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

FORM 10-Q

(MARK ONE)

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

For the quarterly period ended June 30, 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 July 31, 2022:

Class A	6,577,100
Class B	65,717,179
Class C	661,688
Class D	14,285

UNIVERSAL HEALTH SERVICES, INC.

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This Quarterly Report on Form 10-Q is for the quarter ended June 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.

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

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

	Three months ended June 30,		Six months ended June 30,	
	2022	2021	2022	2021
Net revenues	$ 3,323,407	$ 3,197,880	$ 6,616,363	$ 6,210,867
Operating charges:				
Salaries, wages and benefits	1,691,472	1,487,935	3,383,742	2,985,708
Other operating expenses	867,885	769,810	1,688,819	1,479,518
Supplies expense	354,993	338,033	726,066	685,143
Depreciation and amortization	143,850	133,985	287,634	265,388
Lease and rental expense	31,773	29,149	63,811	60,473
	3,089,973	2,758,912	6,150,072	5,476,230
Income from operations	233,434	438,968	466,291	734,637
Interest expense, net	25,676	21,299	47,349	43,256
Other (income) expense, net	(1,972)	(9,129)	9,229	(8,294)
Income before income taxes	209,730	426,798	409,713	699,675
Provision for income taxes	50,949	101,522	99,911	165,329
Net income	158,781	325,276	309,802	534,346
Less: Net income (loss) attributable to noncontrolling interests	(5,281)	252	(8,173)	231
Net income attributable to UHS	$ 164,062	$ 325,024	$ 317,975	$ 534,115
Basic earnings per share attributable to UHS	$ 2.22	$ 3.85	$ 4.27	$ 6.31
Diluted earnings per share attributable to UHS	$ 2.20	$ 3.79	$ 4.22	$ 6.22
Weighted average number of common shares - basic	73,682	84,224	74,356	84,503
Add: Other share equivalents	753	1,400	882	1,207
Weighted average number of common shares and equivalents - diluted	74,435	85,624	75,238	85,710

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 June 30,		Six months ended June 30,	
	2022	2021	2022	2021
Net income	$ 158,781	$ 325,276	$ 309,802	$ 534,346
Other comprehensive income (loss):				
Foreign currency translation adjustment	(28,232)	(3,717)	(46,702)	(14,063)
Other comprehensive income (loss) before tax	(28,232)	(3,717)	(46,702)	(14,063)
Income tax expense (benefit) related to items of other comprehensive income (loss)	68	(601)	(876)	(2,067)
Total other comprehensive income (loss), net of tax	(28,300)	(3,116)	(45,826)	(11,996)
Comprehensive income	130,481	322,160	263,976	522,350
Less: Comprehensive income (loss) attributable to noncontrolling interests	(5,281)	252	(8,173)	231
Comprehensive income attributable to UHS	$ 135,762	$ 321,908	$ 272,149	$ 522,119

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)

