpatient hospital days attributable to Medicare Part C enrollee patients in the numerator and denominator of the Medicare/SSI fraction used to calculate a hospital's DSH payments. This ruling addresses CMS's attempts to impose the policy espoused in its vacated 2004 rulemaking to a fiscal year in the 2004–2013 time period without using notice-and-comment rulemaking. This decision should require CMS to recalculate hospitals' DSH Medicare/SSI fractions, with Medicare Part C days excluded, for at least federal fiscal year 2012, but likely federal fiscal years 2005 through 2013. In August, 2020, CMS issued a rule that proposed to retroactively negate the effects of the aforementioned Supreme Court decision, which rule has yet to be finalized. Although we can provide no assurance that we will ultimately receive additional funds, we estimate that the favorable impact of this court ruling on certain prior year hospital Medicare DSH payments could range between $18 million to $28 million in the aggregate.

The 2011 Act included 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. Recent legislation suspended payment reductions through December 31, 2021, in exchange for extended cuts through 2030. In December, 2021, the suspended 2% payment reduction was extended until June 30, 2022 and partially suspended at a 1% payment reduction for an additional three-month period that ended on June 30, 2022.

Inpatient services furnished by psychiatric hospitals under the Medicare program are paid under a Psychiatric Prospective Payment System ("Psych PPS"). Medicare payments to psychiatric hospitals are based on a prospective per diem rate with adjustments to account for certain facility and patient characteristics. The Psych PPS also contains provisions for outlier payments and an adjustment to a psychiatric hospital's base payment if it maintains a full-service emergency department.

In July, 2022, CMS published its Psych PPS final rule for the federal fiscal year 2023. Under this final rule, payments to our behavioral health care hospitals and units are estimated to increase by 3.8% compared to federal fiscal year 2022. This amount includes the effect of the 4.1% net market basket update which reflects the offset of a 0.3% productivity adjustment.

In July, 2021, CMS published its Psych PPS final rule for the federal fiscal year 2022. Under this final rule, payments to our psychiatric hospitals and units are estimated to increase by 2.2% compared to federal fiscal year 2021. This amount includes the effect of the 2.0% net market basket update which reflects the offset of a 0.7% productivity adjustment.

CMS's calendar year 2018 final OPPS rule, issued on November 13, 2017, substantially reduced Medicare Part B reimbursement for 340B Program drugs paid to hospitals. Beginning January 1, 2018, CMS reimbursement for certain separately payable drugs or biologicals that are acquired through the 340B Program by a hospital paid under the OPPS (and not excepted from the payment adjustment policy) is the average sales price of the drug or biological minus 22.5 percent, an effective reduction of 26.89% in payments for 340B program drugs. In December, 2018, the U.S. District Court for the District of Columbia ruled that HHS did not have statutory authority to implement the 2018 Medicare OPPS rate reduction related to hospitals that qualify for drug discounts under the federal 340B Program and granted a permanent injunction against the payment reduction. On July 31, 2020, the U.S. Court of Appeals for the D.C. Circuit reversed the District Court and held that HHS's decision to lower drug reimbursement rates for 340B hospitals rests on a reasonable interpretation of the Medicare statute. As a result, we recognized $8 million of revenues during 2020 that were previously reserved in a prior year. These payment reductions were challenged before the U.S. Supreme Court, which held in *American Hospital Association v. Becerra* that because HHS did not conduct a survey of hospitals' acquisition costs in 2018 and 2019, its decision to vary reimbursement rates only for 340B hospitals in those years was unlawful. The matter has been remanded for further consideration, and so the final result of such lawsuit cannot be fully predicted at this time.

In November, 2022, CMS issued its OPPS final rule for 2023. The hospital market basket increase is 4.1% and the productivity adjustment reduction is -0.3% for a net market basket increase of 3.8%. The final rule provides that in light of the Supreme Court decision in *American Hospital Association v. Becerra*, CMS is applying the default rate, generally average sales price plus 6 percent, to 340B acquired drugs and biologicals for 2023. CMS stated they will address the remedy for 340B drug payments from 2018-2022 in future rulemaking prior to the CY 2024 OPPS/ASC proposed rule. During the 2018-2022 time period, we recorded an aggregate of approximately $45 million to $50 million of Medicare revenues related to the prior 340B payment policy. When other statutorily required adjustments and hospital patient service mix are considered as well as impact of the aforementioned 340B Program policy change, we estimate that our overall Medicare OPPS update for 2023 will aggregate to a net increase of 0.9% which includes a 0.3% increase to behavioral health division partial hospitalization rates.

On November 2, 2021, CMS issued its OPPS final rule for 2022. The hospital market basket increase is 2.7% and the productivity adjustment reduction is -0.7% for a net market basket increase of 2.0%. When other statutorily required adjustments and hospital patient service mix are considered, we estimate that our overall Medicare OPPS update for 2022 will aggregate to a net increase of 2.4% which includes a 3.0% increase to behavioral health division partial hospitalization rates.

In December, 2020, CMS published its OPPS final rule for 2021. The hospital market basket increase is 2.4% and there is no productivity adjustment reduction to the 2021 OPPS market basket. When other statutorily required adjustments and hospital patient service mix are considered, we estimate that our overall Medicare OPPS update for 2021 will aggregate to a net increase of 3.3% which includes a 9.2% increase to behavioral health division partial hospitalization rates.

In November, 2019, CMS finalized its Hospital Price Transparency rule that implements certain requirements under the June 24, 2019 Presidential Executive Order related to Improving Price and Quality Transparency in American Healthcare to Put Patients First. Under this final rule, effective January 1, 2021, CMS will require: (1) hospitals make public their standard changes (both gross charges and payer-specific negotiated charges) for all items and services online in a machine-readable format, and; (2) hospitals to make public standard charge data for a limited set of "shoppable services" the hospital provides in a form and manner that is more consumer friendly. On November 2, 2021, CMS released a final rule increasing the monetary penalty that CMS can impose on hospitals that fail to comply with the price transparency requirements. We believe that our hospitals are in full compliance with the applicable federal regulations.

Medicaid: Medicaid is a joint federal-state funded health care benefit program that is administered by the states to provide benefits to qualifying individuals. 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 revenues from various state and county-based programs, including Medicaid in all the states in which we operate. We receive annual Medicaid revenues of approximately $100 million, or greater, from each of Texas, California, Nevada, Illinois, Pennsylvania, Washington, D.C., Kentucky, Florida and Massachusetts. We also receive 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.

The Legislation 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 Legislation requiring states to expand their Medicaid programs in exchange for increased federal funding. Accordingly, many states in which we operate have not expanded Medicaid coverage to individuals at 133% of the federal poverty level. Facilities in states not opting to expand Medicaid coverage under the Legislation may be additionally penalized by corresponding reductions to Medicaid disproportionate share hospital payments beginning in fiscal year 2024, 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.

In January, 2020, CMS announced a new opportunity to support states with greater flexibility to improve the health of their Medicaid populations. The new 1115 Waiver Block Grant Type Demonstration program, titled Healthy Adult Opportunity ("HAO"), emphasizes the concept of value-based care while granting states extensive flexibility to administer and design their programs within a defined budget. CMS believes this state opportunity will enhance the Medicaid program's integrity through its focus on accountability for results and quality improvement, making the Medicaid program stronger for states and beneficiaries. The Biden administration has signaled its intent to withdraw the HAO demonstration. Accordingly, we are unable to predict whether the HAO demonstration will impact our future results of operations.

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. As outlined below, 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.

Included in these Provider Tax programs are reimbursements received in connection with the Texas Uncompensated Care/Upper Payment Limit program ("UC/UPL") and Texas Delivery System Reform Incentive Payments program ("DSRIP"). Additional disclosure related to the Texas UC/UPL and DSRIP programs is provided below.

Texas Uncompensated Care/Upper Payment Limit Payments:

Certain of our acute care hospitals located in various counties of Texas (Grayson, 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.

On December 21, 2017, CMS approved the 1115 Waiver for the period January 1, 2018 to September 30, 2022. The Waiver continued to include UC and DSRIP payment pools with modifications and new state specific reporting deadlines that if not met by THHSC will result in material decreases in the size of the UC and DSRIP pools. For UC during the initial two years of this renewal, the UC program will remain relatively the same in size and allocation methodology. For year three of this waiver renewal, the federal fiscal year ("FFY") 2020, and through FFY 2022, the size and distribution of the UC pool will be determined based on charity care costs reported to HHSC in accordance with Medicare cost report Worksheet S-10 principles. In September 2019, CMS approved the annual UC pool size in the amount of $3.9 billion for demonstration years ("DYs") 9, 10 and 11 (October 1, 2019 to September 30, 2022). In June 2022, HHSC announced that CMS approved the UC Pool size for Demonstration Years 12 through 16 (October 1, 2022 to September 30, 2027) for the current 1115 Waiver which will be $4.51 billion per year. The UC pool will be resized again in 2027 for DYs 17 through 19 (October 1, 2027 to September 30, 2030). On April 16, 2021, CMS rescinded its January 15, 2021, 1115 Waiver ten year expedited renewal approval that was effective through September 30, 2030. In July, 2021, HHSC submitted another 1115 Waiver renewal application to CMS which reflects the same terms and conditions agreed to by CMS on January 15, 2021, in order to receive an extension beyond September 30, 2022. On April 22, 2022, CMS withdrew its rescission of the 1115 Waiver and now considers the 1115 Waiver approved as extended and governed by the special terms and conditions that CMS approved on January 15, 2021.

Effective April 1, 2018, certain of our acute care hospitals located in Texas began to receive Medicaid managed care rate enhancements under the Uniform Hospital Rate Increase Program ("UHRIP"). The non-federal share component of these UHRIP rate enhancements are financed by Provider Taxes. The Texas 1115 Waiver rules require UHRIP rate enhancements be considered in the Texas UC payment methodology which results in a reduction to our UC payments. The UC amounts reported in the State Medicaid Supplemental Payment Program Table below reflect the impact of this new UHRIP program. In July 2020, THHSC announced CMS approval of an increase to UHRIP pool for the state's 2021 fiscal year to $2.7 billion from its prior funding level of $1.6 billion.

On March 26, 2021, HHSC published a final rule that will apply to program periods on or after September 1, 2021, and UHRIP will be re-named the Comprehensive Hospital Increase Reimbursement Program ("CHIRP"). CHIRP will be comprised of a UHRIP component and an Average Commercial Incentive Award component. CHIRP has a pool size of $4.7 billion. On March 25, 2022, CMS approved the CHIRP program retroactive to September 1, 2021 through August 31, 2022. The impact of the CHIRP program is reflected in the State Medicaid Supplemental Payment Program Table below including approximately $12 million of estimated CHIRP revenues which were recorded during the first quarter of 2022, attributable to the period September 1, 2021 through December 31, 2021, net of associated provider taxes. On August 1, 2022, CMS approved the CHIRP program, with a pool of $5.2 billion, for the rate period effective September 1, 2022 to August 31, 2023.

During the three and nine-month periods ended September 30, 2022, certain of our acute care hospitals located in Texas recorded an aggregate of $25 million in Quality Incentive Fund ("QIF") payments, applicable to the period September 1, 2020 to August 31, 2021 in connection with the state's UHRIP program. This revenue was earned pursuant to contract terms with various Medicaid managed care plans which requires the annual payout of QIF funds when a managed care service delivery area's actual claims-based UHRIP payments are less than targeted UHRIP payments for a specific rate year. We anticipate that these hospitals may be entitled to an additional $5 million of QIF revenue during the fourth quarter of 2022, increasing the 2022 aggregate to approximately $30 million. We also anticipate that these hospitals may be entitled to a comparable amount of aggregate QIF revenue during 2023.

On January 11, 2021, HHSC announced that CMS approved the pre-print modification that HHSC submitted for UHRIP period March 1, 2021 through August 31, 2021. CMS approved rate changes that will now increase rates for private Institutions of Mental Disease ("IMD") for services provided to patients under age 21 or patients 65 years of age or older. Subsequent CMS UHRIP and CHIRP program approvals continue to include IMD's eligible patient population. The impact of these programs are included in the Medicaid Supplemental Payment Programs table below.

On September 24, 2021, HHSC finalized New Fee-for-Service Supplemental Payment Program: Hospital Augmented Reimbursement Program ("HARP") to be effective October 1, 2021. The HARP program continues the financial transition for providers who have historically participated in the Delivery System Reform Incentive Payment program described below. The program will provide additional funding to hospitals to help offset the cost hospitals incur while providing Medicaid services.

HHSC financial model released concurrent with the publication of the final rule indicates net potential incremental Medicaid reimbursements to us of approximately $15 million annually, without consideration of any potential adverse impact on future Medicaid DSH or Medicaid UC payments. This program remains subject to CMS approval.

Texas Delivery System Reform Incentive Payments:

In addition, the Texas Medicaid Section 1115 Waiver included 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 FFY 2022, DSRIP funding under the waiver is eliminated except for certain carryover DSRIP projects. In connection with this DSRIP program, our results of operations included revenues of approximately $18 million and $30 million recorded during the nine-month periods ended September 30, 2022 and 2021, respectively, all of which was recorded during the second quarter of each year.

Summary of Amounts Related To The Above-Mentioned Various State Medicaid Supplemental Payment Programs:

The following table summarizes the revenues, Provider Taxes and net benefit related to each of the above-mentioned Medicaid supplemental programs for the three and nine-month periods ended September 30, 2022 and 2021. The Provider Taxes are recorded in other operating expenses on the Condensed Consolidated Statements of Income as included herein.

	(amounts in millions)			
	Three Months Ended		Nine Months Ended	
	September 30, 2022	September 30, 2021	September 30, 2022	September 30, 2021
Texas UC/UPL:				
Revenues	$ 87	$ 40	$ 213	$ 107
Provider Taxes	(30)	(12)	(76)	(31)
Net benefit	$ 57	$ 28	$ 137	$ 76
Texas DSRIP:				
Revenues	$ 0	$ 0	$ 27	$ 44
Provider Taxes	0	0	(9)	(14)
Net benefit	$ 0	$ 0	$ 18	$ 30
Various other state programs:				
Revenues	$ 112	$ 83	$ 329	$ 317
Provider Taxes	(41)	(36)	(119)	(111)
Net benefit	$ 71	$ 47	$ 210	$ 206
Total all Provider Tax programs:				
Revenues	$ 199	$ 123	$ 569	$ 468
Provider Taxes	(71)	(48)	(204)	(156)
Net benefit	$ 128	$ 75	$ 365	$ 312

We estimate that our aggregate net benefit from the Texas and various other state Medicaid supplemental payment programs will approximate $491 million (net of Provider Taxes of $289 million) during the year ending December 31, 2022. These amounts are based upon various terms and conditions that are out of our control including, but not limited to, the states'/CMS's continued approval of the programs and the applicable hospital district or county making IGTs consistent with 2021 levels.

Future changes to these terms and conditions could materially reduce our net benefit derived from the programs which could have a material adverse impact on our future consolidated results of operations. In addition, 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 future consolidated results of operations. As described below in *2019 Novel Coronavirus Disease Medicare and Medicaid Payment Related Legislation*, a 6.2% increase to the Medicaid Federal Matching Assistance Percentage ("FMAP") is included in the Families First Coronavirus Response Act. The impact of the enhanced FMAP Medicaid supplemental and DSH payments are reflected in our financial results for the three and nine-month periods ended September 30, 2022 and 2021. We are unable to estimate the prospective financial impact of this provision at this time as our financial impact is contingent on unknown state action during future eligible federal fiscal quarters.

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 2023 DSH fiscal year (covering the period of October 1, 2022 through September 30, 2023).

In connection with these DSH programs, included in our financial results was an aggregate of approximately $17 million and $12 million during the three-month periods ended September 30, 2022 and 2021, respectively, and approximately $41 million and $35 million during the nine-month periods ended September 30, 2022 and 2021, respectively. We expect the aggregate reimbursements to our hospitals pursuant to the Texas and South Carolina 2022 fiscal year programs to be approximately $54 million.

The Legislation and subsequent federal legislation provides for a significant reduction in Medicaid disproportionate share payments beginning in federal fiscal year 2024 (see above in *Sources of Revenues and Health Care Reform-Medicaid Revisions* for additional disclosure related to the delay of these DSH reductions). HHS 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 be reduced in the coming years. Based on the CMS final rule published in September, 2019, beginning in fiscal year 2024 (as amended by the CARES Act and the CAA), annual Medicaid DSH payments in South Carolina and Texas could be reduced by approximately 65% and 41%, respectively, from 2021 DSH payment levels.

Our behavioral health care facilities in Texas have been receiving Medicaid DSH payments since FFY 2016. As with all Medicaid DSH payments, hospitals are subject to state audits that typically occur up to three years after their receipt. DSH payments are subject to a federal Hospital Specific Limit ("HSL") and are not fully known until the DSH audit results are concluded. In general, freestanding psychiatric hospitals tend to provide significantly less charity care than acute care hospitals and therefore are at more risk for retroactive recoupment of prior year DSH payments in excess of their respective HSL. In light of the retroactive HSL audit risk for freestanding psychiatric hospitals, we have established DSH reserves for our facilities that have been receiving funds since FFY 2016. These DSH reserves are also impacted by the resolution of federal DSH litigation related to Children's Hospital Association of Texas v. Azar ("CHAT") where the calculation of HSL was being challenged. In August, 2019, DC Circuit Court of Appeals issued a unanimous decision in CHAT and reversed the judgment of the district court in favor of CMS and ordered that CMS's "2017 Rule" (regarding Medicaid DSH Payments—Treatment of Third Party Payers in Calculating Uncompensated Care Costs) be reinstated. CMS has not issued any additional guidance post the ruling. In April 2020, the plaintiffs in the case have petitioned the Supreme Court of the United States to hear their case. Additionally, there have been separate legal challenges on this same issue in the Fifth and Eight Circuits. On November 4, 2019, in *Missouri Hosp. Ass'n v. Azar*, the United States Court of Appeals for the Eighth Circuit issued an opinion upholding the 2017 Rule. On April 20, 2020, in *Baptist Memorial Hospital v. Azar*, the United States Court of Appeals of the Fifth Circuit issued a decision also upholding the 2017 Rule. In light of these court decisions, we continue to maintain reserves in the financial statements for cumulative Medicaid DSH and UC reimbursements related to our behavioral health hospitals located in Texas that amounted to $37 million as of September 30, 2022 and $40 million as of December 31, 2021.

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. This SPA has been approved for additional state fiscal years including the 2022 fiscal year covering the period of July 1, 2021 through June 30, 2022. CMS approval for the 2023 fiscal year, which is still pending, is expected to occur.

In connection with this program, included in our financial results was approximately $5 million during each of the three-month period ended September 30, 2022 and 2021, and approximately $16 million during each of the nine-month periods ended September 30, 2022 and 2021. We estimate that our reimbursements pursuant to this program will approximate $21 million during the year ended December 31, 2022.

California SPA:

In California, CMS issued formal approval of the 2017-19 Hospital Fee Program in December, 2017 retroactive to January 1, 2017 through September 30, 2019. In September, 2019, the state submitted a request to renew the Hospital Fee Program for the period July 1, 2019 to December 31, 2021. On February 25, 2020, CMS approved this renewed program. These approvals include the Medicaid inpatient and outpatient fee-for-service supplemental payments and the overall provider tax structure but did not yet include the

approval of the managed care rate setting payment component for certain rate periods (see table below). The managed care payment component consists of two categories of payments, “pass-through” payments and “directed” payments. The pass-through payments are similar in nature to the prior Hospital Fee Program payment method whereas the directed payment method will be based on actual concurrent hospital Medicaid managed care in-network patient volume.

California Hospital Fee Program CMS Approval Status:

Hospital Fee Program Component	CMS Methodology Approval Status	CMS Rate Setting Approval Status
Fee For Service Payment	Approved through December 31, 2022	Approved through December 31, 2021; Paid through December 31, 2021
Managed Care-Pass-Through Payment	Approved through December 31, 2022	Approved through June 30, 2019; Paid in advance of approval through December 31, 2021
Managed Care-Directed Payment	Approved through December 31, 2022	Approved through June 30, 2019; Paid in advance of approval through December 30, 2020

In connection with the existing program, included in our financial results was approximately $10 million and $11 million during the three-month periods ended September 30, 2022 and 2021, respectively, and $38 million and $35 million during the nine-month periods ended September 30, 2022 and 2021, respectively. We estimate that our reimbursements pursuant to this program will approximate $50 million during the year ended December 31, 2022. The aggregate impact of the California supplemental payment program, as outlined above, is included in the above *State Medicaid Supplemental Payment Program* table.

Kentucky Hospital Rate Increase Program (“HRIP”):

In early 2021, CMS approved the Kentucky Medicaid Managed Care Hospital Rate Increase Program (“HRIP”) for SFY 2021, which covered the period of July 1, 2020 through June 30, 2021. In December 2021, CMS approved the HRIP program period for the period July 1, 2021 to December 31, 2021. Included in our financial results was approximately $18 million and $8 million during the three-month periods ended September 30, 2022 and 2021, respectively, and approximately $47 million and $65 million during the nine-month periods ended September 30, 2022 and 2021, respectively.

Programs such as HRIP require an annual state submission and approval by CMS. In December, 2021, CMS approved the program for the period of January 1, 2022 through December 31, 2022 at rates similar to the prior year. We estimate that our reimbursements pursuant to HRIP will approximate $59 million during the year ended December 31, 2022.

Florida Medicaid Managed Care Directed Payment Program (“DPP”):

During the fourth quarter of 2021, we recorded approximately $23 million of increased reimbursement resulting from the Medicaid managed care directed payment program for the 2021 rate period (covering the period of October 1, 2020 to September 30, 2021). Various DPP related legislative and regulatory approvals result in the retroactive payment of the increased reimbursement after the applicable rate year has ended. The payment methodology and amount of the 2022 DPP (covering the period of October 1, 2021 to September 30, 2022) is expected to be comparable to the 2021 DPP. As a result, if CMS and other legislative and regulatory approvals occur in connection with the 2022 DPP, we estimate that our reimbursements pursuant to the 2022 DPP will approximate $32 million, net of Provider Taxes, during the year ended December 31, 2022, all of which we expect to record during the fourth quarter. This amount reflects additional Medicaid managed regions in the state participating in the program during the 2022 DPP year.

Oklahoma Transition to Managed Care and Implementation of a Medicaid Managed Care DPP

In May, 2022, Oklahoma enacted legislation (SB 1337 and SB 1396) that directs the Oklahoma Health Care Authority to: (i) transition its Medicaid program from a fee for service payment model to a managed care payment model by no later than October 1, 2023, and: (ii) concurrently implement a Medicaid managed care DPP using a managed care gap of ninety percent (90%) average commercial rates. Although we estimate that the DPP as enacted may have a favorable impact on our future results of operations, we are unable to quantify the ultimate impact since implementation of this legislation is subject to various administrative and regulatory steps including the awarding of managed care contracts as well as CMS’ approval of the DPP.

Risk Factors Related To State Supplemental Medicaid Payments:

As outlined above, we receive substantial reimbursement from multiple states in connection with various supplemental Medicaid payment programs. The states include, but are not limited to, Texas, Kentucky, California, Illinois, Indiana and Nevada. 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.

In April, 2016, CMS published its final Medicaid Managed Care Rule which explicitly permits but phases out the use of pass-through payments (including supplemental payments) by Medicaid Managed Care Organizations ("MCO") to hospitals over ten years but allows for a transition of the pass-through payments into value-based payment structures, delivery system reform initiatives or payments tied to services under a MCO contract. Since we are unable to determine the financial impact of this aspect of the final rule, we can provide no assurance that the final rule will not have a material adverse effect on our future results of operations. In November, 2020, CMS issued a final rule permitting pass-through supplemental provider payments during a time-limited period when states transition populations or services from fee-for-service Medicaid to managed care.

HITECH Act: In July 2010, 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 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 qualified 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.

All of our acute care hospitals have met the applicable meaningful use criteria. 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.

In the 2019 IPPS final rule, CMS overhauled the Medicare and Medicaid EHR Incentive Program to focus on interoperability, improve flexibility, relieve burden and place emphasis on measures that require the electronic exchange of health information between providers and patients. We can provide no assurance that the changes will not have a material adverse effect on our future results of operations.

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 payers than we do from traditional indemnity insurers, however, during the past few years we have secured price increases from many of our commercial payers 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 payers and states and is generally based on contracts negotiated between the hospital and the payer.

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.

Surprise Billing Interim Final Rule: On September 30, 2021, the Department of Labor, and the Department of the Treasury, along with the Office of Personnel Management ("OPM"), released an interim final rule with comment period, entitled "Requirements Related to Surprise Billing; Part II." This rule is related to Title I (the "No Surprises Act") of Division BB of the Consolidated Appropriations Act, 2021, and establishes new protections from surprise billing and excessive cost sharing for consumers receiving health care items/services. It implements additional protections against surprise medical bills under the No Surprises Act, including provisions related to the independent dispute resolution process, good faith estimates for uninsured (or self-pay) individuals, the patient-provider dispute resolution process, and expanded rights to external review. On February 28, 2022, a district judge in the Eastern District of Texas invalidated portions of the rule governing aspects of the Independent Dispute Resolution ("IDR") process. In light of this decision, the government issued a final rule on August 19, 2022 eliminating the rebuttable presumption in favor of the qualifying payment amount ("QPA") by the IDR entity and providing additional factors the IDR entity should consider when choosing between two competing offers. On September 22, 2022, the Texas Medical Association filed a lawsuit challenging the IDR process provided in the updated final rule and alleging that the final rule unlawfully elevates the QPA above other factors the IDR entity must consider. The American Hospital Association and American Medical Association have announced their intent to join this case as amici supporting the Texas Medical Association. We do not expect the interim final rule or the August 19, 2022 final rule to have a material impact on our results of operations.

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.

Health Care Reform: Listed below are the Medicare, Medicaid and other health care industry changes which have been, or are scheduled to be, implemented as a result of the Legislation.

Implemented Medicare Reductions and Reforms:

- The Legislation 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, 0.30% in 2014, 0.20% in each of 2015 and 2016 and 0.75% in each of 2017, 2018 and 2019.
- The Legislation 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 DSH payments, effective in 2014, as discussed above.

Medicaid Revisions:

- Expanded Medicaid eligibility and related special federal payments, effective in 2014.
- The Legislation (as amended by subsequent federal legislation) requires annual aggregate reductions in federal DSH funding from FFY 2024 through FFY 2027. Medicaid DSH reductions have been delayed several times. Commencing in federal fiscal year 2024, and continuing through 2027, DSH payments will be reduced by $8 billion annually.

Health Insurance Revisions:

- Large employer insurance reforms, effective in 2015.
- Individual insurance mandate and related federal subsidies, effective in 2014. As noted above in *Health Care Reform*, the Tax Cuts and Jobs Act enacted into law in December, 2017 eliminated the individual insurance federal mandate penalty beginning January 1, 2019.
- Federally mandated insurance coverage reforms, effective in 2010 and forward.

The Legislation seeks to increase competition among private health insurers by providing for transparent federal and state insurance exchanges. The Legislation 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 Legislation required HHS to implement a value-based purchasing program for inpatient hospital services which became effective on October 1, 2012. The Legislation requires HHS to reduce inpatient hospital payments for all discharges by 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. As part of the FFY 2022

IPPS final rule and FFY 2023 final rule, as discussed above, and as a result of the on-going COVID-19 pandemic, CMS has implemented a budget neutral payment policy to fully offset the 2% VBP withhold during each of FFY 2022 and FFY 2023.

Hospital Acquired Conditions:

The Legislation 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. As part of the FFY 2023 final rule discussed above, and as a result of the on-going COVID-19 pandemic, CMS will suppress all six measures in the HAC Reduction Program for the FY 2023 program year and eliminate the HAC reduction program's one percent payment penalty.

Readmission Reduction Program:

In the Legislation, Congress also mandated implementation of the hospital readmission reduction program ("HRRP"). 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 HRRP currently assesses penalties on hospitals having excess readmission rates for heart failure, myocardial infarction, pneumonia, acute exacerbation of chronic obstructive pulmonary disease (COPD) and elective total hip arthroplasty (THA) and/or total knee arthroplasty (TKA), excluding planned readmissions, when compared to expected rates. In the fiscal year 2015 IPPS final rule, CMS added readmissions for coronary artery bypass graft (CABG) surgical procedures beginning in fiscal year 2017. To account for excess readmissions, an applicable hospital's base operating DRG payment amount is adjusted for each discharge occurring during the fiscal year. Readmissions payment adjustment factors can be no more than a 3 percent reduction. As part of the FFY 2023 IPPS final rule discussed above, CMS will modify all of the condition-specific readmission measures to include an adjustment for patient history of COVID-19 for FFY 2024.

Accountable Care Organizations:

The Legislation 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. CMS is also developing and implementing more advanced ACO payment models that require ACOs to assume greater risk for attributed beneficiaries. On December 21, 2018, CMS published a final rule that, in general, requires ACO participants to take on additional risk associated with participation in the program. On April 30, 2020, CMS issued an interim final rule with comment in response to the COVID-19 national emergency permitting ACOs with current agreement periods expiring on December 31, 2020 the option to extend their existing agreement period by one year, and permitting certain ACOs to retain their participation level through 2021. It remains unclear to what extent providers will pursue federal ACO status or whether the required investment would be warranted by increased payment.

2019 Novel Coronavirus Disease Medicare and Medicaid Payment Related Legislation

In response to the growing threat of COVID-19, on March 13, 2020 a national emergency was declared. The declaration empowered the HHS Secretary to waive certain Medicare, Medicaid and Children's Health Insurance Program ("CHIP") program requirements and Medicare conditions of participation under Section 1135 of the Social Security Act. Having been granted this authority by HHS, CMS issued a broad range of blanket waivers, which eased certain requirements for impacted providers, including:

- Waivers and Flexibilities for Hospitals and other Healthcare Facilities including those for physical environment requirements and certain Emergency Medical Treatment & Labor Act provisions
- Provider Enrollment Flexibilities
- Flexibility and Relief for State Medicaid Programs including those under section 1135 Waivers
- Suspension of Certain Enforcement Activities

In addition to the national emergency declaration, Congress passed and Presidents Trump and Biden have signed various forms of legislation intended to support state and local authority responses to COVID-19 as well as provide fiscal support to businesses, individuals, financial markets, hospitals and other healthcare providers.

Some of the financial support included in the various legislative actions include:

- Medicaid FMAP Enhancement
  - The FMAP was increased by 6.2% retroactive to the federal fiscal quarter beginning January 1, 2020 and each subsequent federal fiscal quarter for all states and U.S. territories during the declared public health emergency, in accordance with specified conditions.
- Public Health Emergency Declaration

- The HHS Secretary renewed the public health emergency ("PHE") effective October 13, 2022 for ninety (90) days. As a result, states would be eligible for the enhanced FMAP through the end of federal fiscal quarter ending March 31, 2023 should the PHE not be rescinded by the Secretary before the end of the ninety day period.

- Creation of a $250 billion Public Health and Social Services Emergency Fund ("PHSSEF")
  - Makes grants available to hospitals and other healthcare providers to cover unreimbursed healthcare related expenses or lost revenues attributable to the public health emergency resulting from the coronavirus.
  - During 2021, we received approximately $189 million in PHSSEF grants from the federal government as provided for by the CARES Act. As previously disclosed, we returned these funds to HHS during the second quarter of 2021. Since our intent was to return these funds, our financial results for the year ended December 31, 2021 include no impact from the receipt of these federal funds. Reimbursements recorded pursuant the PHSSEF and other various state and local governmental stimulus programs did not have a significant impact on our financial results during the nine-month period ended September 30, 2022. Our results of operations for the nine-month period ended September 30, 2021 included approximately $13 million of reimbursements recorded in connection with these programs.
  - During the year ended December 31, 2020, we received approximately $417 million of funds from various governmental stimulus programs, most notably the PHSSEF as provided for by the CARES Act. As mentioned above, included financial results for the year ended December 31, 2020 was approximately $413 million of revenues recognized in connection with funds received from these federal, state and local governmental stimulus programs.
  - All PHSSEF receipts are subject to meeting the applicable terms and conditions of the various distribution programs as of September 30, 2021. The Consolidated Appropriations Act, 2021 (H.R. 133) enacted on December 27, 2020 includes language that provides specific instructions on: (1) the redistribution of PHSSEF grant payments by a parent company among its subsidiaries, and; (2) the calculation of lost revenue in a PHSSEF grant entitlement determination. The HHS terms and conditions for all grant recipients and specific fund distributions are located at https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/for-providers/index.html
- Reimburse hospitals at Medicare rates for uncompensated COVID-19 care for the uninsured
  - Our financial results included revenues recorded in connection with this COVID-19 uninsured program amounting to approximately $4 million and $19 million during the three-month periods ended September 30, 2022 and 2021, respectively, and $22 million and $50 million during the nine-month periods ended September 30, 2022 and 2021, respectively. Revenue for the eligible patient encounters is recorded in the period in which the encounter is deemed eligible for this program net of any normal accounting reserves.
  - Effective March 22, 2022, HHS announced that the HRSA COVID-19 Uninsured Program and Coverage Assistance Fund is no longer accepting claims due to insufficient funding.
- Medicare Sequestration Relief
  - Suspension of the 2% Medicare sequestration offset for Medicare services provided from May 1, 2020 through December 31, 2021 by various legislative extensions. In December, 2021, the suspended 2% payment reduction was extended until March 31, 2022 and partially suspended at a 1% payment reduction for an additional three-month period that ended on June 30, 2022.
  - Our financial results included revenues recorded in connection with this Medicare sequestration relief program amounting to $0 and $11 million during the three-month periods ended September 30, 2022 and 2021, respectively, and $17 million and $34 million during the nine-month periods ended September 30, 2022 and 2021, respectively.
- Medicare add-on for inpatient hospital COVID-19 patients
  - Increases the payment that would otherwise be made to a hospital for treating a Medicare patient admitted with COVID-19 by twenty percent (20%) for the duration of the COVID-19 public health emergency.
  - Our financial results included revenues recorded in connection with this COVID-19 Medicare add-on program amounting to approximately $7 million and $8 million during the three-month periods ended September 30, 2022 and 2021, respectively, and approximately $25 million and $27 million during the nine-month periods ended September 30, 2022 and 2021, respectively. These payments were intended to offset the increased expenses associated with the treatment of Medicare COVID-19 patients.
- Expansion of the Medicare Accelerated and Advance Payment Program ("MAAPP")
  - In March, 2021, we fully repaid the $695 million of Medicare Accelerated payments received during 2020.

In addition to statutory and regulatory changes to the Medicare program 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 payers could have a material adverse effect on our financial position and our results.

Other Operating Results

Interest Expense:

As reflected on the schedule below, interest expense was $36 million and $21 million during the three-month periods ended September 30, 2022 and 2021, respectively, and $83 million and $64 million during the nine-month periods ended September 30, 2022 and 2021, respectively (amounts in thousands):

	Three Months Ended September 30, 2022	Three Months Ended September 30, 2021	Nine Months Ended September 30, 2022	Nine Months Ended September 30, 2021
Revolving credit & demand notes (a.)	$ 1,440	$ 502	$ 7,752	$ 1,502
Tranche A term loan facility (a.)	22,177	6,460	37,710	20,576
Tranche B term loan facility (a.)	-	1,352	-	5,941
$400 million, 5.00% Senior Notes due 2026 (b.)	-	4,000	-	14,000
$800 million, 2.65% Senior Notes due 2030 (c.)	5,356	5,356	16,069	16,113
$700 million, 1.65% Senior Notes due 2026 (d.)	2,931	1,205	8,794	1,205
$500 million, 2.65% Senior Notes due 2032 (e.)	3,345	1,376	10,035	1,376
Accounts receivable securitization program (f.)	10	10	30	777
Subtotal-revolving credit, demand notes, Senior Notes, term loan facilities and accounts receivable securitization program	35,259	20,261	80,390	61,490
Amortization of financing fees	1,259	1,087	3,481	3,205
Other combined interest expense	1,441	1,322	5,052	4,197
Capitalized interest on major projects	(2,199)	(1,305)	(5,738)	(2,957)
Interest income	(107)	(166)	(183)	(1,480)
Interest expense, net	$ 35,653	$ 21,199	$ 83,002	$ 64,455

(a.) In June, 2022 we entered into the ninth amendment to our credit agreement dated November 15, 2010, as amended (the "Credit Agreement"), which, among other things, added a new incremental tranche A term loan facility in the aggregate principal amount of $700 million. In September, 2021 we entered into an eighth amendment which modified the definition of "Adjusted LIBO Rate". In August, 2021 we entered into a seventh amendment to our Credit Agreement which provided for the amendment and restatement of the previously existing credit facility including, among other things, the following: (i) a $1.2 billion aggregate amount revolving credit facility that is scheduled to mature in August, 2026 ($189.2 million of borrowings outstanding as of September 30, 2022); (ii) a tranche A term loan facility with $2.35 billion of outstanding borrowings as of September 30, 2022 (including the $700 million increase provided for by the ninth amendment in June, 2022), and; (iii) repayment of a portion of the previously outstanding tranche A term loan facility borrowings ($150 million) and all of the tranche B term loan facility borrowings ($488 million). Repayment of the $638 million of previously outstanding borrowings under the tranche A and tranche B term loan facilities were funded utilizing a portion of the proceeds generated from the August, 2021 issuance of the $700 million, 1.65% Senior Notes due in 2026, and the $500 million, 2.65%, Senior Notes due in 2032.

(b.) In September, 2021 we redeemed the entire $400 million aggregate principal amount of our previously outstanding 5.00% Senior Secured Notes that were scheduled to mature in 2026 at a cash redemption price equal to the sum of 102.50% of the aggregate principal amount. This redemption was funded utilizing a portion of the proceeds generated from the August, 2021 issuance of the $700 million, 1.65% Senior Notes due in 2026, and the $500 million, 2.65% Senior Notes due in 2032, as discussed in (d.) and (e.) below.

(c.) In September, 2020 we completed the offering of $800 million aggregate principal amount of 2.65% Senior Notes due in 2030.

(d.) In August, 2021 we completed the offering of $700 million aggregate principal amount of 1.65% Senior Notes due in 2026.

(e.) In August, 2021 we completed the offering of $500 million aggregate principal amount of 2.65% Senior Notes due in 2032.

(f.) Our accounts receivable securitization program was amended in April, 2021 to reduce the borrowing commitment to $20 million (from $450 million previously), amended in April, 2022 to extend the maturity date to July 22, 2022, amended in July, 2022 to extend the maturity date to September, 2022, and amended in September, 2022 to extend the maturity date to December, 2022. There are no outstanding borrowings as of September 30, 2022.

Interest expense increased approximately $14 million during the three-month period ended September 30, 2022, as compared to the three-month period ended September 30, 2021, due primarily to a net $15 million increase in aggregate interest expense on our revolving credit, demand notes, senior notes, term loan facilities and accounts receivable securitization program. The increase resulted from: (i) an increase in the aggregate average outstanding borrowings ($4.46 billion during the three months ended September 30, 2022 as compared to $3.70 billion during the three months ended September 30, 2021), and; (ii) an increase in the weighted average cost of borrowings pursuant to these facilities (3.08% and 2.13% during the three-month periods ended September 30, 2022 and 2021, respectively). The weighted average effective interest rate pursuant to these facilities, including amortization of deferred financing costs, original issue discount and designated interest rate swap expense/income, was 3.21% and 2.26% during the three-month periods ended September 30, 2022 and 2021, respectively.

Interest expense increased approximately $19 million during the nine-month period ended September 30, 2022, as compared to the nine-month period ended September 30, 2021, primarily due to a net $19 million increase on our revolving credit, demand notes, senior notes, term loan facilities and accounts receivable securitization program. The increase resulted from: (i) an increase in the aggregate average outstanding borrowings ($4.37 billion during the nine months ended September 30, 2022 as compared to $3.69 billion during the nine months ended September 30, 2021), and; (ii) an increase in the weighted average cost of borrowings pursuant to these facilities (2.41% and 2.19% during the nine-month periods ended September 30, 2022 and 2021, respectively). The weighted average effective interest rates pursuant to these facilities, including amortization of deferred financing costs, original issue discount and designated interest rate swap expense/income, were 2.53% and 2.31% during the nine-month periods ended September 30, 2022 and 2021, respectively.

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 nine-month periods ended September 30, 2022 and 2021 (dollar amounts in thousands):

	Three months ended		Nine months ended	
	September 30, 2022	September 30, 2021	September 30, 2022	September 30, 2021
Provision for income taxes	$ 57,401	$ 67,515	$ 157,312	$ 232,844
Income before income taxes	234,212	286,890	643,925	986,565
Effective tax rate	24.5%	23.5%	24.4%	23.6%

The provision for income taxes decreased $10 million during the three-month period ended September 30, 2022, as compared to the third quarter of 2021, due primarily to the income tax benefit recorded in connection with the $46 million decrease in pre-tax income.

The provision for income taxes decreased $76 million during the nine-month period ended September 30, 2022, as compared to the comparable period of 2021, due primarily to the income tax benefit recorded in connection with the $327 million decrease in pre-tax income.

Liquidity

Net cash provided by operating activities

Net cash provided by operating activities was $699 million during the nine-month period ended September 30, 2022 and $562 million during the first nine months of 2021. The net increase of $137 million was attributable to the following:

- a favorable change of $695 million from the early return of the Medicare accelerated payments which were received during 2020 and repaid during the first quarter of 2021;
- an unfavorable change of $245 million resulting from a decrease in net income plus depreciation and amortization expense, stock-based compensation expense, gain/loss on sale of assets and businesses, costs related to extinguishment of debt and provision for asset impairment;
- an unfavorable change of $227 million from other working capital accounts due primarily to the timing of disbursements for accrued compensation;
- an unfavorable change of $126 million in accounts receivable due, in part, to the timing of receipt of certain supplemental reimbursements and the opening of new facilities, and;
- $40 million of other combined net favorable changes.

Days sales outstanding ("DSO"): Our DSO are calculated by dividing our net revenue by the number of days in the nine-month periods. The result is divided into the accounts receivable balance at September 30th of each year to obtain the DSO. Our DSO were 52 days and 51 days at September 30, 2022 and 2021, respectively.

Net cash used in investing activities

During the first nine months of 2022, we used $399 million of net cash in investing activities as follows:

- $570 million spent on capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities;
- $177 million received in connection with net cash inflows from forward exchange contracts that hedge our investment in the U.K. against movements in exchange rates;
- $19 million spent on the acquisition of businesses and property, and;
- $12 million received from the sales of assets and businesses.