	June 30, 2022	December 31, 2021
Assets		
Current assets:		
Cash and cash equivalents	$ 132,658	$ 115,301
Accounts receivable, net	1,835,238	1,746,635
Supplies	209,569	206,839
Other current assets	258,760	194,781
Total current assets	2,436,225	2,263,556
Property and equipment	11,057,885	10,770,702
Less: accumulated depreciation	(5,087,166)	(4,896,427)
	5,970,719	5,874,275
Other assets:		
Goodwill	3,912,382	3,962,624
Deferred income taxes	51,548	45,707
Right of use assets-operating leases	360,791	367,477
Deferred charges	6,188	6,525
Other	558,250	573,379
Total Assets	$ 13,296,103	$ 13,093,543
Liabilities and Stockholders' Equity		
Current liabilities:		
Current maturities of long-term debt	$ 66,205	$ 48,409
Accounts payable and other liabilities	1,861,467	1,860,496
Operating lease liabilities	63,630	64,484
Federal and state taxes	396	10,720
Total current liabilities	1,991,698	1,984,109
Other noncurrent liabilities	496,639	464,759
Operating lease liabilities noncurrent	300,197	304,624
Long-term debt	4,599,204	4,141,879
Redeemable noncontrolling interests	4,449	5,119
Equity:		
UHS common stockholders' equity	5,814,660	6,089,664
Noncontrolling interest	89,256	103,389
Total equity	5,903,916	6,193,053
Total Liabilities and Stockholders' Equity	$ 13,296,103	$ 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 Six Months ended June 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, April 1, 2022	$ 4,314	$ 66	$ 676	$ 7	$ 0	$ (560,450)	$ 6,414,808	$ 12,765	$ 5,867,872	$ 94,706	$ 5,962,578
Common Stock											
Issued/(converted)	—	—	1	—	—	—	3,149	—	3,150	—	3,150
Repurchased	—	—	(17)	—	—	—	(199,660)	—	(199,677)	—	(199,677)
Restricted share-based compensation expense	—	—	—	—	—	—	4,661	—	4,661	—	4,661
Dividends paid and accrued	—	—	—	—	—	(14,748)	—	—	(14,748)	—	(14,748)
Stock option expense	—	—	—	—	—	—	17,640	—	17,640	—	17,640
Distributions to noncontrolling interests	—	—	—	—	—	—	—	—	—	(34)	(34)
Sale of ownership interests by minority members	—	—	—	—	—	—	—	—	—	—	—
Comprehensive income:											
Net income to UHS / noncontrolling interests	135	—	—	—	—	—	164,062	—	164,062	(5,416)	158,646
Foreign currency translation adjustments, net of income tax	—	—	—	—	—	—	—	(28,300)	(28,300)	—	(28,300)
Subtotal - comprehensive income	135	—	—	—	—	—	164,062	(28,300)	135,762	(5,416)	130,346
Balance, June 30, 2022	$ 4,449	$ 66	$ 660	$ 7	$ 0	$ (575,198)	$ 6,404,660	$ (15,535)	$ 5,814,660	$ 89,256	$ 5,903,916

	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)	—	—	6	—	—	—	6,789	—	6,795	—	6,795
Repurchased	—	—	(44)	—	—	—	(565,138)	—	(565,182)	—	(565,182)
Restricted share-based compensation expense	—	—	—	—	—	—	8,103	—	8,103	—	8,103
Dividends paid and accrued	—	—	—	—	—	(29,711)	—	—	(29,711)	—	(29,711)
Stock option expense	—	—	—	—	—	—	32,842	—	32,842	—	32,842
Distributions to noncontrolling interests	(650)	—	—	—	—	—	—	—	—	(4,673)	(4,673)
Sale of ownership interests by minority members	—	—	—	—	—	—	—	—	—	(1,307)	(1,307)
Comprehensive income:											
Net income (loss) to UHS / noncontrolling interests	(20)	—	—	—	—	—	317,975	—	317,975	(8,153)	309,822
Foreign currency translation adjustments, net of income tax	—	—	—	—	—	—	—	(45,826)	(45,826)	—	(45,826)
Subtotal - comprehensive income	(20)	—	—	—	—	—	317,975	(45,826)	272,149	(8,153)	263,996
Balance, June 30, 2022	$ 4,449	$ 66	$ 660	$ 7	$ 0	$ (575,198)	$ 6,404,660	$ (15,535)	$ 5,814,660	$ 89,256	$ 5,903,916