During the first nine months of 2021, we used $660 million of net cash in investing activities as follows:

- $666 million spent on capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities;
- $39 million spent on acquisition of business and property;
- $21 million received from the sale of our equity interest in a business;
- $20 million received in connection with the implementation of information technology applications (consists primarily of refunded costs previously paid), and;
- $4 million received in connection with net cash inflows from forward exchange contracts that hedge our investment in the U.K. against movements in exchange rates.

Net cash used in financing activities

During the first nine months of 2022, we used $303 million of net cash in financing activities as follows:

- generated $705 million of additional borrowings consisting primarily of the $700 million generated pursuant to the new tranche A term loan facility which commenced in June, 2022;
- spent $723 million to repurchase shares of our Class B Common Stock in connection with: (i) open market purchases pursuant to our stock repurchase program ($703 million), and; (ii) income tax withholding obligations related to stock-based compensation programs ($20 million);
- spent $194 million on net repayments of debt as follows: (i) $153 million related to our revolving credit facility; (ii) $36 million related to our tranche A term loan facility, and; (iii) $5 million related to other debt facilities;
- spent $49 million in connection with the purchase of ownership interests from minority members, net of sales, consisting primarily of our purchase of George Washington University's 20% ownership in George Washington University Hospital (we now own 100% of the hospital);

- spent $44 million to pay quarterly cash dividends of $.20 per share;
- generated $10 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans;
- spent $5 million to pay profit distributions related to noncontrolling interests in majority owned businesses, and;
- spent $3 million to pay financing costs.

During the first nine months of 2021, we used $936 million of net cash in financing activities as follows:

- spent $3.027 billion on net repayments of debt as follows: (i) $1.9 billion related to our tranche A term loan facility; (ii) $490 million related to our previously outstanding tranche B term loan facility; (iii) $410 million related to the early redemption of our previously outstanding $400 million, 5.00% senior secured notes which were scheduled to mature in June, 2026; (iv) $225 million in connection with our accounts receivable securitization program, and; (v) $2 million related to other debt facilities;
- generated $2.912 billion of additional borrowings as follows: (i) $1.7 billion related to our tranche A term loan facility; (ii) $699 million (net of discount) related to the August, 2021 issuance of $700 million, 1.65% senior secured notes due in September, 2026; (iii) $499 million (net of discount) related to the August, 2021 issuance of $500 million, 2.65% senior secured notes due in January, 2032, and; (iv) received $14 million of proceeds related to other debt facilities;
- spent $770 million to repurchase shares of our Class B Common Stock in connection with: (i) open market purchases pursuant to our stock repurchase program ($751 million), and; (ii) income tax withholding obligations related to stock-based compensation programs ($19 million);
- spent $50 million to pay quarterly cash dividends of $.20 per share;
- spent $18 million to pay financing costs incurred in connection with various financing transactions;
- received $13 million in connection with the sale of ownership interest to minority members;
- generated $10 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans, and;
- spent $6 million to pay profit distributions related to noncontrolling interests in majority owned businesses.

Expected capital expenditures during remainder of 2022

During the full year of 2022, we expect to spend approximately $760 million to $810 million on capital expenditures which includes expenditures for capital equipment, construction of new facilities, and renovations and expansions at existing hospitals. During the first nine months of 2022, we spent approximately $570 million on capital expenditures. During the remaining three months of 2022, we expect to spend approximately $190 million to $240 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

In June, 2022 we entered into a ninth amendment to our credit agreement dated as of November 15, 2010, as amended and restated as of September, 2012, August, 2014, October, 2018, August, 2021, and September, 2021, among UHS, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders, and JPMorgan Chase Bank, N.A., as administrative agent, (the "Credit Agreement"). The ninth amendment provided for, among other things, the following: (i) a new incremental tranche A term loan facility in the aggregate principal amount of $700 million which is scheduled to mature on August 24, 2026, and; (ii) replaces the option to make Eurodollar borrowings (which bear interest by reference to the LIBOR Rate) with Term Benchmark Loans, which will bear interest by reference to the Secured Overnight Financing Rate ("SOFR"). The net proceeds generated from the incremental tranche A term loan facility were used to repay a portion of the borrowings that were previously outstanding under our revolving credit facility.

In September, 2021 we entered into an eighth amendment to our Credit Agreement which modified the definition of "Adjusted LIBO Rate".

In August, 2021 we entered into a seventh amendment to our Credit Agreement which, among other things, provided for the following:

- a $1.2 billion aggregate amount revolving credit facility, which is scheduled to mature on August 24, 2026, representing an increase of $200 million over the $1.0 billion previous commitment. As of September 30, 2022, this facility had $189 million of borrowings outstanding and $1.007 billion of available borrowing capacity, net of $4 million of outstanding letters of credit;

- a $1.7 billion initial tranche A term loan facility which was subsequently increased by $700 million in June, 2022 by the above-mentioned ninth amendment. The seventh amendment also provided for repayment of $150 million of borrowings outstanding pursuant to the previous tranche A term loan facility, and;
- repayment of approximately $488 million of outstanding borrowings and termination of the previous tranche B term loan facility.

The terms of the tranche A term loan facility, as amended, which had $2.353 billion of outstanding borrowings as of September 30, 2022, provides for installment payments of $15.0 million per quarter during the period of September, 2022 through September, 2023, and $30.0 million per quarter during the period of December, 2023 through June, 2026. The unpaid principal balance at June 30, 2026 is payable on the August 24, 2026 scheduled maturity date of the Credit Agreement.

Revolving credit and tranche A term loan borrowings under the Credit Agreement bear interest at our election at either (1) the ABR rate which is defined as the rate per annum equal to 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 SOFR rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.25% to 0.625%, or (2) the one, three or six month SOFR rate plus 0.1% (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.25% to 1.625%. As of September 30, 2022, the applicable margins were 0.50% for ABR-based loans and 1.50% for SOFR-based loans under the revolving credit and term loan A facilities. 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 (which generally excludes asset classes such as substantially all of the patient-related accounts receivable of our acute care hospitals, and certain real estate assets and assets held in joint-ventures with third parties) and is guaranteed by our material subsidiaries.

The Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement also contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens, indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage. We were in compliance with all required covenants as of September 30, 2022 and December 31, 2021.

On August 24, 2021, we completed the following via private offerings 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:

- Issued $700 million of aggregate principal amount of 1.65% senior secured notes due on September 1, 2026, and;
- Issued $500 million of aggregate principal amount of 2.65% senior secured notes due on January 15, 2032.

In April, 2021 our accounts receivable securitization program ("Securitization") was amended (the eighth amendment) to: (i) reduce the aggregate borrowing commitments to $20 million (from $450 million previously); (ii) slightly reduce the borrowing rates and commitment fee, and; (iii) extend the maturity date to April 25, 2022. In April, 2022, the Securitization was amended (the ninth amendment) to extend the maturity date to July 22, 2022. In July, 2022, the Securitization was amended (the tenth amendment) to extend the maturity date to September 20, 2022. In September, 2022, the Securitization was amended (the eleventh amendment) to extend the maturity date to December 20, 2022. Substantially all other material terms and conditions remained unchanged. There were no borrowings outstanding pursuant to the Securitization as of September 30, 2022.

On September 13, 2021, we redeemed $400 million of aggregate principal amount of 5.00% senior secured notes, that were scheduled to mature on June 1, 2026, at 102.50% of the aggregate principal, or $410 million.

As of September 30, 2022, we had combined aggregate principal of $2.0 billion from the following senior secured notes:

- $700 million aggregate principal amount of 1.65% senior secured notes due in September, 2026 ("2026 Notes") which were issued on August 24, 2021.
- $800 million aggregate principal amount of 2.65% senior secured notes due in October, 2030 ("2030 Notes") which were issued on September 21, 2020.
- $500 million of aggregate principal amount of 2.65% senior secured notes due in January, 2032 ("2032 Notes") which were issued on August 24, 2021.

On September 28, 2020, we redeemed the entire $700 million aggregate principal amount of our previously outstanding 4.75% senior secured notes, which were scheduled to mature in August, 2022, at 100% of the aggregate principal amount.

Interest on the 2026 Notes is payable on March 1st and September 1st until the maturity date of September 1, 2026. Interest on the 2030 Notes payable on April 15th and October 15th, until the maturity date of October 15, 2030. Interest on the 2032 Notes is payable on January 15th and July 15th until the maturity date of January 15, 2032.

The 2026 Notes, 2030 Notes and 2032 Notes (collectively "The 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 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.

The Notes are guaranteed (the "*Guarantees*") on a senior secured basis by all of our existing and future direct and indirect wholly-owned subsidiaries (the "*Subsidiary Guarantors*") that guarantee our Credit Agreement, or other first lien obligations or any junior lien obligations. The Notes and the Guarantees are secured by first-priority liens, subject to permitted liens, on certain of the Company's and the Subsidiary Guarantors' assets now owned or acquired in the future by the Company or the Subsidiary Guarantors (other than real property, accounts receivable sold pursuant to the Company's Existing Receivables Facility (as defined in the Indentures pursuant to which The Notes were issued (the "Indentures")), and certain other excluded assets). The Company's obligations with respect to The Notes, the obligations of the Subsidiary Guarantors under the Guarantees, and the performance of all of the Company's and the Subsidiary Guarantors' other obligations under the Indentures, are secured equally and ratably with the Company's and the Subsidiary Guarantors' obligations under the Credit Agreement and The Notes by a perfected first-priority security interest, subject to permitted liens, in the collateral owned by the Company and its Subsidiary Guarantors, whether now owned or hereafter acquired. However, the liens on the collateral securing The Notes and the Guarantees will be released if: (i) The Notes have investment grade ratings; (ii) no default has occurred and is continuing, and; (iii) the liens on the collateral securing all first lien obligations (including the Credit Agreement and The Notes) and any junior lien obligations are released or the collateral under the Credit Agreement, any other first lien obligations and any junior lien obligations is released or no longer required to be pledged. The liens on any collateral securing The Notes and the Guarantees will also be released if the liens on that collateral securing the Credit Agreement, other first lien obligations and any junior lien obligations are released.

In connection with the issuance of The Notes, the Company, the Subsidiary Guarantors and the representatives of the several initial purchasers, entered into Registration Rights Agreements (the "*Registration Rights Agreements*"), whereby the Company and the Subsidiary Guarantors have agreed, at their expense, to use commercially reasonable best efforts to: (i) cause to be filed a registration statement enabling the holders to exchange The Notes and the Guarantees for registered senior secured notes issued by the Company and guaranteed by the then Subsidiary Guarantors under the Indentures (the "*Exchange Securities*"), containing terms identical to those of The Notes (except that the Exchange Securities will not be subject to restrictions on transfer or to any increase in annual interest rate for failure to comply with the Registration Rights Agreements); (ii) cause the registration statement to become effective; (iii) complete the exchange offer not later than 60 days after such effective date and in any event on or prior to a target registration date of March 21, 2023 in the case of the 2030 Notes and February 24, 2024 in the case of the 2026 and 2032 Notes, and; (iv) file a shelf registration statement for the resale of The Notes if the exchange offers cannot be effected within the time periods listed above. The interest rate on The Notes will increase and additional interest thereon will be payable if the Company does not comply with its obligations under the Registration Rights Agreements.

On November 4, 2022, as required under the terms of the Credit Agreement, we added certain additional subsidiary guarantors of our obligations under the Credit Agreement. As a result, and as required under the terms of the Indentures, we, together with the Subsidiary Guarantors, U.S. Bank Trust Company, National Association, as trustee, and JPMorgan Chase Bank, N.A., as collateral agent, entered into:

- a supplemental indenture (the "2020 Supplemental Indenture") to the Indenture, dated as of September 21, 2020 (as amended, supplemented and otherwise modified from time to time prior to the date hereof, the "2020 Indenture"), governing our 2030 Notes; and
- a supplemental indenture (the "2021 Supplemental Indenture" and, together with the 2020 Supplemental Indenture, the "Supplemental Indentures") to that certain Indenture, dated as of August 24, 2021 (as amended, supplemented and otherwise modified from time to time prior to the date hereof, the "2021 Indenture" and, together with the 2020 Indenture, the "Indentures"), governing our 2026 Notes and 2032 Notes.

The Supplemental Indentures added additional Subsidiary Guarantors as guarantors under the Indentures as required under the terms of the Indentures.

The foregoing description of the Supplemental Indentures is a summary, does not purport to be complete and is qualified in its entirety by reference to the full text of the Supplemental Indentures, which are filed as Exhibits 4.1 and 4.2 to this Report and are incorporated herein by reference.

As discussed in *Note 2 to the Consolidated Financial Statements-Relationship with Universal Health Realty Income Trust and Other Related Party Transactions*, on December 31, 2021, we (through wholly-owned subsidiaries of ours) entered into an asset purchase and sale agreement with Universal Health Realty Income Trust (the "Trust"). Pursuant to the terms of the agreement, which was amended during the first quarter of 2022, we, among other things, transferred to the Trust, the real estate assets of Aiken Regional Medical Center ("Aiken") and Canyon Creek Behavioral Health ("Canyon Creek"). In connection with this transaction, Aiken and Canyon Creek (as lessees), entered into a master lease and individual property leases, as amended, (with the Trust as lessor), for initial lease terms on each property of approximately twelve years, ending on December 31, 2033. As a result of our purchase option within the Aiken and Canyon Creek lease agreements, this asset purchase and sale transaction is accounted for as a failed sale leaseback in accordance with U.S. GAAP and we have accounted for the transaction as a financing arrangement. Our lease payments payable to the Trust are recorded to interest expense and as a reduction of the outstanding financial liability, and the amount allocated to interest expense is determined based upon our incremental borrowing rate and the outstanding financial liability. In connection with this

transaction, our Consolidated Balance Sheets at September 30, 2022 and December 31, 2021 reflect financial liabilities, which are included in debt, of approximately $82 million as of each date.

At September 30, 2022, the carrying value and fair value of our debt were approximately $4.7 billion and $4.3 billion, respectively. At December 31, 2021, the carrying value and fair value of our debt were each approximately $4.2 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 approximately 45% at September 30, 2022 and 41% at December 31, 2021.

We expect to finance all capital expenditures and acquisitions and pay dividends and potentially repurchase shares of our common stock utilizing internally generated and additional funds. Additional funds may be obtained through: (i) borrowings under our existing revolving credit facility, which had $1.007 billion of available borrowing capacity as of September 30, 2022, or through refinancing the existing Credit Agreement; (ii) the issuance of other short-term and/or long-term debt, and/or; (iii) the issuance of equity. We believe that our operating cash flows, cash and cash equivalents, available commitments under existing agreements, 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.

Supplemental Guarantor Financial Information

As of September 30, 2022, we had combined aggregate principal of $2.0 billion from The Notes:

- $700 million aggregate principal amount of the 2026 Notes;
- $800 million aggregate principal amount of the 2030 Notes, and;
- $500 million of aggregate principal amount of the 2032 Notes.

The Notes are fully and unconditionally guaranteed pursuant to the Guarantees on a senior secured basis by the Subsidiary Guarantors. The Notes and the Guarantees are secured by first-priority liens, subject to permitted liens, on certain of the Company’s and the Subsidiary Guarantors’ assets now owned or acquired in the future by the Company or the Subsidiary Guarantors (other than real property, accounts receivable sold pursuant to the Company’s existing receivables facility (as defined in the Indentures pursuant to which The Notes were issued), and certain other excluded assets). The Company’s obligations with respect to The Notes, the obligations of the Subsidiary Guarantors under the Guarantees, and the performance of all of the Company’s and the Subsidiary Guarantors’ other obligations under the Indentures, are secured equally and ratably with the Company’s and the Subsidiary Guarantors’ obligations under the Credit Agreement and The Notes by a perfected first-priority security interest, subject to permitted liens, in the collateral owned by the Company and its Subsidiary Guarantors, whether now owned or hereafter acquired. However, the liens on the collateral securing The Notes and the Guarantees will be released if: (i) The Notes have investment grade ratings; (ii) no default has occurred and is continuing, and; (iii) the liens on the collateral securing all first lien obligations (including the Credit Agreement and The Notes) and any junior lien obligations are released or the collateral under the Credit Agreement, any other first lien obligations and any junior lien obligations is released or no longer required to be pledged. The liens on any collateral securing The Notes and the Guarantees will also be released if the liens on that collateral securing the Credit Agreement, other first lien obligations and any junior lien obligations are released.

The Notes will be structurally subordinated to all obligations of our existing and future subsidiaries that are not and do not become Subsidiary Guarantors of The Notes. No appraisal of the value of the collateral has been made, and the value of the collateral in the event of liquidation will depend on market and economic conditions, the availability of buyers and other factors. Consequently, liquidating the collateral securing The Notes may not produce proceeds in an amount sufficient to pay any amounts due on The Notes.

We and our subsidiaries may be able to incur significant additional indebtedness in the future. Although our Credit Agreement contains restrictions on the incurrence of additional indebtedness and our Credit Agreement and The Notes contain restrictions on our ability to incur liens to secure additional indebtedness, these restrictions are subject to a number of qualifications and exceptions, and the additional indebtedness incurred in compliance with these restrictions could be substantial. These restrictions also will not prevent us from incurring obligations that do not constitute indebtedness. In addition, if we incur any additional indebtedness secured by liens that rank equally with The Notes, subject to collateral arrangements, the holders of that debt will be entitled to share ratably with you in any proceeds distributed in connection with any insolvency, liquidation, reorganization, dissolution or other winding up of our company. This may have the effect of reducing the amount of proceeds paid to holders of The Notes.

Federal and state fraudulent transfer and conveyance statutes may apply to the issuance of The Notes and the incurrence of the Guarantees. Under federal bankruptcy law and comparable provisions of state fraudulent transfer or conveyance laws, which may vary from state to state, The Notes or the Guarantees (or the grant of collateral securing any such obligations) could be voided as a fraudulent transfer or conveyance if we or any of the Subsidiary Guarantors, as applicable, (a) issued The Notes or incurred the Guarantees with the intent of hindering, delaying or defrauding creditors or (b) under certain circumstances received less than reasonably equivalent value or fair consideration in return for either issuing The Notes or incurring the Guarantees.

Basis of Presentation

The following tables include summarized financial information of Universal Health Services, Inc. and the other obligors in respect of debt issued by Universal Health Services, Inc. The summarized financial information of each obligor group is presented on a combined basis with balances and transactions within the obligor group eliminated. Investments in and the equity in earnings of non-guarantor subsidiaries, which would otherwise be consolidated in accordance with GAAP, are excluded from the below summarized financial information pursuant to SEC Regulation S-X Rule 13-01.

The summarized balance sheet information for the consolidated obligor group of debt issued by Universal Health Services, Inc. is presented in the table below:

(in thousands)	September 30, 2022	December 31, 2021
Current assets	$ 2,012,942	$ 1,865,568
Noncurrent assets (1)	$ 8,720,431	$ 8,695,985
Current liabilities	$ 1,735,242	$ 1,818,415
Noncurrent liabilities	$ 6,576,774	$ 6,164,650
Due to non-guarantors	$ 955,780	$ 940,852

(1) Includes goodwill of $3,257 million as of September 30, 2022 and December 31, 2021.

The summarized results of operations information for the consolidated obligor group of debt issued by Universal Health Services, Inc. is presented in the table below:

(in thousands)	Nine Months Ended September 30, 2022	Twelve Months Ended December 31, 2021
Net revenues	$ 8,091,788	$ 10,310,332
Operating charges	7,377,037	9,044,261
Interest expense, net	83,248	149,394
Other (income) expense, net	14,464	(14,513)
Net income	$ 469,771	$ 878,065

Affiliates Whose Securities Collateralize the Senior Secured Notes

The Notes and the Guarantees are secured by, among other things, pledges of the capital stock of our subsidiaries held by us or by our secured Guarantors, in each case other than certain excluded assets and subject to permitted liens. Such collateral securities are secured equally and ratably with our and the Guarantors' obligations under our Credit Agreement. For a list of our subsidiaries the capital stock of which has been pledged to secure The Notes, see Exhibit 22.1 to this Report.

Upon the occurrence and during the continuance of an event of default under the indentures governing The Notes, subject to the terms of the Security Agreement relating to The Notes provide for (among other available remedies) the foreclosure upon and sale of the Collateral (including the pledged stock) and the distribution of the net proceeds of any such sale to the holders of The Notes, the lenders under the Credit Agreement and the holders of any other permitted first priority secured obligations on a pro rata basis, subject to any prior liens on the collateral.

No appraisal of the value of the collateral securities has been made, and the value of the collateral securities in the event of liquidation will depend on market and economic conditions, the availability of buyers and other factors. Consequently, liquidating the collateral securities securing The Notes may not produce proceeds in an amount sufficient to pay any amounts due on The Notes.

The security agreement relating to The Notes provides that the representative of the lenders under our Credit Agreement will initially control actions with respect to that collateral and, consequently, exercise of any right, remedy or power with respect to enforcing interests in or realizing upon such collateral will initially be at the direction of the representative of the lenders.

No trading market exists for the capital stock pledged as collateral.

The assets, liabilities and results of operations of the combined affiliates whose securities are pledged as collateral are not materially different than the corresponding amounts presented in the consolidated financial information of Universal Health Services, Inc.

Off-Balance Sheet Arrangements

During the three months ended September 30, 2022 there have been no material changes in the off-balance sheet arrangements consisting of standby letters of credit and surety bonds.

As of September 30, 2022 we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds which totaled $169 million consisting of: (i) $159 million related to our self-insurance programs, and; (ii) $10 million of other debt and public utility guarantees.

Item 3. Quantitative and Qualitative Disclosures About Market Risk

There have been no material changes in the quantitative and qualitative disclosures about market risk during the three months ended September 30, 2022. 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, 2021.

Item 4. Controls and Procedures

As of September 30, 2022, 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 third quarter of 2022 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

See *Note 6-Commitments and Contingencies* to our condensed consolidated financial statements in Item 1 of Part I of this report for a description of our legal proceedings. Such information is hereby incorporated by reference.

Item 1A. Risk Factors

Our Annual Report on Form 10-K for the year ended December 31, 2021 includes a listing of risk factors to be considered by investors in our securities. During the third quarter of 2022, 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, 2021.

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

As of December 31, 2021, we had an aggregate available repurchase authorization of $358.2 million. In February, 2022, our Board of Directors authorized a $1.4 billion increase to the program. As of September 30, 2022, we had an aggregate available repurchase authorization of $1.05 billion. Pursuant to this program, shares of our Class B Common Stock may be repurchased, from time to time as conditions allow, on the open market or in negotiated private transactions. There is no expiration date for our stock repurchase program.

As reflected below, during the three-month period ended September 30, 2022, we have repurchased approximately 1.60 million shares at an aggregate cost of approximately $157.86 million (approximately $98.56 per share) pursuant to the terms of our stock repurchase program. In addition, during the three-month period ended September 30, 2022, 3,390 shares were repurchased in connection with income tax withholding obligations resulting from stock-based compensation programs.

During the period of July 1, 2022 through September 30, 2022, 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 for shares purchased as part of publicly announced program (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)
July, 2022	$ -	643	956	$ 0.01	—	$ -	$ -	—	$ 1,212,458
August, 2022	$ -	209,149	367	$ 0.01	208,761	$ 109.94	$ 22,951	—	$ 1,189,507
September, 2022	$ -	1,395,291	798	$ 0.01	1,392,932	$ 96.85	$ 134,910	—	$ 1,054,597
Total July through September, 2022	$ -	1,605,083	2,121	$ 0.01	1,601,693	98.56	$ 157,861		

Dividends

During the quarter ended September 30, 2022, we declared and paid dividends of $.20 per share. Dividend equivalents are accrued on unvested restricted stock units and will be paid upon vesting of the restricted stock unit.

Item 6. Exhibits

4.1	Third Supplemental Indenture, dated as of November 4, 2022, among the Company, the Subsidiary Guarantors party thereto, U.S. Bank Trust Company, National Association (as successor to U.S. Bank National Association), as trustee, and JPMorgan Chase Bank, N.A., as collateral agent, to the indenture, dated as of September 21, 2020, governing the Company's 2.650% Senior Secured Notes due 2030.
4.2	Second Supplemental Indenture, dated as of November 4, 2022, among the Company, the Subsidiary Guarantors party thereto, U.S. Bank Trust Company, National Association (as successor to U.S. Bank National Association), as trustee, and JPMorgan Chase Bank, N.A., as collateral agent, to the indenture, dated as of August 24, 2021, governing the Company's 1.650% Senior Secured Notes due 2026 and the Company's 2.650% Senior Secured Notes due 2032.
10.1	Tenth Amendment to Amended and Restated Credit and Security Agreement, dated as of July 22, 2022, previously filed as Exhibit 10.5 to the Company's Quarterly Report on Form 10-Q for the Quarter Ended June 30, 2022, is incorporated herein by reference.
10.2	Eleventh Amendment to Amended and Restated Credit and Security Agreement, dated as of September 20, 2022.
22.1	List of Guarantor Subsidiaries and Issuers of Guaranteed Securities and Affiliates Whose Securities Collateralize Securities of the Registrant.
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	Inline XBRL Instance Document –the instance document does not appear in the Interactive Data file because its XBRL tags are embedded within the Inline XBRL document.
101.SCH	Inline XBRL Taxonomy Extension Schema Document
101.CAL	Inline XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase Document
101.LAB	Inline XBRL Taxonomy Extension Label Linkbase Document
101.PRE	Inline XBRL Taxonomy Extension Presentation Linkbase Document
104	The cover page from the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2022, has been formatted in Inline XBRL.

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: November 8, 2022

/s/ MARC D. MILLER

Marc D. Miller,
President and Chief Executive Officer
(Principal Executive Officer)

/s/ STEVE FILTON

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

Exhibit 4.1

THIRD SUPPLEMENTAL INDENTURE

This THIRD SUPPLEMENTAL INDENTURE, dated as of November 4, 2022 (this "Supplemental Indenture"), among Universal Health Services, Inc., a Delaware corporation (the "Issuer"), each of the direct or indirect subsidiaries of the Issuer identified on Schedule 1 attached hereto as a guaranteeing subsidiary (each, a "Guaranteeing Subsidiary" and collectively, the "Guaranteeing Subsidiaries"), the other Guarantors (as defined in the Indenture (defined below)), U.S. Bank Trust Company, National Association (as successor to U.S. Bank National Association), as trustee (the "Trustee").

RECITALS

WHEREAS, the Issuer and the Guarantors have heretofore executed and delivered to the Trustee an indenture, dated as of September 21, 2020 (the "Indenture"), providing for the issuance of 2.650% Senior Secured Notes due 2030 (the "Notes");

WHEREAS, the Issuer, the Guarantors and the Guaranteeing Subsidiaries have authorized the execution and delivery of this Supplemental Indenture, and all things necessary to make this Supplemental Indenture a valid agreement of the Issuer, the Guarantors, the Guaranteeing Subsidiaries and the Collateral Agent have been done;

WHEREAS, the Indenture provides that under certain circumstances each Guaranteeing Subsidiary shall execute and deliver to the Trustee a supplemental indenture pursuant to which each Guaranteeing Subsidiary shall unconditionally Guarantee all of the Issuer's Obligations under the Notes and the Indenture on the terms and conditions set forth herein and under the Indenture;

WHEREAS, Section 9.01(a)(5) of the Indenture provides that the Trustee may amend the Indenture to add a Guarantor of the Notes; and

WHEREAS, pursuant to Section 9.01 of the Indenture, the Trustee is authorized to execute and deliver this Supplemental Indenture;

NOW THEREFORE, in consideration of the foregoing and for other good and valuable consideration, the receipt of which is hereby acknowledged, the parties mutually covenant and agree for the equal and ratable benefit of the Holders as follows:

1. **Capitalized Terms**. Capitalized terms used herein without definition shall have the meanings assigned to them in the Indenture.

2. **Guarantor**. Each Guaranteeing Subsidiary hereby agrees to be a Guarantor under this Indenture and to be bound by the terms of the Indenture applicable to Guarantors, including Article 10 thereof. As of the date hereof, each Guaranteeing Subsidiary will be a Secured Guarantor.

3. **Ratification of the Indenture**. The Indenture, as supplemented by this Supplemental Indenture, is in all respects ratified and confirmed, and this Supplemental Indenture shall be deemed part of the Indenture in the manner and to the extent herein and therein provided.

4. **Governing Law**. THIS SUPPLEMENTAL INDENTURE WILL BE GOVERNED BY, AND CONSTRUED IN ACCORDANCE WITH, THE LAWS OF THE STATE OF NEW YORK.

5. **Waiver of Jury Trial**. EACH OF THE ISSUER, EACH GUARANTOR, EACH GUARANTEEING SUBSIDIARY AND THE TRUSTEE HEREBY IRREVOCABLY WAIVES, TO THE FULLEST EXTENT PERMITTED BY APPLICABLE LAW, ANY AND ALL RIGHT TO TRIAL BY JURY IN ANY LEGAL PROCEEDING ARISING OUT OF OR RELATING TO THIS SUPPLEMENTAL INDENTURE, THE INDENTURE, THE NOTES OR THE TRANSACTIONS CONTEMPLATED HEREBY OR THEREBY.

6. **Counterparts**. The parties may sign any number of copies of this Supplemental Indenture. Each signed copy shall be an original, but all of them together represent the same agreement.

7. **Headings**. The headings of the Sections of this Supplemental Indenture have been inserted for convenience of reference only, are not to be considered a part of this Supplemental Indenture and shall in no way modify or restrict any of the terms or provisions hereof.

[*Signature Page of Supplemental Indenture Follows*]

IN WITNESS WHEREOF, the parties hereto have caused this Supplemental Indenture to be duly executed, all as of the date first above written.

ISSUER:

UNIVERSAL HEALTH SERVICES, INC.,
as Issuer

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President, Chief Financial Officer

Secretary

TRUSTEE:

U.S. BANK TRUST COMPANY, NATIONAL ASSOCIATION, as Trustee

By: /s/ Gregory P. Guim
Name: Gregory P. Guim
Title: Vice President

GUARANTEEING SUBSIDIARIES:

DISTRICT HOSPITAL PARTNERS, L.P.

By: UHS of D.C., Inc., its General Partner

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

PASTEUR HEALTHCARE PROPERTIES, LLC

By: UHS of Delaware, Inc., its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President and Chief Financial Officer

UHS CAPITOL ACQUISITION, LLC

By: UHS of Delaware, Inc., its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President and Chief Financial Officer

GUARANTORS:

[Guarantor signature blocks begin on the following page]

UHS OF DELAWARE, INC.

By: /s/ Steve Filton

Name: Steve Filton

Title: Executive Vice President and Chief Financial Officer

LANCASTER HOSPITAL CORPORATION
MERION BUILDING MANAGEMENT, INC.
NORTHWEST TEXAS HEALTHCARE SYSTEM, INC.
UHS HOLDING COMPANY, INC.
UHS OF CORNERSTONE, INC.
UHS OF CORNERSTONE HOLDINGS, INC.
UHS OF D.C., INC.
UHS-CORONA, INC.
UNIVERSAL HEALTH SERVICES OF PALMDALE, INC.
VALLEY HOSPITAL MEDICAL CENTER, INC.
MCALLEN MEDICAL CENTER, INC.
SPARKS FAMILY HOSPITAL, INC.
UHS OF RIVER PARISHES, INC.
UHS OF TEXOMA, INC.
UNIVERSAL HEALTH SERVICES OF RANCHO SPRINGS, INC.

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

ABS LINCS SC, INC.
ABS LINCS VA, INC.
ALLIANCE HEALTH CENTER, INC.
ALTERNATIVE BEHAVIORAL SERVICES, INC.
ASCEND HEALTH CORPORATION
BENCHMARK BEHAVIORAL HEALTH SYSTEM, INC.
BHC ALHAMBRA HOSPITAL, INC.
BHC BELMONT PINES HOSPITAL, INC.
BHC FAIRFAX HOSPITAL, INC.
BHC FOX RUN HOSPITAL, INC.
BHC FREMONT HOSPITAL, INC.
BHC HEALTH SERVICES OF NEVADA, INC.
BHC HERITAGE OAKS HOSPITAL, INC.
BHC HOLDINGS, INC.
BHC INTERMOUNTAIN HOSPITAL, INC.
BHC MONTEVISTA HOSPITAL, INC.
BHC SIERRA VISTA HOSPITAL, INC.
BHC STREAMWOOD HOSPITAL, INC.
BRENTWOOD ACQUISITION, INC.
BRENTWOOD ACQUISITION - SHREVEPORT, INC.
BRYNN MARR HOSPITAL, INC.
CALVARY CENTER, INC.
CANYON RIDGE HOSPITAL, INC.
CCS/LANSING, INC.
CEDAR SPRINGS HOSPITAL, INC.
CHILDREN'S COMPREHENSIVE SERVICES, INC.
DEL AMO HOSPITAL, INC.
FIRST HOSPITAL CORPORATION OF VIRGINIA BEACH
FORT LAUDERDALE HOSPITAL, INC.
FRN, INC.
FRONTLINE BEHAVIORAL HEALTH, INC.
GREAT PLAINS HOSPITAL, INC.
GULF COAST TREATMENT CENTER, INC.
H. C. CORPORATION
HARBOR POINT BEHAVIORAL HEALTH CENTER, INC.
HAVENWYCK HOSPITAL INC.
HHC AUGUSTA, INC.
HHC DELAWARE, INC.
HHC INDIANA, INC.
HHC OHIO, INC.
HHC RIVER PARK, INC.
HHC SOUTH CAROLINA, INC.
HHC ST. SIMONS, INC.
HORIZON HEALTH AUSTIN, INC.
HORIZON HEALTH CORPORATION
HSA HILL CREST CORPORATION
KIDS BEHAVIORAL HEALTH OF UTAH, INC.
LAUREL OAKS BEHAVIORAL HEALTH CENTER, INC.
MERIDELL ACHIEVEMENT CENTER, INC.
MICHIGAN PSYCHIATRIC SERVICES, INC.
NORTH SPRING BEHAVIORAL HEALTHCARE, INC.
OAK PLAINS ACADEMY OF TENNESSEE, INC.
PARK HEALTHCARE COMPANY
PENNSYLVANIA CLINICAL SCHOOLS, INC.
PREMIER BEHAVIORAL SOLUTIONS, INC.
PREMIER BEHAVIORAL SOLUTIONS OF FLORIDA, INC.
PSYCHIATRIC SOLUTIONS, INC.
PSYCHIATRIC SOLUTIONS OF VIRGINIA, INC.
RAMSAY YOUTH SERVICES OF GEORGIA, INC.
RIVER OAKS, INC.
RIVEREDGE HOSPITAL HOLDINGS, INC.
SOUTHEASTERN HOSPITAL CORPORATION
SPRINGFIELD HOSPITAL, INC.
STONINGTON BEHAVIORAL HEALTH, INC.
SUMMIT OAKS HOSPITAL, INC.
TEMECULA VALLEY HOSPITAL, INC.
TEMPLE BEHAVIORAL HEALTHCARE HOSPITAL, INC.
TEXAS HOSPITAL HOLDINGS, INC.
THE ARBOUR, INC.
TWO RIVERS PSYCHIATRIC HOSPITAL, INC.
UHS CHILDREN SERVICES, INC.
UHS OF DENVER, INC.
UHS OF FAIRMOUNT, INC.
UHS OF FULLER, INC.
UHS OF GEORGIA, INC.
UHS OF GEORGIA HOLDINGS, INC.
UHS OF HAMPTON, INC.
UHS OF HARTGROVE, INC
UHS OF PARKWOOD, INC.
UHS OF PENNSYLVANIA, INC.
UHS OF PROVO CANYON, INC.
UHS OF PUERTO RICO, INC.
UHS OF SPRING MOUNTAIN, INC.

UHS OF TIMBERLAWN, INC.
UHS OF TIMPANOGOS, INC.
UHS OF WESTWOOD PEMBROKE, INC.
UHS OF WYOMING, INC.
UHS SAHARA, INC.
UNITED HEALTHCARE OF HARDIN, INC.
WINDMOOR HEALTHCARE INC.
WINDMOOR HEALTHCARE OF PINELLAS PARK, INC.
WISCONSIN AVENUE PSYCHIATRIC CENTER, INC.

UHS OF MADERA, INC.
FOREST VIEW PSYCHIATRIC HOSPITAL, INC.

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

AIKEN REGIONAL MEDICAL CENTERS, LLC
LA AMISTAD RESIDENTIAL TREATMENT CENTER, LLC
PALM POINT BEHAVIORAL HEALTH, LLC
TENNESSEE CLINICAL SCHOOLS, LLC
THE BRIDGEWAY, LLC
TURNING POINT CARE CENTER, LLC
UHS OF BENTON, LLC
UHS OF BOWLING GREEN, LLC
UHS OF GREENVILLE, LLC
UHS OF LAKESIDE, LLC
UHS OF PHOENIX, LLC
UHS OF RIDGE, LLC
UHS OF ROCKFORD, LLC
UHS OF TUCSON, LLC
UHS SUB III, LLC
UHSD, L.L.C.
WELLINGTON REGIONAL MEDICAL CENTER, LLC

By: Universal Health Services, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President, Secretary and Chief Financial Officer

FORT DUNCAN MEDICAL CENTER, L.P.

By: Fort Duncan Medical Center, Inc.
Its general partner

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

FRONTLINE HOSPITAL, LLC
FRONTLINE RESIDENTIAL TREATMENT CENTER, LLC

By: Frontline Behavioral Health, Inc.
Its sole member

By:	/s/ Steve Filton
Name:	Steve Filton
Title:	Vice President

KEYS GROUP HOLDINGS LLC

By: UHS Children Services, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

KEYSTONE/CCS PARTNERS LLC

By: Children's Comprehensive Services, Inc.
Its Minority Member

By: KEYS Group Holdings LLC
Its Managing Member and sole member of the minority member

By: UHS Children Services, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

KEYSTONE CONTINUUM, LLC
KEYSTONE NPS LLC
KEYSTONE RICHLAND CENTER LLC

By: Keystone/CCS Partners LLC
Its sole member
By: Children's Comprehensive Services, Inc.
Its minority member
By: KEYS Group Holdings LLC
Its managing member and sole member of the minority member
By: UHS Children Services, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

KEYSTONE EDUCATION AND YOUTH SERVICES, LLC

By: KEYS Group Holdings LLC
Its sole member
By: UHS Children Services, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

KEYSTONE MARION, LLC
KEYSTONE MEMPHIS, LLC
KEYSTONE NEWPORT NEWS, LLC
KEYSTONE WSNC, L.L.C.

By: Keystone Education and Youth Services, LLC
Its sole member
By: KEYS Group Holdings LLC
Its sole member
By: UHS Children Services, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

MANATEE MEMORIAL HOSPITAL, L.P.

By: Wellington Regional Medical Center, LLC
Its general partner

By: Universal Health Services, Inc.,
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President, Secretary and Chief Financial Officer

MCALLEN HOSPITALS, L.P.

By: McAllen Medical Center, Inc.
Its general partner

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

PENDLETON METHODIST HOSPITAL, L.L.C.

By: UHS of River Parishes, Inc.
Its managing member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

GULPH MILLS ASSOCIATES, LLC
TBD ACQUISITION II, LLC
UHS KENTUCKY HOLDINGS, L.L.C.
UHS OF LANCASTER, LLC
UHS OF NEW ORLEANS, LLC
UHS OF OKLAHOMA, LLC
UHSL, L.L.C.
AZ HOLDING 4, LLC
UHS MIDWEST BEHAVIORAL HEALTH, LLC
RIVERSIDE MEDICAL CLINIC PATIENT SERVICES, L.L.C.

By: UHS of Delaware, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President and Chief Financial Officer

UHS OF ANCHOR, L.P.
UHS OF LAUREL HEIGHTS, L.P.
UHS OF PEACHFORD, L.P.

By: UHS of Georgia, Inc.
Its general partner

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

UHS OF CENTENNIAL PEAKS, L.L.C.

By: UHS of Denver, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

UHS OF DOVER, L.L.C.

By: UHS of Rockford, LLC
Its sole member

By: Universal Health Services, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President, Secretary and Chief Financial Officer

UHS OF DOYLESTOWN, L.L.C.

By: UHS of Pennsylvania, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

UHS OF SALT LAKE CITY, L.L.C.

By: UHS of Provo Canyon, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

UHS OF SAVANNAH, L.L.C.

By: UHS of Georgia Holdings, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

UHS OKLAHOMA CITY LLC
UHS OF SPRINGWOODS, L.L.C.

By: UHS of New Orleans, LLC
Its sole member

By: UHS of Delaware, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President and Chief Financial Officer

UHS OF SUMMITRIDGE, L.L.C.

By: UHS of Peachford, L.P.
Its sole member
By: UHS of Georgia, Inc.
Its general partner

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

PSYCHIATRIC SOLUTIONS HOSPITALS, LLC

By: Psychiatric Solutions, Inc.
Its Sole Member

By:	/s/ Steve Filton
Name:	Steve Filton
Title:	Vice President

DIAMOND GROVE CENTER, LLC
KMI ACQUISITION, LLC
LIBERTY POINT BEHAVIORAL HEALTHCARE, LLC
PSJ ACQUISITION, LLC
SHADOW MOUNTAIN BEHAVIORAL HEALTH SYSTEM, LLC
SUNSTONE BEHAVIORAL HEALTH, LLC
TBD ACQUISITION, LLC

By: Psychiatric Solutions Hospitals, LLC
Its Sole Member

By: Psychiatric Solutions, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

ATLANTIC SHORES HOSPITAL, LLC
EMERALD COAST BEHAVIORAL HOSPITAL, LLC
OCALA BEHAVIORAL HEALTH, LLC
PALMETTO BEHAVIORAL HEALTH HOLDINGS, LLC
RAMSAY MANAGED CARE, LLC
SAMSON PROPERTIES, LLC
TBJ BEHAVIORAL CENTER, LLC
THREE RIVERS HEALTHCARE GROUP, LLC
WEKIVA SPRINGS CENTER, LLC
ZEUS ENDEAVORS, LLC

By: Premier Behavioral Solutions, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

PALMETTO BEHAVIORAL HEALTH SYSTEM, L.L.C.

By: Palmetto Behavioral Health Holdings, LLC
Its Sole Member

By: Premier Behavioral Solutions, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

PALMETTO LOWCOUNTRY BEHAVIORAL HEALTH, L.L.C.