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 Six Months ended June 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, April 1, 2021	$ 4,470	$ 66	$ 781	$ 7	$ 0	$ (496,521)	$ 6,970,289	$ 39,240	$ 6,513,862	$ 87,977	$ 6,601,839
Common Stock											
Issued/(converted)	—	—	1	—	—	—	3,083	—	3,084	—	3,084
Repurchased	—	—	(22)	—	—	—	(360,594)	—	(360,616)	—	(360,616)
Restricted share-based compensation expense	—	—	—	—	—	—	3,240	—	3,240	—	3,240
Dividends paid	—	—	—	—	—	(16,856)	—	—	(16,856)	—	(16,856)
Stock option expense	—	—	—	—	—	—	15,478	—	15,478	—	15,478
Distributions to noncontrolling interests	(203)	—	—	—	—	—	—	—	—	(889)	(889)
Purchase of ownership interests by minority members	—	—	—	—	—	—	—	—	—	5,066	5,066
Comprehensive income:											
Net income to UHS / noncontrolling interests	426	—	—	—	—	—	325,024	—	325,024	(174)	324,850
Foreign currency translation adjustments	—	—	—	—	—	—	—	(3,116)	(3,116)	—	(3,116)
Subtotal - comprehensive income	426	—	—	—	—	—	325,024	(3,116)	321,908	(174)	321,734
Balance, June 30, 2021	$ 4,693	$ 66	$ 760	$ 7	$ 0	$ (513,377)	$ 6,956,520	$ 36,124	$ 6,480,100	$ 91,980	$ 6,572,080

	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, 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	—	—	—	6,439	—	6,444	—	6,444
Repurchased	—	—	(23)	—	—	—	(368,057)	—	(368,080)	—	(368,080)
Restricted share-based compensation expense	—	—	—	—	—	—	6,102	—	6,102	—	6,102
Dividends paid	—	—	—	—	—	(33,874)	—	—	(33,874)	—	(33,874)
Stock option expense	—	—	—	—	—	—	30,243	—	30,243	—	30,243
Distributions to noncontrolling interests	(203)	—	—	—	—	—	—	—	—	(5,414)	(5,414)
Purchase of ownership interests by minority members	—	—	—	—	—	—	—	—	—	12,669	12,669
Comprehensive income:											
Net income (loss) to UHS / noncontrolling interests	327	—	—	—	—	—	534,115	—	534,115	(96)	534,019
Foreign currency translation adjustments	—	—	—	—	—	—	—	(11,996)	(11,996)	—	(11,996)
Subtotal - comprehensive income	327	—	—	—	—	—	534,115	(11,996)	522,119	(96)	522,023
Balance, June 30, 2021	$ 4,693	$ 66	$ 760	$ 7	$ 0	$ (513,377)	$ 6,956,520	$ 36,124	$ 6,480,100	$ 91,980	$ 6,572,080

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)

	Six months ended June 30,	
	2022	2021
Cash Flows from Operating Activities:		
Net income	$ 309,802	$ 534,346
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation & amortization	287,634	265,388
(Gain) loss on sale of assets and businesses	1,084	(4,803)
Stock-based compensation expense	41,640	37,031
Provision for asset impairment	-	7,195
Changes in assets & liabilities, net of effects from acquisitions and dispositions:		
Accounts receivable	(89,729)	(35,903)
Accrued interest	1,329	(1,459)
Accrued and deferred income taxes	(34,260)	(26,769)
Other working capital accounts	(98,811)	3,560
Medicare accelerated payments and deferred CARES Act and other grants	5,339	(697,011)
Other assets and deferred charges	30,278	(28,763)
Other	(15,763)	5,052
Accrued insurance expense, net of commercial premiums paid	97,570	104,079
Payments made in settlement of self-insurance claims	(58,066)	(42,495)
Net cash provided by operating activities	478,047	119,448
Cash Flows from Investing Activities:		
Property and equipment additions	(407,962)	(482,211)
Proceeds received from sales of assets and businesses	10,232	21,143
Acquisition of businesses and property	(12,485)	-
Inflows (outflows) from foreign exchange contracts that hedge our net U.K. investment	84,535	(21,487)
Decrease in capital reserves of commercial insurance subsidiary	100	100
Costs incurred for purchase of information technology applications, net of refunds	-	(1,246)
Net cash used in investing activities	(325,580)	(483,701)
Cash Flows from Financing Activities:		
Repayments of long-term debt	(226,854)	(278,785)
Additional borrowings, net	700,000	6,578
Financing costs	(2,387)	-
Repurchase of common shares	(565,182)	(368,080)
Dividends paid	(29,641)	(33,844)
Issuance of common stock	6,661	6,442
Profit distributions to noncontrolling interests	(5,323)	(5,617)
Purchase (sale) of ownership interests by (from) minority members	(1,307)	11,433
Net cash used in financing activities	(124,033)	(661,873)
Effect of exchange rate changes on cash, cash equivalents and restricted cash	(5,457)	660
Increase (decrease) in cash, cash equivalents and restricted cash	22,977	(1,025,466)
Cash, cash equivalents and restricted cash, beginning of period	178,934	1,279,154
Cash, cash equivalents and restricted cash, end of period	$ 201,911	$ 253,688
Supplemental Disclosures of Cash Flow Information:		
Interest paid	$ 43,796	$ 43,641
Income taxes paid, net of refunds	$ 145,448	$ 189,979
Noncash purchases of property and equipment	$ 112,420	$ 95,979

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 June 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 six 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 six-month periods ended June 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 June 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 June 30, 2022 and 2021, respectively, and approximately $2.5 million and $2.2 million during the six-month periods ended June 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 $307,000 and $394,000 during the three-month periods ended June 30, 2022 and 2021, respectively, and approximately $607,000 and $701,000 during the six-month periods ended June 30, 2022 and 2021, respectively. Included in our share of the Trust's income for the three and six-month periods ended June 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 $551,000 during the three-month periods ended June 30, 2022 and 2021, respectively, and $1.1 million during each of the six-month periods ended June 30, 2022 and 2021. The carrying value of our investment in the Trust was approximately $8.9 million and $9.4 million at June 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 $41.9 million at June 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 June 30, 2022 reflects a financial liability of $82.5 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 $10 million during the three and six months ended June 30, 2022, respectively. The aggregate rental for the leases on the three wholly-owned hospital facilities with the Trust was approximately $4 million and $8 million during the three and six months ended June 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 $622,000 for the three months ended June 30, 2022 and 2021, respectively, and approximately $1.3 million and $1.2 million for the six months ended June 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 June 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, 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 $80 million and $92 million as of June 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 six-month periods ended June 30, 2022. Additionally, Premier declared and paid quarterly cash dividends during each of the first two quarters of 2022 and 2021. Our share of the cash dividends amounted to approximately $450,000 and $400,000 for the three-month periods ended June 30, 2022 and 2021, respectively, and approximately $900,000 and $800,000 for the six-month periods ended June 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 June 30, 2022, outside owners held noncontrolling, minority ownership interests of: (i) 20% in an acute care facility located in Washington, D.C.; (ii) approximately 7% in an acute care facility located in Texas; (iii) 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; (iv) approximately 5% in an acute care facility located in Nevada. The noncontrolling interest and redeemable noncontrolling interest balances of $89 million and $4 million, respectively, as of June 30, 2022, consist primarily of the third-party ownership interests in these hospitals.

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 June 30, 2022, this facility had $140 million of borrowings outstanding and $1.056 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 $2.368 billion of outstanding borrowings as of June 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 June 30, 2022, the applicable margins were 0.375% for ABR-based loans and 1.375% 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 June 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. Substantially all other material terms and conditions remained unchanged. There were no borrowings outstanding pursuant to the Securitization as of June 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 June 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 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* above, 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 June 30, 2022 and December 31, 2021 reflect financial liabilities, which are included in debt, of approximately $82 million as of each date.

At June 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.

Cash Flow Hedges:

During the six-month period ended June 30, 2022 and the year ended December 31, 2021, we had no cash flow hedges outstanding.

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 $85 million during the six-month period ended June 30, 2022 and net cash outflows of $21 million during the six-month period ended June 30, 2021.