By: Palmetto Behavioral Health System, L.L.C.
Its Sole Member

By: Palmetto Behavioral Health Holdings, LLC
Its Sole Member

By: Premier Behavioral Solutions, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

SP BEHAVIORAL, LLC
UNIVERSITY BEHAVIORAL, LLC

By: Ramsay Managed Care, LLC
Its Sole Member

By: Premier Behavioral Solutions, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

THREE RIVERS BEHAVIORAL HEALTH, LLC

By: Three Rivers Healthcare Group, LLC
Its Sole Member

By: Premier Behavioral Solutions, Inc.
Its Sole Member

By:	/s/ Steve Filton
Name:	Steve Filton
Title:	Vice President

THE NATIONAL DEAF ACADEMY, LLC

By: Zeus Endeavors, LLC
Its Sole Member

By: Premier Behavioral Solutions, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

WILLOW SPRINGS, LLC

By: BHC Health Services of Nevada, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

BEHAVIORAL HEALTHCARE LLC
By: BHC Holdings, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

BHC PINNACLE POINTE HOSPITAL, LLC
BHC PROPERTIES, LLC
COLUMBUS HOSPITAL PARTNERS, LLC
HOLLY HILL HOSPITAL, LLC
LEBANON HOSPITAL PARTNERS, LLC
NORTHERN INDIANA PARTNERS, LLC
ROLLING HILLS HOSPITAL, LLC
VALLE VISTA HOSPITAL PARTNERS, LLC

By: Behavioral Healthcare LLC
Its Sole Member

By: BHC Holdings, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

BHC MESILLA VALLEY HOSPITAL, LLC
BHC NORTHWEST PSYCHIATRIC HOSPITAL, LLC
CUMBERLAND HOSPITAL PARTNERS, LLC

By: BHC Properties, LLC
Its Sole Member

By: Behavioral Healthcare LLC
Its Sole Member

By: BHC Holdings, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

CUMBERLAND HOSPITAL, LLC

By: Cumberland Hospital Partners, LLC
Its Managing Member

By: BHC Properties, LLC
Its Minority Member and Sole Member of the Managing Member

By: Behavioral Healthcare LLC
Its Sole Member

By: BHC Holdings, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

VALLE VISTA, LLC

By: BHC of Indiana, General Partnership
Its Sole Member

By: Columbus Hospital Partners, LLC
Its General Partner

By: Lebanon Hospital Partners, LLC
Its General Partner

By: Northern Indiana Partners, LLC
Its General Partner

By: Valle Vista Hospital Partners, LLC
Its General Partner

By: Behavioral Healthcare LLC
The Sole Member of each of the above General Partners

By: BHC Holdings, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

WELLSTONE REGIONAL HOSPITAL ACQUISITION, LLC

By: Wellstone Holdings, Inc.
Its Minority Member

By: Behavioral Healthcare LLC
Its Managing Member and Sole Member of the Minority Member

By: BHC Holdings, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

HORIZON HEALTH HOSPITAL SERVICES, LLC
HORIZON MENTAL HEALTH MANAGEMENT, LLC

By: Horizon Health Corporation
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

HHC PENNSYLVANIA, LLC
HHC POPLAR SPRINGS, LLC
KINGWOOD PINES HOSPITAL, LLC
SCHICK SHADEL OF FLORIDA, LLC
TOLEDO HOLDING CO., LLC

By: Horizon Health Hospital Services, LLC
Its Sole Member

By: Horizon Health Corporation
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

HICKORY TRAIL HOSPITAL, L.P.
MILLWOOD HOSPITAL, L.P.
NEURO INSTITUTE OF AUSTIN, L.P.
TEXAS CYPRESS CREEK HOSPITAL, L.P.
TEXAS LAUREL RIDGE HOSPITAL, L.P.
TEXAS OAKS PSYCHIATRIC HOSPITAL, L.P.
TEXAS SAN MARCOS TREATMENT CENTER, L.P.
TEXAS WEST OAKS HOSPITAL, L.P.

By: Texas Hospital Holdings, LLC
Its General Partner

By: Psychiatric Solutions Hospitals, LLC
Its Sole Member

By: Psychiatric Solutions, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

SHC-KPH, LP

By: HHC Kingwood Investment, LLC
Its General Partner

By: Horizon Health Hospital Services, LLC
Sole member of the General Partner

By: Horizon Health Corporation
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

H.C. PARTNERSHIP

By: H. C. Corporation
Its General Partner

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

By: HSA Hill Crest Corporation
Its General Partner

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

BHC OF INDIANA, GENERAL PARTNERSHIP

By: Columbus Hospital Partners, LLC
Its General Partner

By: Lebanon Hospital Partners, LLC
Its General Partner

By: Northern Indiana Partners, LLC
Its General Partner

By: Valle Vista Hospital Partners, LLC
Its General Partner

By: BHC Healthcare, LLC
The Sole Member of each of the above General Partners

By: BHC Holdings, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

INDEPENDENCE PHYSICIAN MANAGEMENT, LLC

By: UHS of Fairmount, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

BEHAVIORAL HEALTH MANAGEMENT, LLC
BEHAVIORAL HEALTH REALTY, LLC
CAT REALTY, LLC
CAT SEATTLE, LLC
MAYHILL BEHAVIORAL HEALTH, LLC
PSYCHIATRIC REALTY, LLC
RR RECOVERY, LLC
SALT LAKE BEHAVIORAL HEALTH, LLC
SALT LAKE PSYCHIATRIC REALTY, LLC
UBH OF OREGON, LLC
UBH OF PHOENIX, LLC
UBH OF PHOENIX REALTY, LLC
UNIVERSITY BEHAVIORAL HEALTH OF EL PASO, LLC

By: Ascend Health Corporation
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

GARFIELD PARK HOSPITAL, LLC

By: UHS of Hartgrove, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

ABS LINCS KY, LLC
HUGHES CENTER, LLC

By: Alternative Behavioral Services, Inc.
Its sole member

By:	/s/ Steve Filton
Name:	Steve Filton
Title:	Vice President

VALLEY HEALTH SYSTEM LLC

By: Valley Hospital Medical Center, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

UHP LP

By: Island 77 LLC
Its general partner

By: Ascend Health Corporation
Its sole member

By:	/s/ Steve Filton
Name:	Steve Filton
Title:	Vice President

BEACH 77 LP

By: 2026 W. University Properties, LLC
Its general partner

By: Ascend Health Corporation
Its sole member

By:	/s/ Steve Filton
Name:	Steve Filton
Title:	Vice President

CORAL SHORES BEHAVIORAL HEALTH, LLC
By: Children's Comprehensive Services, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

DVH HOSPITAL ALLIANCE LLC

By: UHS Holding Company, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

DHP 2131 K ST, LLC

By: Universal Health Services, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President, Secretary and Chief Financial Officer

UHS FUNDING, LLC

By: UHS of Delaware, Inc.
Its majority member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President and Chief Financial Officer

By: Universal Health Services, Inc.
Its minority member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President, Chief Financial Officer and Secretary

MILWAUKEE BEHAVIORAL HEALTH, LLC

By: UHS of Delaware, Inc.
Its minority member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President and Chief Financial Officer

By: UHS Funding, LLC
Its majority member

By: UHS of Delaware, Inc.
Its majority member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President and Chief Financial Officer

FANNIN MANAGEMENT SERVICES, LLC

By: UHS of Texoma, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

RIDGE OUTPATIENT COUNSELING, L.L.C.

By: UHS of Ridge, LLC
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

BLOOMINGTON MEADOWS, GENERAL PARTNERSHIP

By: BHC of Indiana, General Partnership,
its General Partner
By: Columbus Hospital Partners, LLC,
its General Partner
By: Lebanon Hospital Partners, LLC,
its General Partner
By: Northern Indiana Partners, LLC,
its General Partner
By: Valle Vista Hospital Partners, LLC,
its General Partner

By: BHC Healthcare, LLC,
the Sole Member of each of the
above General Partners

By: BHC Holdings, Inc.
its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

By: Indiana Psychiatric Institutes, LLC,
its General Partner

By: BHC Healthcare, LLC,
its Sole Member

By: BHC Holdings, Inc.
its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

SCHEDULE 1

GUARANTEEING SUBSIDIARIES

1. District Hospital Partners, L.P., a District of Columbia limited partnership
2. Pasteur Healthcare Properties, LLC a Delaware limited liability company
3. UHS Capitol Acquisition, LLC, a Delaware limited liability company

Exhibit 4.2

SECOND SUPPLEMENTAL INDENTURE

This SECOND SUPPLEMENTAL INDENTURE, dated as of November 4, 2022 (this "Supplemental Indenture"), among Universal Health Services, Inc., a Delaware corporation (the "Issuer"), each of the direct or indirect subsidiaries of the Issuer identified on Schedule 1 attached hereto as a guaranteeing subsidiary (each, a "Guaranteeing Subsidiary" and collectively, the "Guaranteeing Subsidiaries"), the other Guarantors (as defined in the Indenture (defined below)), and U.S. Bank Trust Company, National Association (as successor to U.S. Bank National Association), as trustee (the "Trustee").

RECITALS

WHEREAS, the Issuer and the Guarantors have heretofore executed and delivered to the Trustee an indenture, dated as of August 24, 2021 (the "Indenture"), providing for the issuance of (i) 1.650% Senior Secured Notes due 2026 and (ii) 2.650% Senior Secured Notes due 2032 (collectively, the "Notes");

WHEREAS, the Issuer, the Guarantors and the Guaranteeing Subsidiaries have authorized the execution and delivery of this Supplemental Indenture, and all things necessary to make this Supplemental Indenture a valid agreement of the Issuer, the Guarantors, the Guaranteeing Subsidiaries and the Collateral Agent have been done;

WHEREAS, the Indenture provides that under certain circumstances each Guaranteeing Subsidiary shall execute and deliver to the Trustee a supplemental indenture pursuant to which each Guaranteeing Subsidiary shall unconditionally Guarantee all of the Issuer's Obligations under the Notes and the Indenture on the terms and conditions set forth herein and under the Indenture;

WHEREAS, Section 9.01(a)(5) of the Indenture provides that the Trustee may amend the Indenture to add a Guarantor of the Notes; and

WHEREAS, pursuant to Section 9.01 of the Indenture, the Trustee is authorized to execute and deliver this Supplemental Indenture;

NOW THEREFORE, in consideration of the foregoing and for other good and valuable consideration, the receipt of which is hereby acknowledged, the parties mutually covenant and agree for the equal and ratable benefit of the Holders as follows:

1. **Capitalized Terms**. Capitalized terms used herein without definition shall have the meanings assigned to them in the Indenture.

2. **Guarantor**. Each Guaranteeing Subsidiary hereby agrees to be a Guarantor under this Indenture and to be bound by the terms of the Indenture applicable to Guarantors, including Article 10 thereof. As of the date hereof, each Guaranteeing Subsidiary will be a Secured Guarantor.

3. **Ratification of the Indenture**. The Indenture, as supplemented by this Supplemental Indenture, is in all respects ratified and confirmed, and this Supplemental Indenture shall be deemed part of the Indenture in the manner and to the extent herein and therein provided.

4. **Governing Law**. THIS SUPPLEMENTAL INDENTURE WILL BE GOVERNED BY, AND CONSTRUED IN ACCORDANCE WITH, THE LAWS OF THE STATE OF NEW YORK.

5. **Waiver of Jury Trial**. EACH OF THE ISSUER, EACH GUARANTOR, EACH GUARANTEEING SUBSIDIARY AND THE TRUSTEE HEREBY IRREVOCABLY WAIVES, TO THE FULLEST EXTENT PERMITTED BY APPLICABLE LAW, ANY AND ALL RIGHT TO TRIAL BY JURY IN ANY LEGAL PROCEEDING ARISING OUT OF OR RELATING TO THIS SUPPLEMENTAL INDENTURE, THE INDENTURE, THE NOTES OR THE TRANSACTIONS CONTEMPLATED HEREBY OR THEREBY.

6. **Counterparts**. The parties may sign any number of copies of this Supplemental Indenture. Each signed copy shall be an original, but all of them together represent the same agreement.

7. **Headings**. The headings of the Sections of this Supplemental Indenture have been inserted for convenience of reference only, are not to be considered a part of this Supplemental Indenture and shall in no way modify or restrict any of the terms or provisions hereof.

[*Signature Page of Supplemental Indenture Follows*]

IN WITNESS WHEREOF, the parties hereto have caused this Supplemental Indenture to be duly executed, all as of the date first above written.

ISSUER:

UNIVERSAL HEALTH SERVICES, INC.,
as Issuer

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President, Chief Financial Officer

Secretary

TRUSTEE:

U.S. BANK TRUST COMPANY, NATIONAL ASSOCIATION, as Trustee

By: /s/ Gregory P. Guim
Name: Gregory P. Guim
Title: Vice President

GUARANTEEING SUBSIDIARIES:

DISTRICT HOSPITAL PARTNERS, L.P.

By: UHS of D.C., Inc., its General Partner

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

PASTEUR HEALTHCARE PROPERTIES, LLC

By: UHS of Delaware, Inc., its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President and Chief Financial Officer

UHS CAPITOL ACQUISITION, LLC

By: UHS of Delaware, Inc., its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President and Chief Financial Officer

GUARANTORS:

[Guarantor signature blocks begin on the following page]

UHS OF DELAWARE, INC.

By: /s/ Steve Filton

Name: Steve Filton

Title: Executive Vice President and Chief Financial Officer

LANCASTER HOSPITAL CORPORATION
MERION BUILDING MANAGEMENT, INC.
NORTHWEST TEXAS HEALTHCARE SYSTEM, INC.
UHS HOLDING COMPANY, INC.
UHS OF CORNERSTONE, INC.
UHS OF CORNERSTONE HOLDINGS, INC.
UHS OF D.C., INC.
UHS-CORONA, INC.
UNIVERSAL HEALTH SERVICES OF PALMDALE, INC.
VALLEY HOSPITAL MEDICAL CENTER, INC.
MCALLEN MEDICAL CENTER, INC.
SPARKS FAMILY HOSPITAL, INC.
UHS OF RIVER PARISHES, INC.
UHS OF TEXOMA, INC.
UNIVERSAL HEALTH SERVICES OF RANCHO SPRINGS, INC.

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

ABS LINCS SC, INC.
ABS LINCS VA, INC.
ALLIANCE HEALTH CENTER, INC.
ALTERNATIVE BEHAVIORAL SERVICES, INC.
ASCEND HEALTH CORPORATION
BENCHMARK BEHAVIORAL HEALTH SYSTEM, INC.
BHC ALHAMBRA HOSPITAL, INC.
BHC BELMONT PINES HOSPITAL, INC.
BHC FAIRFAX HOSPITAL, INC.
BHC FOX RUN HOSPITAL, INC.
BHC FREMONT HOSPITAL, INC.
BHC HEALTH SERVICES OF NEVADA, INC.
BHC HERITAGE OAKS HOSPITAL, INC.
BHC HOLDINGS, INC.
BHC INTERMOUNTAIN HOSPITAL, INC.
BHC MONTEVISTA HOSPITAL, INC.
BHC SIERRA VISTA HOSPITAL, INC.
BHC STREAMWOOD HOSPITAL, INC.
BRENTWOOD ACQUISITION, INC.
BRENTWOOD ACQUISITION - SHREVEPORT, INC.
BRYNN MARR HOSPITAL, INC.
CALVARY CENTER, INC.
CANYON RIDGE HOSPITAL, INC.
CCS/LANSING, INC.
CEDAR SPRINGS HOSPITAL, INC.
CHILDREN'S COMPREHENSIVE SERVICES, INC.
DEL AMO HOSPITAL, INC.
FIRST HOSPITAL CORPORATION OF VIRGINIA BEACH
FORT LAUDERDALE HOSPITAL, INC.
FRN, INC.
FRONTLINE BEHAVIORAL HEALTH, INC.
GREAT PLAINS HOSPITAL, INC.
GULF COAST TREATMENT CENTER, INC.
H. C. CORPORATION
HARBOR POINT BEHAVIORAL HEALTH CENTER, INC.
HAVENWYCK HOSPITAL INC.
HHC AUGUSTA, INC.
HHC DELAWARE, INC.
HHC INDIANA, INC.
HHC OHIO, INC.
HHC RIVER PARK, INC.
HHC SOUTH CAROLINA, INC.
HHC ST. SIMONS, INC.
HORIZON HEALTH AUSTIN, INC.
HORIZON HEALTH CORPORATION
HSA HILL CREST CORPORATION
KIDS BEHAVIORAL HEALTH OF UTAH, INC.
LAUREL OAKS BEHAVIORAL HEALTH CENTER, INC.
MERIDELL ACHIEVEMENT CENTER, INC.
MICHIGAN PSYCHIATRIC SERVICES, INC.
NORTH SPRING BEHAVIORAL HEALTHCARE, INC.
OAK PLAINS ACADEMY OF TENNESSEE, INC.
PARK HEALTHCARE COMPANY
PENNSYLVANIA CLINICAL SCHOOLS, INC.
PREMIER BEHAVIORAL SOLUTIONS, INC.
PREMIER BEHAVIORAL SOLUTIONS OF FLORIDA, INC.
PSYCHIATRIC SOLUTIONS, INC.
PSYCHIATRIC SOLUTIONS OF VIRGINIA, INC.
RAMSAY YOUTH SERVICES OF GEORGIA, INC.
RIVER OAKS, INC.
RIVEREDGE HOSPITAL HOLDINGS, INC.
SOUTHEASTERN HOSPITAL CORPORATION
SPRINGFIELD HOSPITAL, INC.
STONINGTON BEHAVIORAL HEALTH, INC.
SUMMIT OAKS HOSPITAL, INC.
TEMECULA VALLEY HOSPITAL, INC.
TEMPLE BEHAVIORAL HEALTHCARE HOSPITAL, INC.
TEXAS HOSPITAL HOLDINGS, INC.
THE ARBOUR, INC.
TWO RIVERS PSYCHIATRIC HOSPITAL, INC.
UHS CHILDREN SERVICES, INC.
UHS OF DENVER, INC.
UHS OF FAIRMOUNT, INC.
UHS OF FULLER, INC.
UHS OF GEORGIA, INC.
UHS OF GEORGIA HOLDINGS, INC.
UHS OF HAMPTON, INC.
UHS OF HARTGROVE, INC
UHS OF PARKWOOD, INC.
UHS OF PENNSYLVANIA, INC.
UHS OF PROVO CANYON, INC.
UHS OF PUERTO RICO, INC.
UHS OF SPRING MOUNTAIN, INC.

UHS OF TIMBERLAWN, INC.
UHS OF TIMPANOGOS, INC.
UHS OF WESTWOOD PEMBROKE, INC.
UHS OF WYOMING, INC.
UHS SAHARA, INC.
UNITED HEALTHCARE OF HARDIN, INC.
WINDMOOR HEALTHCARE INC.
WINDMOOR HEALTHCARE OF PINELLAS PARK, INC.
WISCONSIN AVENUE PSYCHIATRIC CENTER, INC.

UHS OF MADERA, INC.
FOREST VIEW PSYCHIATRIC HOSPITAL, INC.

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

AIKEN REGIONAL MEDICAL CENTERS, LLC
LA AMISTAD RESIDENTIAL TREATMENT CENTER, LLC
PALM POINT BEHAVIORAL HEALTH, LLC
TENNESSEE CLINICAL SCHOOLS, LLC
THE BRIDGEWAY, LLC
TURNING POINT CARE CENTER, LLC
UHS OF BENTON, LLC
UHS OF BOWLING GREEN, LLC
UHS OF GREENVILLE, LLC
UHS OF LAKESIDE, LLC
UHS OF PHOENIX, LLC
UHS OF RIDGE, LLC
UHS OF ROCKFORD, LLC
UHS OF TUCSON, LLC
UHS SUB III, LLC
UHSD, L.L.C.
WELLINGTON REGIONAL MEDICAL CENTER, LLC

By: Universal Health Services, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President, Secretary and Chief Financial Officer

FORT DUNCAN MEDICAL CENTER, L.P.

By: Fort Duncan Medical Center, Inc.
Its general partner

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

FRONTLINE HOSPITAL, LLC
FRONTLINE RESIDENTIAL TREATMENT CENTER, LLC

By: Frontline Behavioral Health, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

KEYS GROUP HOLDINGS LLC

By: UHS Children Services, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

KEYSTONE/CCS PARTNERS LLC

By: Children's Comprehensive Services, Inc.
Its Minority Member

By: KEYS Group Holdings LLC
Its Managing Member and sole member of the minority member

By: UHS Children Services, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

KEYSTONE CONTINUUM, LLC
KEYSTONE NPS LLC
KEYSTONE RICHLAND CENTER LLC

By: Keystone/CCS Partners LLC
Its sole member
By: Children's Comprehensive Services, Inc.
Its minority member
By: KEYS Group Holdings LLC
Its managing member and sole member of the minority member
By: UHS Children Services, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

KEYSTONE EDUCATION AND YOUTH SERVICES, LLC

By: KEYS Group Holdings LLC
Its sole member
By: UHS Children Services, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

KEYSTONE MARION, LLC
KEYSTONE MEMPHIS, LLC
KEYSTONE NEWPORT NEWS, LLC
KEYSTONE WSNC, L.L.C.

By: Keystone Education and Youth Services, LLC
Its sole member
By: KEYS Group Holdings LLC
Its sole member
By: UHS Children Services, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

MANATEE MEMORIAL HOSPITAL, L.P.

By: Wellington Regional Medical Center, LLC
Its general partner

By: Universal Health Services, Inc.,
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President, Secretary and Chief Financial Officer

MCALLEN HOSPITALS, L.P.