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 six-month periods ended June 30, 2022 and 2021 (in thousands):

	Gain/(Loss) recognized in AOCI			
	Three months ended		Six months ended	
	June 30, 2022	June 30, 2021	June 30, 2022	June 30, 2021
Net Investment Hedge relationships				
Foreign currency foreign exchange contracts	$ 64,464	$ (9,917)	$ 81,576	$ (31,031)

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):

	June 30, 2022	June 30, 2021	December 31, 2021
Cash and cash equivalents	$ 132,658	$ 199,017	$ 115,301
Restricted cash (a)	69,253	54,671	63,633
Total cash, cash equivalents and restricted cash	$ 201,911	$ 253,688	$ 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 June 30, 2022	Balance Sheet Location	Basis of Fair Value Measurement Level 1	Level 2	Level 3
Assets:					
Money market mutual funds	85,037	Other assets	85,037		
Certificates of deposit	2,200	Other assets		2,200	
Equity securities	79,662	Other assets	79,662		
Deferred compensation assets	38,690	Other assets	38,690		
Foreign currency exchange contracts	1,602	Other current assets		1,602	
	$ 207,191		$ 203,389	$ 3,802	-
Liabilities:					
Deferred compensation liability	38,690	Other noncurrent liabilities	38,690		
	$ 38,690		$ 38,690	-	-

(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 June 30, 2022, the total net accrual for our professional and general liability claims was $382 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 three and six-month periods ended June 30, 2022 and $36 million during the three and six-month periods ended June 30, 2021. Our estimated liability for self-insured professional and general liability claims is based on a number of factors including, among other things, the number of asserted claims and reported incidents, estimates of losses for these claims based on recent and historical settlement amounts, estimates of incurred but not reported claims based on historical experience, and estimates of amounts recoverable under our commercial insurance policies. While we continuously monitor these factors, our ultimate liability for professional and general liability claims could change materially from our current estimates due to inherent uncertainties involved in making this estimate. Given our significant self-insured exposure for professional and general liability claims, there can be no assurance that a sharp increase in the number and/or severity of claims asserted against us will not have a material adverse effect on our future results of operations.

As of June 30, 2022, the total accrual for our workers' compensation liability claims was $121 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. We are uncertain as to potential liability or financial exposure, if any, which may be associated with this matter.

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 claims 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 includes claims for breach of contract, breach of fiduciary duty, and unjust enrichment. We deny liability and intend to defend 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. At this time, we are uncertain as to potential liability or financial exposure, if any, which may be associated with this matter.

During the second quarter of 2022, the parties have reached a settlement, which is subject to regulatory approval from the District of Columbia's State Health Planning and Development Agency, which would provide 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. Although we can provide no assurance that regulatory approval will be granted, the litigation will be dismissed if the settlement is finalized. If finalized, we do not expect this transaction to have a material impact on our future results of operations.

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 FFY 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 are uncertain as to potential liability or financial exposure, if any, which may be associated with this matter. We maintain commercial insurance coverage for claims of this nature, subject to specified deductibles and limitations.

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 June 30, 2022			
	Acute Care Hospital Services	Behavioral Health Services (a)	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 9,706,731	$ 2,561,553	$ -	$ 12,268,284
Gross outpatient revenues	$ 6,206,039	$ 268,489	$ -	$ 6,474,528
Total net revenues	$ 1,875,516	$ 1,433,920	$ 13,971	$ 3,323,407
Income/(loss) before allocation of corporate overhead and income taxes	$ 95,059	$ 249,958	$ (135,287)	$ 209,730
Allocation of corporate overhead	$ (63,213)	$ (45,063)	$ 108,276	$ 0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 31,846	$ 204,895	$ (27,011)	$ 209,730
Total assets as of June 30, 2022	$ 5,785,470	$ 7,251,966	$ 258,667	$ 13,296,103