By: McAllen Medical Center, Inc.
Its general partner

By:	/s/ Steve Filton
Name:	Steve Filton
Title:	Vice President

PENDLETON METHODIST HOSPITAL, L.L.C.

By: UHS of River Parishes, Inc.
Its managing member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

GULPH MILLS ASSOCIATES, LLC
TBD ACQUISITION II, LLC
UHS KENTUCKY HOLDINGS, L.L.C.
UHS OF LANCASTER, LLC
UHS OF NEW ORLEANS, LLC
UHS OF OKLAHOMA, LLC
UHSL, L.L.C.
AZ HOLDING 4, LLC
UHS MIDWEST BEHAVIORAL HEALTH, LLC
RIVERSIDE MEDICAL CLINIC PATIENT SERVICES, L.L.C.

By: UHS of Delaware, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President and Chief Financial Officer

UHS OF ANCHOR, L.P.
UHS OF LAUREL HEIGHTS, L.P.
UHS OF PEACHFORD, L.P.

By: UHS of Georgia, Inc.
Its general partner

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

UHS OF CENTENNIAL PEAKS, L.L.C.

By: UHS of Denver, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

UHS OF DOVER, L.L.C.

By: UHS of Rockford, LLC
Its sole member

By: Universal Health Services, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President, Secretary and Chief Financial Officer

UHS OF DOYLESTOWN, L.L.C.

By: UHS of Pennsylvania, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

UHS OF SALT LAKE CITY, L.L.C.

By: UHS of Provo Canyon, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

UHS OF SAVANNAH, L.L.C.

By: UHS of Georgia Holdings, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

UHS OKLAHOMA CITY LLC
UHS OF SPRINGWOODS, L.L.C.

By: UHS of New Orleans, LLC
Its sole member

By: UHS of Delaware, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President and Chief Financial Officer

UHS OF SUMMITRIDGE, L.L.C.

By: UHS of Peachford, L.P.
Its sole member
By: UHS of Georgia, Inc.
Its general partner

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

PSYCHIATRIC SOLUTIONS HOSPITALS, LLC

By: Psychiatric Solutions, Inc.
Its Sole Member

By:	/s/ Steve Filton
Name:	Steve Filton
Title:	Vice President

DIAMOND GROVE CENTER, LLC
KMI ACQUISITION, LLC
LIBERTY POINT BEHAVIORAL HEALTHCARE, LLC
PSJ ACQUISITION, LLC
SHADOW MOUNTAIN BEHAVIORAL HEALTH SYSTEM, LLC
SUNSTONE BEHAVIORAL HEALTH, LLC
TBD ACQUISITION, LLC

By: Psychiatric Solutions Hospitals, LLC
Its Sole Member

By: Psychiatric Solutions, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

ATLANTIC SHORES HOSPITAL, LLC
EMERALD COAST BEHAVIORAL HOSPITAL, LLC
OCALA BEHAVIORAL HEALTH, LLC
PALMETTO BEHAVIORAL HEALTH HOLDINGS, LLC
RAMSAY MANAGED CARE, LLC
SAMSON PROPERTIES, LLC
TBJ BEHAVIORAL CENTER, LLC
THREE RIVERS HEALTHCARE GROUP, LLC
WEKIVA SPRINGS CENTER, LLC
ZEUS ENDEAVORS, LLC

By: Premier Behavioral Solutions, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

PALMETTO BEHAVIORAL HEALTH SYSTEM, L.L.C.

By: Palmetto Behavioral Health Holdings, LLC
Its Sole Member

By: Premier Behavioral Solutions, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

PALMETTO LOWCOUNTRY BEHAVIORAL HEALTH, L.L.C.

By: Palmetto Behavioral Health System, L.L.C.
Its Sole Member

By: Palmetto Behavioral Health Holdings, LLC
Its Sole Member

By: Premier Behavioral Solutions, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

SP BEHAVIORAL, LLC
UNIVERSITY BEHAVIORAL, LLC

By: Ramsay Managed Care, LLC
Its Sole Member

By: Premier Behavioral Solutions, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

THREE RIVERS BEHAVIORAL HEALTH, LLC

By: Three Rivers Healthcare Group, LLC
Its Sole Member

By: Premier Behavioral Solutions, Inc.
Its Sole Member

By:	/s/ Steve Filton
Name:	Steve Filton
Title:	Vice President

THE NATIONAL DEAF ACADEMY, LLC

By: Zeus Endeavors, LLC
Its Sole Member

By: Premier Behavioral Solutions, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

WILLOW SPRINGS, LLC

By: BHC Health Services of Nevada, Inc.
Its Sole Member

By:	/s/ Steve Filton
Name:	Steve Filton
Title:	Vice President

BEHAVIORAL HEALTHCARE LLC
By: BHC Holdings, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

BHC PINNACLE POINTE HOSPITAL, LLC
BHC PROPERTIES, LLC
COLUMBUS HOSPITAL PARTNERS, LLC
HOLLY HILL HOSPITAL, LLC
LEBANON HOSPITAL PARTNERS, LLC
NORTHERN INDIANA PARTNERS, LLC
ROLLING HILLS HOSPITAL, LLC
VALLE VISTA HOSPITAL PARTNERS, LLC

By: Behavioral Healthcare LLC
Its Sole Member

By: BHC Holdings, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

BHC MESILLA VALLEY HOSPITAL, LLC
BHC NORTHWEST PSYCHIATRIC HOSPITAL, LLC
CUMBERLAND HOSPITAL PARTNERS, LLC

By: BHC Properties, LLC
Its Sole Member

By: Behavioral Healthcare LLC
Its Sole Member

By: BHC Holdings, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

CUMBERLAND HOSPITAL, LLC

By: Cumberland Hospital Partners, LLC
Its Managing Member

By: BHC Properties, LLC
Its Minority Member and Sole Member of the Managing Member

By: Behavioral Healthcare LLC
Its Sole Member

By: BHC Holdings, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

VALLE VISTA, LLC

By: BHC of Indiana, General Partnership
Its Sole Member

By: Columbus Hospital Partners, LLC
Its General Partner

By: Lebanon Hospital Partners, LLC
Its General Partner

By: Northern Indiana Partners, LLC
Its General Partner

By: Valle Vista Hospital Partners, LLC
Its General Partner

By: Behavioral Healthcare LLC
The Sole Member of each of the above General Partners

By: BHC Holdings, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

WELLSTONE REGIONAL HOSPITAL ACQUISITION, LLC

By: Wellstone Holdings, Inc.
Its Minority Member

By: Behavioral Healthcare LLC
Its Managing Member and Sole Member of the Minority Member

By: BHC Holdings, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

HORIZON HEALTH HOSPITAL SERVICES, LLC
HORIZON MENTAL HEALTH MANAGEMENT, LLC

By: Horizon Health Corporation
Its Sole Member

By:	/s/ Steve Filton
Name:	Steve Filton
Title:	Vice President

HHC PENNSYLVANIA, LLC
HHC POPLAR SPRINGS, LLC
KINGWOOD PINES HOSPITAL, LLC
SCHICK SHADEL OF FLORIDA, LLC
TOLEDO HOLDING CO., LLC

By: Horizon Health Hospital Services, LLC
Its Sole Member

By: Horizon Health Corporation
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

HICKORY TRAIL HOSPITAL, L.P.
MILLWOOD HOSPITAL, L.P.
NEURO INSTITUTE OF AUSTIN, L.P.
TEXAS CYPRESS CREEK HOSPITAL, L.P.
TEXAS LAUREL RIDGE HOSPITAL, L.P.
TEXAS OAKS PSYCHIATRIC HOSPITAL, L.P.
TEXAS SAN MARCOS TREATMENT CENTER, L.P.
TEXAS WEST OAKS HOSPITAL, L.P.

By: Texas Hospital Holdings, LLC
Its General Partner

By: Psychiatric Solutions Hospitals, LLC
Its Sole Member

By: Psychiatric Solutions, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

SHC-KPH, LP

By: HHC Kingwood Investment, LLC
Its General Partner

By: Horizon Health Hospital Services, LLC
Sole member of the General Partner

By: Horizon Health Corporation
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

H.C. PARTNERSHIP

By: H. C. Corporation
Its General Partner

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

By: HSA Hill Crest Corporation
Its General Partner

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

BHC OF INDIANA, GENERAL PARTNERSHIP

By: Columbus Hospital Partners, LLC
Its General Partner

By: Lebanon Hospital Partners, LLC
Its General Partner

By: Northern Indiana Partners, LLC
Its General Partner

By: Valle Vista Hospital Partners, LLC
Its General Partner

By: BHC Healthcare, LLC
The Sole Member of each of the above General Partners

By: BHC Holdings, Inc.
Its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

INDEPENDENCE PHYSICIAN MANAGEMENT, LLC

By: UHS of Fairmount, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

BEHAVIORAL HEALTH MANAGEMENT, LLC
BEHAVIORAL HEALTH REALTY, LLC
CAT REALTY, LLC
CAT SEATTLE, LLC
MAYHILL BEHAVIORAL HEALTH, LLC
PSYCHIATRIC REALTY, LLC
RR RECOVERY, LLC
SALT LAKE BEHAVIORAL HEALTH, LLC
SALT LAKE PSYCHIATRIC REALTY, LLC
UBH OF OREGON, LLC
UBH OF PHOENIX, LLC
UBH OF PHOENIX REALTY, LLC
UNIVERSITY BEHAVIORAL HEALTH OF EL PASO, LLC

By: Ascend Health Corporation
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

GARFIELD PARK HOSPITAL, LLC

By: UHS of Hartgrove, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

ABS LINCS KY, LLC
HUGHES CENTER, LLC

By: Alternative Behavioral Services, Inc.
Its sole member

By:	/s/ Steve Filton
Name:	Steve Filton
Title:	Vice President

VALLEY HEALTH SYSTEM LLC

By: Valley Hospital Medical Center, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

UHP LP

By: Island 77 LLC
Its general partner

By: Ascend Health Corporation
Its sole member

By:	/s/ Steve Filton
Name:	Steve Filton
Title:	Vice President

BEACH 77 LP

By: 2026 W. University Properties, LLC
Its general partner

By: Ascend Health Corporation
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

CORAL SHORES BEHAVIORAL HEALTH, LLC
By: Children's Comprehensive Services, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

DVH HOSPITAL ALLIANCE LLC

By: UHS Holding Company, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

DHP 2131 K ST, LLC

By: Universal Health Services, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President, Secretary and Chief Financial Officer

UHS FUNDING, LLC

By: UHS of Delaware, Inc.
Its majority member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President and Chief Financial Officer

By: Universal Health Services, Inc.
Its minority member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President, Chief Financial Officer and Secretary

MILWAUKEE BEHAVIORAL HEALTH, LLC

By: UHS of Delaware, Inc.
Its minority member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President and Chief Financial Officer

By: UHS Funding, LLC
Its majority member

By: UHS of Delaware, Inc.
Its majority member

By: /s/ Steve Filton
Name: Steve Filton
Title: Executive Vice President and Chief Financial Officer

FANNIN MANAGEMENT SERVICES, LLC

By: UHS of Texoma, Inc.
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

RIDGE OUTPATIENT COUNSELING, L.L.C.

By: UHS of Ridge, LLC
Its sole member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

BLOOMINGTON MEADOWS, GENERAL PARTNERSHIP

By: BHC of Indiana, General Partnership,
its General Partner
By: Columbus Hospital Partners, LLC,
its General Partner
By: Lebanon Hospital Partners, LLC,
its General Partner
By: Northern Indiana Partners, LLC,
its General Partner
By: Valle Vista Hospital Partners, LLC,
its General Partner

By: BHC Healthcare, LLC,
the Sole Member of each of the
above General Partners

By: BHC Holdings, Inc.
its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

By: Indiana Psychiatric Institutes, LLC,
its General Partner

By: BHC Healthcare, LLC,
its Sole Member

By: BHC Holdings, Inc.
its Sole Member

By: /s/ Steve Filton
Name: Steve Filton
Title: Vice President

SCHEDULE 1

GUARANTEEING SUBSIDIARIES

1. District Hospital Partners, L.P., a District of Columbia limited partnership
2. Pasteur Healthcare Properties, LLC a Delaware limited liability company
3. UHS Capitol Acquisition, LLC, a Delaware limited liability company

Exhibit 10.2
EXECUTION VERSION

ELEVENTH AMENDMENT
TO
AMENDED AND RESTATED CREDIT AND SECURITY AGREEMENT

This ELEVENTH AMENDMENT TO AMENDED AND RESTATED CREDIT AND SECURITY AGREEMENT (this "Amendment"), dated as of September 20, 2022, is entered into by and among the following parties:

(i) the Borrowers identified on the signature pages hereto;

(ii) UHS Receivables Corp., as Collection Agent;

(iii) UHS of Delaware, Inc., as Servicer;

(iv) Universal Health Services, Inc., as Performance Guarantor; and

(v) PNC Bank, National Association ("PNC"), as Liquidity Bank, LC Participant for PNC's Lender Group, Co-Agent for PNC's Lender Group, LC Bank, and Administrative Agent.

Capitalized terms used but not otherwise defined herein have the respective meanings set forth in the Credit and Security Agreement defined below.

BACKGROUND

1. The parties hereto have entered into that certain Amended and Restated Credit and Security Agreement, dated as of October 27, 2010 (as amended, supplemented and otherwise modified from time to time, the "Credit and Security Agreement").

2. The parties hereto desire to amend the Credit and Security Agreement as set forth herein.

NOW, THEREFORE, for good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, the parties hereto agree as follows:

SECTION 1. Amendment to the Credit and Security Agreement. The definition of "Facility Termination Date" in Exhibit I to the Credit and Security Agreement is hereby replaced in its entirety with the following:

"***Facility Termination Date***" means the earlier of (i) December 19, 2022 and (ii) the Amortization Date.

SECTION 2. Representations and Warranties. Each Borrower, the Collection Agent, the Servicer and the Performance Guarantor hereby represents and warrants to the Lenders, the Co-Agents and the Administrative Agent as follows:

(a) Representations and Warranties. The representations and warranties made by such Person in the Transaction Documents are true and correct as of the date hereof and

after giving effect to this Amendment (unless stated to relate solely to an earlier date, in which case such representations or warranties were true and correct as of such earlier date).

(b) Enforceability. The execution and delivery by such Person of this Amendment, and the performance of each of its obligations under this Amendment and the other Transaction Documents to which such Person is a party, as amended hereby, are within each of its organizational powers and have been duly authorized by all necessary organizational action on its part. This Amendment and the other Transaction Documents to which such Person is a party, as amended hereby, are such Person's valid and legally binding obligations, enforceable in accordance with its terms.

(c) No Amortization Event. After giving effect to this Amendment and the transactions contemplated hereby, no Amortization Event or Unmatured Amortization Event has occurred and is continuing.

SECTION 3. Effectiveness. This Amendment shall become effective on the date hereof (the "Effective Date") upon receipt by the Administrative Agent of the counterparts to this Amendment executed by each of the parties hereto.

SECTION 4. CHOICE OF LAW; CONSENT TO JURISDICTION.

(a) THIS AMENDMENT SHALL BE GOVERNED AND CONSTRUED IN ACCORDANCE WITH THE LAWS OF THE STATE OF NEW YORK, WITHOUT REGARD TO ANY PRINCIPLES OF CONFLICTS OF LAWS THEREOF.

(b) EACH PARTY TO THIS AMENDMENT HEREBY IRREVOCABLY SUBMITS TO THE NON-EXCLUSIVE JURISDICTION OF ANY UNITED STATES FEDERAL OR NEW YORK STATE COURT SITTING IN THE BOROUGH OF MANHATTAN, NEW YORK, IN ANY ACTION OR PROCEEDING ARISING OUT OF OR RELATING TO THIS AMENDMENT OR ANY DOCUMENT EXECUTED BY SUCH PERSON PURSUANT TO THIS AMENDMENT, AND EACH SUCH PARTY HEREBY IRREVOCABLY AGREES THAT ALL CLAIMS IN RESPECT OF SUCH ACTION OR PROCEEDING MAY BE HEARD AND DETERMINED IN ANY SUCH COURT AND IRREVOCABLY WAIVES ANY OBJECTION IT MAY NOW OR HEREAFTER HAVE AS TO THE VENUE OF ANY SUCH SUIT, ACTION OR PROCEEDING BROUGHT IN SUCH A COURT OR THAT SUCH COURT IS AN INCONVENIENT FORUM. NOTHING HEREIN SHALL LIMIT THE RIGHT OF ANY AGENT OR ANY LENDER TO BRING PROCEEDINGS AGAINST ANY LOAN PARTY IN THE COURTS OF ANY OTHER JURISDICTION. ANY JUDICIAL PROCEEDING BY ANY LOAN PARTY AGAINST THE AGENT OR ANY LENDER OR ANY AFFILIATE OF THE AGENT OR ANY LENDER INVOLVING, DIRECTLY OR INDIRECTLY, ANY MATTER IN ANY WAY ARISING OUT OF, RELATED TO, OR CONNECTED WITH THIS AMENDMENT OR ANY DOCUMENT EXECUTED BY SUCH LOAN PARTY PURSUANT TO THIS AMENDMENT SHALL BE BROUGHT ONLY IN A COURT IN THE BOROUGH OF MANHATTAN, NEW YORK.

SECTION 5. Effect of Amendment. All provisions of the Credit and Security Agreement, as expressly amended and modified by this Amendment, shall remain in full force and effect. After this Amendment becomes effective, all references in the Credit and Security Agreement (or in any other Transaction Document) to "this Agreement", "hereof", "herein" or words of similar effect referring to the Credit and Security Agreement shall be deemed to be references to the Credit and Security Agreement as amended by this Amendment. This Amendment shall not be deemed, either expressly or impliedly, to waive, amend or supplement any provision of the Credit and Security Agreement other than as set forth herein.

SECTION 6. Counterparts. This Amendment may be executed in any number of counterparts and by different parties on separate counterparts, each counterpart shall be deemed to be an original, and all such counterparts shall together constitute but one and the same agreement. Delivery of an executed counterpart of a signature page to this Amendment by facsimile or other electronic means shall be effective as delivery of a manually executed counterpart of this Amendment.

SECTION 7. Transaction Document. This Amendment shall constitute a Transaction Document for all purposes.

SECTION 8. Section Headings. The various headings of this Amendment are included for convenience only and shall not affect the meaning or interpretation of this Amendment, the Credit and Security Agreement or any provision hereof or thereof.

SECTION 9. Severability. If any one or more of the agreements, provisions or terms of this Amendment shall for any reason whatsoever be held invalid or unenforceable, then such agreements, provisions or terms shall be deemed severable from the remaining agreements, provisions and terms of this Amendment and shall in no way affect the validity or enforceability of the provisions of this Amendment or the Credit and Security Agreement.

SECTION 10. Ratification. After giving effect to this Amendment and each of the other agreements, documents and instruments contemplated in connection herewith, the Performance Undertaking, along with each of the provisions thereof, remains in full force and effect and is hereby ratified and reaffirmed by the Performance Guarantor and each of the other parties hereto.

[Signature pages follow.]

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date first written above.

AIKEN REGIONAL RECEIVABLES, L.L.C.,
DISTRICT HOSPITAL PARTNERS RECEIVABLES, L.L.C.,
FORT DUNCAN MEDICAL RECEIVABLES, L.L.C.,
LANCASTER HOSPITAL RECEIVABLES, L.L.C.,
LAREDO REGIONAL RECEIVABLES, L.L.C.,
MANATEE MEMORIAL RECEIVABLES, L.L.C.,
MCALLEN HOSPITALS RECEIVABLES, L.L.C.,
NORTHWEST TEXAS HEALTHCARE RECEIVABLES, L.L.C.,
SPARKS FAMILY HOSPITAL RECEIVABLES, L.L.C.,
SUMMERLIN HOSPITAL RECEIVABLES, L.L.C.,
TEMECULA VALLEY HOSPITAL RECEIVABLES, L.L.C.,
TEXOMA HEALTHCARE SYSTEM RECEIVABLES, L.L.C.,
UHS OF OKLAHOMA RECEIVABLES, L.L.C.,
UHS-CORONA RECEIVABLES, L.L.C.,
RANCHO SPRINGS RECEIVABLES, L.L.C.,
VALLEY HEALTH SYSTEM RECEIVABLES, L.L.C. AND
WELLINGTON REGIONAL RECEIVABLES, L.L.C.,
AS BORROWERS

By:/s/ Cheryl K. Ramagano
Name: Cheryl K. Ramagano
Title: Treasurer

UHS RECEIVABLES CORP.,
AS COLLECTION AGENT

By:/s/ Cheryl K. Ramagano
Name: Cheryl K. Ramagano
Title: Treasurer

UHS OF DELAWARE, INC.,
AS SERVICER

By:/s/ Cheryl K. Ramagano
Name: Cheryl K. Ramagano
Title: Sr. Vice President and Treasurer

UNIVERSAL HEALTH SERVICES, INC.,
AS PERFORMANCE GUARANTOR

By:/s/ Cheryl K. Ramagano
Name: Cheryl K. Ramagano
Title: Sr. Vice President and Treasurer

PNC BANK, NATIONAL ASSOCIATION,
AS LC PARTICIPANT, LIQUIDITY BANK
AND AS LC BANK

By:/s/ Eric Bruno
Name: Eric Bruno
Title: Senior Vice President

PNC BANK, NATIONAL ASSOCIATION,
AS CO-AGENT AND ADMINISTRATIVE AGENT

By:/s/ Eric Bruno
Name: Eric Bruno
Title: Senior Vice President

Subsidiary Guarantors and Issuers of Guaranteed Securities and Affiliates Whose Securities Collateralize Securities of the Registrant

Guaranteed Securities

The following securities (collectively, the "UHS Senior Secured Notes") issued by Universal Health Services, Inc., a Delaware corporation (the "Company"), were outstanding as of November 8, 2022.

Description of Notes

1.650% Senior Secured Notes due 2026
2.650% Senior Secured Notes due 2030
2.650% Senior Secured Notes due 2032

Obligors

The obligors under the UHS Senior Secured Notes consisted of the Company, as issuer, and its subsidiaries listed in the following table, as Guarantors.

Name of Subsidiary	Jurisdiction of Organization	Obligor Type
ABS LINCS KY, LLC	Virginia	Guarantor
ABS LINCS SC, Inc.	South Carolina	Guarantor
ABS LINCS VA, Inc.	Virginia	Guarantor
Aiken Regional Medical Centers, LLC	South Carolina	Guarantor
Alliance Health Center, Inc.	Mississippi	Guarantor
Alternative Behavioral Services, Inc.	Virginia	Guarantor
Ascend Health Corporation	Delaware	Guarantor
Atlantic Shores Hospital, LLC	Delaware	Guarantor
AZ Holding 4, LLC	Arizona	Guarantor
Beach 77, LP	Delaware	Guarantor
Behavioral Health Management, LLC	Delaware	Guarantor
Behavioral Health Realty, LLC	Delaware	Guarantor
Behavioral Healthcare LLC	Delaware	Guarantor
Benchmark Behavioral Health System, Inc.	Utah	Guarantor
BHC Alhambra Hospital, Inc.	Tennessee	Guarantor
BHC Belmont Pines Hospital, Inc.	Tennessee	Guarantor

Name of Subsidiary	Jurisdiction of Organization	Obligor Type
BHC Fairfax Hospital, Inc.	Tennessee	Guarantor
BHC Fox Run Hospital, Inc.	Tennessee	Guarantor
BHC Fremont Hospital, Inc.	Tennessee	Guarantor
BHC Health Services of Nevada, Inc.	Nevada	Guarantor
BHC Heritage Oaks Hospital, Inc.	Tennessee	Guarantor
BHC Holdings, Inc.	Delaware	Guarantor
BHC Intermountain Hospital, Inc.	Tennessee	Guarantor
BHC Mesilla Valley Hospital, LLC	Delaware	Guarantor
BHC Montevista Hospital, Inc.	Nevada	Guarantor
BHC Northwest Psychiatric Hospital, LLC	Delaware	Guarantor
BHC Of Indiana, General Partnership	Tennessee	Guarantor
BHC Pinnacle Pointe Hospital, LLC	Tennessee	Guarantor
BHC Properties, LLC	Tennessee	Guarantor
BHC Sierra Vista Hospital, Inc.	Tennessee	Guarantor
BHC Streamwood Hospital, Inc.	Tennessee	Guarantor
Bloomington Meadows, General Partnership	Tennessee	Guarantor
Brentwood Acquisition - Shreveport, Inc.	Delaware	Guarantor
Brentwood Acquisition, Inc.	Tennessee	Guarantor
Brynn Marr Hospital, Inc.	North Carolina	Guarantor
Calvary Center, Inc.	Delaware	Guarantor
Canyon Ridge Hospital, Inc.	California	Guarantor
CAT Realty, LLC	Delaware	Guarantor
CAT Seattle, LLC	Delaware	Guarantor
CCS/Lansing, Inc.	Michigan	Guarantor
Cedar Springs Hospital, Inc.	Delaware	Guarantor
Children’s Comprehensive Services, Inc.	Tennessee	Guarantor
Columbus Hospital Partners, LLC	Tennessee	Guarantor
Coral Shores Behavioral Health, LLC	Delaware	Guarantor
Cumberland Hospital Partners, LLC	Delaware	Guarantor
Cumberland Hospital, LLC	Virginia	Guarantor
Del Amo Hospital, Inc.	California	Guarantor
DHP 2131 K St, LLC	Delaware	Guarantor
Diamond Grove Center, LLC	Delaware	Guarantor

Name of Subsidiary	Jurisdiction of Organization	Obligor Type
District Hospital Partners, L.P.	District of Columbia	Guarantor
DVH Hospital Alliance LLC	Delaware	Guarantor
Emerald Coast Behavioral Hospital, LLC	Delaware	Guarantor
Fannin Management Services, LLC	Texas	Guarantor
First Hospital Corporation of Virginia Beach	Virginia	Guarantor
Forest View Psychiatric Hospital, Inc.	Michigan	Guarantor
Fort Duncan Medical Center, L.P.	Delaware	Guarantor
Fort Lauderdale Hospital, Inc.	Florida	Guarantor
FRN, INC.	Delaware	Guarantor
Frontline Behavioral Health, Inc.	Delaware	Guarantor
Frontline Hospital, LLC	Delaware	Guarantor
Frontline Residential Treatment Center, LLC	Delaware	Guarantor
Garfield Park Hospital, LLC	Illinois	Guarantor
Great Plains Hospital, Inc.	Missouri	Guarantor
Gulf Coast Treatment Center, Inc.	Florida	Guarantor
Gulph Mills Associates, LLC	Pennsylvania	Guarantor
H. C. Corporation	Alabama	Guarantor
H.C. Partnership	Alabama	Guarantor
Harbor Point Behavioral Health Center, Inc.	Virginia	Guarantor
Havenwyck Hospital, Inc.	Michigan	Guarantor
HHC Augusta, Inc.	Georgia	Guarantor
HHC Delaware, Inc.	Delaware	Guarantor
HHC Indiana, Inc.	Indiana	Guarantor
HHC Ohio, Inc.	Ohio	Guarantor
HHC Pennsylvania, LLC	Delaware	Guarantor
HHC Poplar Springs, LLC	Virginia	Guarantor
HHC River Park, Inc.	West Virginia	Guarantor
HHC South Carolina, Inc.	South Carolina	Guarantor
HHC St. Simons, Inc.	Georgia	Guarantor
Hickory Trail Hospital, L.P.	Delaware	Guarantor
Holly Hill Hospital, LLC	Tennessee	Guarantor
Horizon Health Austin, Inc.	Texas	Guarantor
Horizon Health Corporation	Delaware	Guarantor
Horizon Health Hospital Services, LLC	Delaware	Guarantor

Name of Subsidiary	Jurisdiction of Organization	Obligor Type
Horizon Mental Health Management, LLC	Texas	Guarantor
HSA Hill Crest Corporation	Alabama	Guarantor
Hughes Center, LLC	Virginia	Guarantor
Independence Physician Management, LLC	Delaware	Guarantor
Keys Group Holdings LLC	Delaware	Guarantor
Keystone Continuum, LLC	Tennessee	Guarantor
Keystone Education And Youth Services, LLC	Tennessee	Guarantor
Keystone Marion, LLC	Virginia	Guarantor
Keystone Memphis, LLC	Tennessee	Guarantor
Keystone Newport News, LLC	Virginia	Guarantor
Keystone NPS LLC	California	Guarantor
Keystone Richland Center LLC	Ohio	Guarantor
Keystone WSNC, L.L.C.	North Carolina	Guarantor
Keystone/CCS Partners LLC	Delaware	Guarantor
Kids Behavioral Health of Utah, Inc.	Utah	Guarantor
Kingwood Pines Hospital, LLC	Texas	Guarantor
KMI Acquisition, LLC	Delaware	Guarantor
La Amistad Residential Treatment Center, LLC	Florida	Guarantor
Lancaster Hospital Corporation	California	Guarantor
Laurel Oaks Behavioral Health Center, Inc.	Delaware	Guarantor
Lebanon Hospital Partners, LLC	Tennessee	Guarantor
Liberty Point Behavioral Healthcare, LLC	Delaware	Guarantor
Manatee Memorial Hospital, L.P.	Delaware	Guarantor
Mayhill Behavioral Health, LLC	Texas	Guarantor
McAllen Hospitals, L.P.	Delaware	Guarantor
McAllen Medical Center, Inc.	Delaware	Guarantor
Meridell Achievement Center, Inc.	Texas	Guarantor
Merion Building Management, Inc.	Delaware	Guarantor
Michigan Psychiatric Services, Inc.	Michigan	Guarantor
Millwood Hospital, L.P.	Texas	Guarantor
Milwaukee Behavioral Health, LLC	Wisconsin	Guarantor
Neuro Institute of Austin, L.P.	Texas	Guarantor
North Spring Behavioral Healthcare, Inc.	Tennessee	Guarantor

Name of Subsidiary	Jurisdiction of Organization	Obligor Type
Northern Indiana Partners, LLC	Tennessee	Guarantor
Northwest Texas Healthcare System, Inc.	Texas	Guarantor
Oak Plains Academy Of Tennessee, Inc.	Tennessee	Guarantor
Ocala Behavioral Health, LLC	Delaware	Guarantor
Palm Point Behavioral Health, LLC	Florida	Guarantor
Palmetto Behavioral Health Holdings, LLC	Delaware	Guarantor
Palmetto Behavioral Health System, L.L.C.	South Carolina	Guarantor
Palmetto Lowcountry Behavioral Health, L.L.C.	South Carolina	Guarantor
Park Healthcare Company	Tennessee	Guarantor
Pasteur Healthcare Properties, LLC	Delaware	Guarantor
Pendleton Methodist Hospital, L.L.C.	Delaware	Guarantor
Pennsylvania Clinical Schools, Inc.	Pennsylvania	Guarantor
Premier Behavioral Solutions Of Florida, Inc.	Delaware	Guarantor
Premier Behavioral Solutions, Inc.	Delaware	Guarantor
PSJ Acquisition, LLC	North Dakota	Guarantor
Psychiatric Realty, LLC	Delaware	Guarantor
Psychiatric Solutions Hospitals, LLC	Delaware	Guarantor
Psychiatric Solutions Of Virginia, Inc.	Tennessee	Guarantor
Psychiatric Solutions, Inc.	Delaware	Guarantor
Ramsay Managed Care, LLC	Delaware	Guarantor
Ramsay Youth Services of Georgia, Inc.	Delaware	Guarantor
Ridge Outpatient Counseling, L.L.C.	Kentucky	Guarantor
River Oaks, Inc.	Louisiana	Guarantor
Riveredge Hospital Holdings, Inc.	Delaware	Guarantor
Riverside Medical Clinic Patient Services, L.L.C.	California	Guarantor
Rolling Hills Hospital, LLC	Tennessee	Guarantor
RR Recovery, LLC	Delaware	Guarantor
Salt Lake Behavioral Health, LLC	Delaware	Guarantor
Salt Lake Psychiatric Realty, LLC	Delaware	Guarantor
Samson Properties, LLC	Florida	Guarantor
Schick Shadel Of Florida, LLC	Florida	Guarantor

Name of Subsidiary	Jurisdiction of Organization	Obligor Type
Shadow Mountain Behavioral Health System, LLC	Delaware	Guarantor
SHC-KPH, LP	Texas	Guarantor
Southeastern Hospital Corporation	Tennessee	Guarantor
SP Behavioral, LLC	Florida	Guarantor
Sparks Family Hospital, Inc.	Nevada	Guarantor
Springfield Hospital, Inc.	Delaware	Guarantor
Stonington Behavioral Health, Inc.	Delaware	Guarantor
Summit Oaks Hospital, Inc.	New Jersey	Guarantor
Sunstone Behavioral Health, LLC	Tennessee	Guarantor
TBD Acquisition II, LLC	Delaware	Guarantor
TBD Acquisition, LLC	Delaware	Guarantor
TBJ Behavioral Center, LLC	Delaware	Guarantor
Temecula Valley Hospital, Inc.	California	Guarantor
Temple Behavioral Healthcare Hospital, Inc.	Texas	Guarantor
Tennessee Clinical Schools, LLC	Tennessee	Guarantor
Texas Cypress Creek Hospital, L.P.	Texas	Guarantor
Texas Hospital Holdings, Inc.	Delaware	Guarantor
Texas Laurel Ridge Hospital, L.P.	Texas	Guarantor
Texas Oaks Psychiatric Hospital, L.P.	Texas	Guarantor
Texas San Marcos Treatment Center, L.P.	Texas	Guarantor
Texas West Oaks Hospital, L.P.	Texas	Guarantor
The Arbour, Inc.	Massachusetts	Guarantor
The Bridgeway, LLC	Arkansas	Guarantor
The National Deaf Academy, LLC	Florida	Guarantor
Three Rivers Behavioral Health, LLC	South Carolina	Guarantor
Three Rivers Healthcare Group, LLC	South Carolina	Guarantor
Toledo Holding Co., LLC	Delaware	Guarantor
Turning Point Care Center, LLC	Georgia	Guarantor
Two Rivers Psychiatric Hospital, Inc.	Delaware	Guarantor
UBH of Oregon, LLC	Delaware	Guarantor
UBH of Phoenix Realty, LLC	Delaware	Guarantor
UBH of Phoenix, LLC	Delaware	Guarantor
UHP, LP	Delaware	Guarantor

Name of Subsidiary	Jurisdiction of Organization	Obligor Type
UHS Capitol Acquisition, LLC	Delaware	Guarantor
UHS Children Services, Inc.	Delaware	Guarantor
UHS Funding, LLC	Delaware	Guarantor
UHS Holding Company, Inc.	Nevada	Guarantor
UHS Kentucky Holdings, L.L.C.	Delaware	Guarantor
UHS Midwest Behavioral Health, LLC	Delaware	Guarantor
UHS of Anchor, L.P.	Delaware	Guarantor
UHS of Benton, LLC	Delaware	Guarantor
UHS of Bowling Green, LLC	Delaware	Guarantor
UHS of Centennial Peaks, L.L.C.	Delaware	Guarantor
UHS of Cornerstone Holdings, Inc.	Delaware	Guarantor
UHS of Cornerstone, Inc.	Delaware	Guarantor
UHS of D.C., Inc.	Delaware	Guarantor
UHS of Delaware, Inc.	Delaware	Guarantor
UHS of Denver, Inc.	Delaware	Guarantor
UHS of Dover, L.L.C.	Delaware	Guarantor
UHS of Doylestown, L.L.C.	Delaware	Guarantor
UHS of Fairmount, Inc.	Delaware	Guarantor
UHS of Fuller, Inc.	Massachusetts	Guarantor
UHS of Georgia Holdings, Inc.	Delaware	Guarantor
UHS of Georgia, Inc.	Delaware	Guarantor
UHS of Greenville, LLC	Delaware	Guarantor
UHS of Hampton, Inc	New Jersey	Guarantor
UHS of Hartgrove, Inc.	Illinois	Guarantor
UHS of Lakeside, LLC	Delaware	Guarantor
UHS of Lancaster, LLC	Pennsylvania	Guarantor
UHS of Laurel Heights, L.P.	Delaware	Guarantor
UHS of Madera, Inc.	Delaware	Guarantor
UHS of New Orleans, LLC	Louisiana	Guarantor
UHS of Oklahoma, LLC	Oklahoma	Guarantor
UHS of Parkwood, Inc.	Delaware	Guarantor
UHS of Peachford, L.P.	Delaware	Guarantor
UHS of Pennsylvania, Inc.	Pennsylvania	Guarantor
UHS of Phoenix, LLC	Delaware	Guarantor

Name of Subsidiary	Jurisdiction of Organization	Obligor Type
UHS of Provo Canyon, Inc.	Delaware	Guarantor
UHS of Puerto Rico, Inc.	Delaware	Guarantor
UHS of Ridge, LLC	Delaware	Guarantor
UHS of River Parishes, Inc.	Louisiana	Guarantor
UHS of Rockford, LLC	Delaware	Guarantor
UHS of Salt Lake City, L.L.C.	Delaware	Guarantor
UHS of Savannah, L.L.C.	Delaware	Guarantor
UHS of Spring Mountain, Inc.	Delaware	Guarantor
UHS of Springwoods, L.L.C.	Delaware	Guarantor
UHS of Summitridge, L.L.C.	Delaware	Guarantor
UHS of Texoma, Inc.	Delaware	Guarantor
UHS of Timberlawn, Inc.	Texas	Guarantor
UHS of Timpanogos, Inc.	Delaware	Guarantor
UHS of Tucson, LLC	Delaware	Guarantor
UHS of Westwood Pembroke, Inc.	Massachusetts	Guarantor
UHS of Wyoming, Inc.	Delaware	Guarantor
UHS Oklahoma City LLC	Oklahoma	Guarantor
UHS Sahara, Inc.	Delaware	Guarantor
UHS Sub III, LLC	Delaware	Guarantor
UHS-Corona, Inc.	Delaware	Guarantor
UHSD, L.L.C.	Nevada	Guarantor
UHSL, L.L.C.	Nevada	Guarantor
United Healthcare of Hardin, Inc.	Tennessee	Guarantor
Universal Health Services Of Palmdale, Inc.	Delaware	Guarantor
Universal Health Services Of Rancho Springs, Inc.	California	Guarantor
University Behavioral Health of El Paso, LLC	Delaware	Guarantor
University Behavioral, LLC	Florida	Guarantor
Valle Vista Hospital Partners, LLC	Tennessee	Guarantor
Valle Vista, LLC	Delaware	Guarantor
Valley Health System LLC	Delaware	Guarantor
Valley Hospital Medical Center, Inc.	Nevada	Guarantor
Wekiva Springs Center, LLC	Delaware	Guarantor
Wellington Regional Medical Center, LLC	Florida	Guarantor

Name of Subsidiary	Jurisdiction of Organization	Obligor Type
Wellstone Regional Hospital Acquisition, LLC	Indiana	Guarantor
Willow Springs, LLC	Delaware	Guarantor
Windmoor Healthcare Inc.	Florida	Guarantor
Windmoor Healthcare Of Pinellas Park, Inc.	Delaware	Guarantor
Wisconsin Avenue Psychiatric Center, Inc.	Delaware	Guarantor
Zeus Endeavors, LLC	Florida	Guarantor

Pledged Security Collateral

As of November 8, 2022, the obligations under the UHS Senior Secured Notes were secured by pledges of the equity of the following affiliates of the Company.

Name of Issuer	Issuer Jurisdiction of Organization	Percent of Interest Owned	Percent of Interest Pledged
2012 W. University Properties, LLC	Delaware	100	100
2026 W. University Properties, LLC	Delaware	100	100
ABS LINCS KY, LLC	Virginia	100	100
ABS LINCS SC, Inc.	South Carolina	100	100
ABS LINCS TN, Inc.	Virginia	100	100
ABS LINCS VA, Inc.	Virginia	100	100
Aiken Regional Medical Centers, LLC	South Carolina	100	100
Alabama Clinical Schools, Inc.	Alabama	100	100
Alliance Health Center, Inc.	Mississippi	100	100
Alternative Behavioral Services, Inc.	Virginia	100	100
Ambulatory Surgery Center of Temecula Valley, Inc.	California	100	100
ASC of Aiken, Inc.	Delaware	100	100
ASC of East New Orleans, Inc.	Delaware	100	100
ASC of Las Vegas, Inc.	Nevada	100	100
ASC of Midwest City, Inc.	Oklahoma	100	100
ASC of Puerto Rico, Inc.	Delaware	100	100
ASC of Wellington, Inc.	Florida	100	100
Ascend Health Corporation	Delaware	100	100
Atlantic Shores Hospital, LLC	Delaware	100	100
Auburn Regional Medical Center, Inc.	Washington	100	100
AZ Holding 4, LLC	Arizona	100	100
Beach 77 LP	Delaware	99	99
Behavioral Educational Services, Inc.	Delaware	100	100
Behavioral Health Connections, Inc.	Texas	100	100
Behavioral Health Management, LLC	Delaware	100	100
Behavioral Health Realty, LLC	Delaware	100	100
Behavioral Healthcare LLC	Delaware	100	100
Benchmark Behavioral Health System, Inc.	Utah	100	100
BHC Alhambra Hospital, Inc.	Tennessee	100	100

Name of Issuer	Issuer Jurisdiction of Organization	Percent of Interest Owned	Percent of Interest Pledged
BH AZ Master, LLC	Arizona	51	51
BHC Fairfax Hospital, Inc.	Tennessee	100	100
BHC Fox Run Hospital, Inc.	Tennessee	100	100
BHC Fremont Hospital, Inc.	Tennessee	100	100
BHC Health Services of Nevada, Inc.	Nevada	100	100
BHC Heritage Oaks Hospital, Inc.	Tennessee	100	100
BHC Holdings, Inc.	Delaware	100	100
BHC Intermountain Hospital, Inc.	Tennessee	100	100
BHC Management Services of Streamwood, LLC	Delaware	100	100
BHC Mesilla Valley Hospital, LLC	Delaware	100	100
BHC Montevista Hospital, Inc.	Nevada	100	100
BHC Northwest Psychiatric Hospital, LLC	Delaware	100	100
BHC of Indiana, General Partnership	Tennessee	100	100
BHC Pinnacle Pointe Hospital, LLC	Tennessee	100	100
BHC Properties, LLC	Tennessee	100	100
BHC Sierra Vista Hospital, Inc.	Tennessee	100	100
BHC Streamwood Hospital, Inc.	Tennessee	100	100
Bloomington Meadows, General Partnership	Tennessee	100	100
Brentwood Acquisition, Inc.	Tennessee	100	100
Brentwood Acquisition-Shreveport, Inc.	Delaware	100	100
Brynn Marr Hospital, Inc.	North Carolina	100	100
Calvary Center, Inc.	Delaware	100	100
Canyon Ridge Hospital, Inc.	California	100	100
Canyon Ridge Real Estate, LLC	Delaware	100	100
CAT Realty, LLC	Delaware	100	100
Cape Girardeau Behavioral Health, LLC	Missouri	75	75
CAT Seattle, LLC	Delaware	100	100
CCS/Lansing, Inc.	Michigan	100	100
Cedar Springs Hospital, Inc.	Delaware	100	100
Central Montgomery Medical Center, L.L.C.	Pennsylvania	100	100
Chalmette Medical Center, Inc.	Louisiana	100	100
Children’s Comprehensive Services, Inc.	Tennessee	100	100
Clive Behavioral Health, LLC	Delaware	52	52
Columbus Hospital Partners, LLC	Tennessee	100	100
Columbus Hospital, LLC	Delaware	100	100
Coral Shores Behavioral Health, LLC	Delaware	100	100
Cornerstone Hospital Management, LLC	Texas	58.3	58.3
Cornerstone Regional Hospital, LP	Texas	50.2	50.2
Crossings Healthcare Solutions, Inc.		100	100
Cumberland Hospital Partners, LLC	Delaware	100	100
Cumberland Hospital, LLC	Virginia	100	100
Cypress Creek Real Estate, L.P.	Delaware	99	99
Del Amo Hospital, Inc.	California	100	100
DHP 2131 K St, LLC	Delaware	100	100
Diamond Grove Center, LLC	Delaware	100	100
District Hospital Partners, L.P.	District of Columbia	100	100
Doctors’ Hospital of Shreveport, Inc.	Louisiana	100	100

Name of Issuer	Issuer Jurisdiction of Organization	Percent of Interest Owned	Percent of Interest Pledged
DVH Hospital Alliance LLC	Delaware	100	100
Edinburg Ambulatory Surgical Center, Inc.	Texas	100	100
Edinburg Holdings, Inc.	Delaware	100	100
Edinburg MOB Properties, LLC	Florida	100	100
Emerald Coast Behavioral Hospital, LLC	Delaware	100	100
Everglades Holdings, LLC	Delaware	100	100
Fannin Management Services, LLC	Texas	100	100
First Hospital Corporation of Virginia Beach	Virginia	100	100
Forest View Psychiatric Hospital, Inc.	Michigan	100	100
Fort Duncan Medical Center, Inc.	Delaware	100	100
Fort Duncan Medical Center, L.P.	Delaware	99	99
Fort Lauderdale Hospital, Inc.	Florida	100	100
Foundations Recovery Network, LLC	Tennessee	100	100
Friends Behavioral Health System, LP	Pennsylvania	79.92	79.92
Friends GP, LLC	Pennsylvania	80	80
FRN, Inc.	Delaware	100	100
Frontline Behavioral Health, Inc.	Delaware	100	100
Frontline Children's Hospital, L.L.C.	Delaware	100	100
Frontline Hospital, LLC	Delaware	100	100
Frontline Residential Treatment Center, LLC	Delaware	100	100
Garfield Park Hospital, LLC	Illinois	100	100
Glen Oaks Hospital, Inc.	Texas	100	100
Great Plains Hospital, Inc.	Missouri	100	100
Gulf Coast Treatment Center, Inc.	Florida	100	100
Gulph Mills Associates, LLC	Pennsylvania	100	100
H. C. Corporation	Alabama	100	100
H. C. Partnership	Alabama	100	100
Harbor Point Behavioral Health Center, Inc.	Virginia	100	100
Havenwyck Hospital Inc.	Michigan	100	100
HHC Augusta, Inc.	Georgia	100	100
HHC Berkeley, Inc.	South Carolina	100	100
HHC Delaware, Inc.	Delaware	100	100
HHC Indiana, Inc.	Indiana	100	100
HHC Kingwood Investment, LLC	Delaware	100	100
HHC Oconee, Inc.	South Carolina	100	100
HHC Ohio, Inc.	Ohio	100	100
HHC Pennsylvania, LLC	Delaware	100	100
HHC Poplar Springs, LLC	Virginia	100	100
HHC River Park, Inc.	West Virginia	100	100
HHC South Carolina, Inc.	South Carolina	100	100
HHC St. Simons, Inc.	Georgia	100	100
Hickory Trail Hospital, L.P.	Delaware	99	99
High Plains Behavioral Health, L.P.	Delaware	99	99
Holly Hill Hospital, LLC	Tennessee	100	100
Holly Hill Real Estate, LLC	North Carolina	100	100
Horizon Health Austin, Inc.	Texas	100	100
Horizon Health Corporation	Delaware	100	100
Horizon Health Hospital Services, LLC	Delaware	100	100

Name of Issuer	Issuer Jurisdiction of Organization	Percent of Interest Owned	Percent of Interest Pledged
Horizon Health Physical Rehabilitation Services, LLC	Delaware	100	100
Horizon Mental Health Management, LLC	Texas	100	100
HRI Clinics, Inc.	Massachusetts	100	100
HRI Hospital, Inc.	Massachusetts	100	100
HSA Hill Crest Corporation	Alabama	100	100
Hughes Center, LLC	Virginia	100	100
Independence Amarillo, LLC	Delaware	100	100
Independence Denison, LLC	Delaware	100	100
Independence Laredo, LLC	Delaware	100	100
Independence McAllen, LLC	Delaware	100	100
Independence Wellington, LLC	Delaware	100	100
Independence Physician Management, LLC	Delaware	100	100
Indiana Psychiatric Institutes, LLC	Delaware	100	100
InfoScriber Corporation	Delaware	100	100
Island 77 LLC	Delaware	100	100
KEYS Group Holdings LLC	Delaware	100	100
Keystone Charlotte LLC	North Carolina	100	100
Keystone Continuum, LLC	Tennessee	100	100
Keystone Education and Youth Services, LLC	Tennessee	100	100
Keystone Marion, LLC	Virginia	100	100
Keystone Memphis, LLC	Tennessee	100	100
Keystone NPS LLC	California	100	100
Keystone Newport News, LLC	Virginia	100	100
Keystone Richland Center LLC	Ohio	100	100
Keystone WSNC, L.L.C.	North Carolina	100	100
Keystone/CCS Partners LLC	Delaware	100	100
Kids Behavioral Health of Utah, Inc.	Utah	100	100
Kingwood Pines Hospital, LLC	Texas	100	100
KMI Acquisition, LLC	Delaware	100	100
KOP Limited	South Carolina	100	100
La Amistad Residential Treatment Center, LLC	Florida	100	100
Lancaster Behavioral Health Hospital, LLC	Pennsylvania	50	50
Lancaster Hospital Corporation	California	100	100
Laredo ASC, Inc.	Texas	100	100
Laredo Holdings, Inc.	Delaware	100	100
Laredo Regional, Inc.	Delaware	100	100
Laredo Regional Medical Center, LP	Delaware	80.14	80.14
Laurel Oaks Behavioral Health Center, Inc.	Delaware	100	100
Lebanon Hospital Partners, LLC	Tennessee	100	100
Liberty Point Behavioral Healthcare, LLC	Delaware	100	100
Manatee Memorial Hospital, L.P.	Delaware	100	100
Mayhill Behavioral Health, LLC	Texas	100	100
Mayhill Behavioral Properties, LLC	Texas	100	100
McAllen Holdings, Inc.	Delaware	100	100
McAllen Hospitals, L.P.	Delaware	100	100
McAllen Medical Center, Inc.	Delaware	100	100
Mental Health Outcomes, LLC	Delaware	100	100

Name of Issuer	Issuer Jurisdiction of Organization	Percent of Interest Owned	Percent of Interest Pledged
Meridell Achievement Center, Inc.	Texas	100	100
Merion Building Management, Inc.	Delaware	100	100
Mesilla Valley Hospital, Inc.	New Mexico	100	100
Michigan BH JV, LLC	Michigan	74	74
Michigan Healthcare Staffing, LLC	Michigan	100	100
Michigan Psychiatric Services, Inc.	Michigan	100	100
Millwood Hospital, L.P.	Texas	99	99
Milwaukee Behavioral Health, LLC	Wisconsin	100	100
Nashville Rehab, LLC	Tennessee	100	100
Neuro Institute of Austin, L.P.	Texas	99	99
NEWCO Oregon, Inc.	Delaware	100	100
North Spring Behavioral Healthcare, Inc.	Tennessee	100	100
Northern Indiana Partners, LLC	Tennessee	100	100
Northern Nevada Diagnostic Imaging-Spanish Springs, L.L.C	Nevada	100	100
Northwest Texas Healthcare System, Inc.	Texas	100	100
NWTHS Management, LLC	Texas	100	100
Oak Plains Academy of Tennessee, Inc.	Tennessee	100	100
Ocala Behavioral Health, LLC	Delaware	100	100
Oregon Psychiatric Realty, LLC	Delaware	100	100
Palm Point Behavioral Health, LLC	Florida	100	100
Palmetto Behavioral Health Holdings, LLC	Delaware	100	100
Palmetto Behavioral Health Solutions, LLC	South Carolina	100	100
Palmetto Behavioral Health System, L.L.C.	South Carolina	100	100
Palmetto Lowcountry Behavioral Health, L.L.C.	South Carolina	100	100
Palmetto Pee Dee Behavioral Health, L.L.C.	South Carolina	100	100
Park Healthcare Company	Tennessee	100	100
Pasteur Healthcare Properties, LLC	Delaware	100	100
Peak Behavioral Health Services, LLC	Delaware	100	100
Pendleton Methodist Hospital, L.L.C.	Delaware	100	100
Pennsylvania Clinical Schools, Inc.	Pennsylvania	100	100
PR Holding II, Inc.	Puerto Rico	100	100
Premier Behavioral Solutions of Florida, Inc.	Delaware	100	100
Premier Behavioral Solutions, Inc.	Delaware	100	100
Pride Institute, Inc.	Minnesota	100	100
PSJ Acquisition, LLC	North Dakota	100	100
Psychiatric Realty, LLC	Delaware	100	100
Psychiatric Solutions, Inc.	Delaware	100	100
Psychiatric Solutions Hospitals, LLC	Delaware	100	100
Psychiatric Solutions of Virginia, Inc.	Tennessee	100	100
PsychManagement Group, Inc.	West Virginia	100	100
Radiation Oncology Center of Aiken, LLC	South Carolina	95	95
Ramsay Managed Care, LLC	Delaware	100	100
Ramsay Youth Services of Georgia, Inc.	Delaware	100	100
Red Rock Solutions, LLC	Delaware	100	100
Relational Therapy Clinic, Inc.	Louisiana	100	100
Ridge Outpatient Counseling, L.L.C.	Kentucky	100	100
River Crest Hospital, Inc.	Texas	100	100

Name of Issuer	Issuer Jurisdiction of Organization	Percent of Interest Owned	Percent of Interest Pledged
River Oaks, Inc.	Louisiana	100	100
Riveredge Hospital Holdings, Inc.	Delaware	100	100
Riveredge Hospital, Inc.	Illinois	100	100
Riveredge Real Estate, Inc.	Illinois	100	100
Riverside Medical Clinic Patient Services, L.L.C.	California	100	100
Rolling Hills Hospital, LLC	Tennessee	100	100
RR Behavioral Realty LLC	Delaware	100	100
RR Recovery, LLC	Delaware	100	100
Salt Lake Behavioral Health, LLC	Delaware	100	100
Salt Lake Psychiatric Realty, LLC	Delaware	100	100
Samson Properties, LLC	Florida	100	100
Schick Shadel of Florida, LLC	Florida	100	100
Shadow Mountain Behavioral Health System, LLC	Delaware	100	100
SHC-KPH, LP	Texas	99.1	99.1
Somerset, Incorporated	California	100	100
Southeastern Hospital Corporation	Tennessee	100	100
Southside Imaging Center, LLC	South Carolina	100	100
SP Behavioral, LLC	Florida	100	100
Sparks Family Hospital, Inc.	Nevada	100	100
Spokane Behavioral Health, LLC	Washington	80	80
Spokane Valley Behavioral Health, LLC	Delaware	100	100
Springfield Hospital, Inc.	Delaware	100	100
St. Louis Behavioral Medicine Institute, Inc.	Missouri	100	100
Stonington Behavioral Health, Inc.	Delaware	100	100
Summerlin Hospital Medical Center, LP	Delaware	93.2	93.2
Summit Oaks Hospital, Inc.	New Jersey	100	100
Sunstone Behavioral Health, LLC	Tennessee	100	100
TBD Acquisition, LLC	Delaware	100	100
TBD Acquisition II, LLC	Delaware	100	100
TBJ Behavioral Center, LLC	Delaware	100	100
Temecula Valley Hospital, Inc.	California	100	100
Temple Behavioral Healthcare Hospital, Inc.	Texas	100	100
Tennessee Clinical Schools, LLC	Tennessee	100	100
Texas Cypress Creek Hospital, L.P.	Texas	99	99
Texas Hospital Holdings, Inc.	Delaware	100	100
Texas Hospital Holdings, LLC	Texas	100	100
Texas Laurel Ridge Hospital, L.P.	Texas	99	99
Texas Oaks Psychiatric Hospital, L.P.	Texas	99	99
Texas San Marcos Treatment Center, L.P.	Texas	99	99
Texas West Oaks Hospital, L.P.	Texas	99	99
The Arbour, Inc.	Massachusetts	100	100
The Bridgeway, LLC	Arkansas	100	100
The National Deaf Academy, LLC	Florida	100	100
Three Rivers Behavioral Health, LLC	South Carolina	100	100
Three Rivers Healthcare Group, LLC	South Carolina	100	100
Three Rivers Residential Treatment/Midlands Campus, Inc.	South Carolina	100	100

Name of Issuer	Issuer Jurisdiction of Organization	Percent of Interest Owned	Percent of Interest Pledged
Three Rivers SPE Holding, LLC	South Carolina	100	100
Toledo Holding Co., LLC	Delaware	100	100
Turning Point Care Center, LLC	Georgia	100	100
Two Rivers Psychiatric Hospital, Inc.	Delaware	100	100
UBH of Phoenix, LLC	Delaware	100	100
UBH of Phoenix Realty, LLC	Delaware	100	100
UBH of Oregon, LLC	Delaware	100	100
UHP LP	Delaware	100	100
UHS Advisory, Inc.	Delaware	100	100
UHS BH Telepsych, LLC	Delaware	100	100
UHS Building Solutions, Inc.	Delaware	100	100
UHS Capitol Acquisition, LLC	Delaware	100	100
UHS Children Services, Inc.	Delaware	100	100
UHS Funding, LLC	Delaware	100	100
UHS Good Samaritan, L.L.C.	Delaware	100	100
UHS Holding Company, Inc.	Nevada	100	100
UHS International, Inc.	Delaware	100	100
UHS Kentucky Holdings, L.L.C.	Delaware	100	100
UHS Midwest Behavioral Health, LLC	Delaware	100	100
UHS Midwest Center for Youth and Families, LLC	Indiana	100	100
UHS Oklahoma City LLC	Oklahoma	100	100
UHS Receivables Corp.	Delaware	100	100
UHS Sahara, Inc.	Delaware	100	100
UHS Surgical Hospital of Texoma, LLC	Texas	100	100
UHS of Anchor, L.P.	Delaware	100	100
UHS of Benton Day School and Treatment Program, Inc.	Delaware	100	100
UHS of Benton, LLC	Delaware	100	100
UHS of Bowling Green, LLC	Delaware	100	100
UHS of Centennial Peaks, L.L.C.	Delaware	100	100
UHS of Cornerstone Holdings, Inc.	Delaware	100	100
UHS of Cornerstone, Inc.	Delaware	100	100
UHS of D.C., Inc.	Delaware	100	100
UHS of Delaware, Inc.	Delaware	100	100
UHS of Denver, Inc.	Delaware	100	100
UHS of Dover, L.L.C.	Delaware	100	100
UHS of Doylestown, L.L.C.	Delaware	100	100
UHS of Fairmount, Inc.	Delaware	100	100
UHS of Fuller, Inc.	Massachusetts	100	100
UHS of GB, Inc.	Delaware	100	100
UHS of Georgia Holdings, Inc.	Delaware	100	100
UHS of Georgia, Inc.	Delaware	100	100
UHS of Greenville, LLC	Delaware	100	100
UHS of Hampton Learning Center, Inc.	New Jersey	100	100
UHS of Hampton, Inc.	New Jersey	100	100
UHS of Hartgrove, Inc.	Illinois	100	100
UHS of Indiana, Inc.	Indiana	100	100
UHS of Kootenai River, Inc.	Delaware	100	100

Name of Issuer	Issuer Jurisdiction of Organization	Percent of Interest Owned	Percent of Interest Pledged
UHS of Lakeside, LLC	Delaware	100	100
UHS of Lancaster, LLC	Pennsylvania	100	100
UHS of Laurel Heights, L.P.	Delaware	100	100
UHS of Madera, Inc.	Delaware	100	100
UHS of New Orleans, LLC	Louisiana	100	100
UHS of No. Nevada, LLC	Nevada	100	100
UHS of Oklahoma Receivables, L.L.C	Delaware	100	100
UHS of Oklahoma, LLC	Oklahoma	100	100
UHS of Parkwood, Inc.	Delaware	100	100
UHS of Peachford, L.P.	Delaware	100	100
UHS of Pennsylvania, Inc.	Pennsylvania	100	100
UHS of Phoenix, LLC	Delaware	100	100
UHS of Provo Canyon, Inc.	Delaware	100	100
UHS of Puerto Rico, Inc.	Delaware	100	100
UHS of Ridge, LLC	Delaware	100	100
UHS of River Parishes, Inc.	Louisiana	100	100
UHS of Rockford, LLC	Delaware	100	100
UHS of Salt Lake City, L.L.C.	Delaware	100	100
UHS of Savannah, L.L.C.	Delaware	100	100
UHS of Spring Mountain, Inc.	Delaware	100	100
UHS of Springwoods, L.L.C.	Delaware	100	100
UHS of SummitRidge, L.L.C.	Delaware	100	100
UHS of Sutton, Inc.	Delaware	100	100
UHS of Talbot, L.P.	Delaware	100	100
UHS of Texoma, Inc.	Delaware	100	100
UHS of Timberlawn, Inc.	Texas	100	100
UHS of Timpanogos, Inc.	Delaware	100	100
UHS of Tuscon, LLC	Delaware	100	100
UHS of Westwood Pembroke, Inc.	Massachusetts	100	100
UHS of Wyoming, Inc.	Delaware	100	100
UHS-Corona, Inc.	Delaware	100	100
UHS-Lakeland Medical Center, L.L.C.	Delaware	100	100
UHS Sub III, LLC	Delaware	100	100
UHSD, L.L.C	Nevada	100	100
UHSF, L.L.C	Delaware	100	100
UHSL, L.L.C	Nevada	100	100
UK Acquisition No. 6, Ltd	United Kingdom	100	65
United Healthcare of Hardin, Inc.	Tennessee	100	100
Universal Community Behavioral Health, Inc.	Pennsylvania	100	100
Universal HMO, Inc.	Nevada	100	100
Universal Health Network, Inc.	Nevada	100	100
Universal Health Recovery Centers, Inc.	Pennsylvania	100	100
Universal Health Services of Cedar Hill, Inc.	Texas	100	100
Universal Health Services of Palmdale, Inc.	Delaware	100	100
Universal Health Services of Rancho Springs, Inc.	California	100	100
Universal Treatment Centers, Inc.	Delaware	100	100
University Behavioral, LLC	Florida	100	100
University Behavioral Health of El Paso, LLC	Delaware	100	100

Name of Issuer	Issuer Jurisdiction of Organization	Percent of Interest Owned	Percent of Interest Pledged
Valle Vista Hospital Partners, LLC	Tennessee	100	100
Valle Vista, LLC	Delaware	100	100
Valley Health System LLC	Delaware	100	100
Valley Hospital Medical Center, Inc.	Nevada	100	100
Virgin Islands Behavioral Services, Inc.	Virginia	100	100
Vista Diagnostic Center, L.L.C.	Nevada	100	100
Wekiva Springs Center, LLC	Delaware	100	100
Wellington Physician Alliances, Inc.	Florida	100	100
Wellington Regional Medical Center, LLC	Florida	100	100
Wellstone Holdings, LLC	Delaware	100	100
Wellstone Regional Hospital Acquisition, LLC	Indiana	98	98
West Church Partnership	Illinois	100	100
West Oaks Real Estate, L.P.	Texas	99	99
Westside Outpatient Center, LLC	Florida	50	50
Willow Springs, LLC	Delaware	100	100
Windmoor Healthcare Inc.	Florida	100	100
Windmoor Healthcare of Pinellas Park, Inc.	Delaware	100	100
Wisconsin Avenue Psychiatric Center, Inc.	Delaware	100	100
Zeus Endeavors, LLC	Florida	100	100

Exhibit 31.1

CERTIFICATION—Chief Executive Officer

I, Marc D. 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; and

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

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

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

Date: November 8, 2022

/s/ Marc D. 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; and

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

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

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

Date: November 8, 2022

/s/ Steve Filton
Executive 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 September 30, 2022, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Marc D. 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/ Marc D. Miller
Chief Executive Officer
November 8, 2022

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 September 30, 2022, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Steve Filton, Executive 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
Executive Vice President and Chief Financial Officer
November 8, 2022

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.