	Six months ended June 30, 2022			
	Acute Care Hospital Services	Behavioral Health Services (a)	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 19,945,962	$ 4,998,027	$ -	$ 24,943,989
Gross outpatient revenues	$ 11,981,578	$ 525,602	$ -	$ 12,507,180
Total net revenues	$ 3,787,832	$ 2,800,387	$ 28,144	$ 6,616,363
Income/(loss) before allocation of corporate overhead and income taxes	$ 243,739	$ 455,746	$ (289,772)	$ 409,713
Allocation of corporate overhead	$ (125,497)	$ (90,064)	$ 215,561	$ 0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 118,242	$ 365,682	$ (74,211)	$ 409,713
Total assets as of June 30, 2022	$ 5,785,470	$ 7,251,966	$ 258,667	$ 13,296,103

	Three months ended June 30, 2021			
	Acute Care Hospital Services	Behavioral Health Services (a)	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 8,662,335	$ 2,527,776	$ 0	$ 11,190,111
Gross outpatient revenues	$ 5,357,888	$ 266,328	$ 0	$ 5,624,216
Total net revenues	$ 1,754,431	$ 1,431,497	$ 11,952	$ 3,197,880
Income/(loss) before allocation of corporate overhead and income taxes	$ 218,663	$ 324,577	$ (116,442)	$ 426,798
Allocation of corporate overhead	$ (58,227)	$ (43,099)	$ 101,326	$ 0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 160,436	$ 281,478	$ (15,116)	$ 426,798
Total assets as of June 30, 2021	$ 5,162,252	$ 7,159,426	$ 490,957	$ 12,812,635

	Six months ended June 30, 2021			
	Acute Care Hospital Services	Behavioral Health Services (a)	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 17,781,519	$ 5,001,341	$ 0	$ 22,782,860
Gross outpatient revenues	$ 9,938,608	$ 513,092	$ 0	$ 10,451,700
Total net revenues	$ 3,448,973	$ 2,746,834	$ 15,060	$ 6,210,867
Income/(loss) before allocation of corporate overhead and income taxes	$ 391,781	$ 555,902	$ (248,008)	$ 699,675
Allocation of corporate overhead	$ (116,334)	$ (86,049)	$ 202,383	$ 0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 275,447	$ 469,853	$ (45,625)	$ 699,675
Total assets as of June 30, 2021	$ 5,162,252	$ 7,159,426	$ 490,957	$ 12,812,635

(a) Includes net revenues generated from our behavioral health care facilities located in the U.K. amounting to approximately $173 million and $172 million for the three-month periods ended June 30, 2022 and 2021, respectively, and approximately $349 million and $337 million for the six-month periods ended June 30, 2022 and 2021, respectively. Total assets at our U.K. behavioral health care facilities were approximately $1.220 billion and $1.369 billion as of June 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 June 30,		Six months ended June 30,	
	2022	2021	2022	2021
Basic and Diluted:				
Net income attributable to UHS	$ 164,062	$ 325,024	$ 317,975	$ 534,115
Less: Net income attributable to unvested restricted share grants	(164)	(661)	(413)	(1,213)
Net income attributable to UHS – basic and diluted	$ 163,898	$ 324,363	$ 317,562	$ 532,902
Weighted average number of common shares - basic	73,682	84,224	74,356	84,503
Net effect of dilutive stock options and grants based on the treasury stock method	753	1,400	882	1,207
Weighted average number of common shares and equivalents - diluted	74,435	85,624	75,238	85,710
Earnings per basic share attributable to UHS:	$ 2.22	$ 3.85	$ 4.27	$ 6.31
Earnings per diluted share attributable to UHS:	$ 2.20	$ 3.79	$ 4.22	$ 6.22

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 5.6 million for the three and six-months ended June 30, 2022. The excluded weighted-average stock options totaled 4.2 million for the three months ended June 30, 2021 and 4.4 million for the six months ended June 30, 2021. All classes of our common stock have the same dividend rights.

Stock-Based Compensation:

During the three-month periods ended June 30, 2022 and 2021, pre-tax compensation costs of $17.6 million and $15.5 million, respectively, was recognized related to outstanding stock options. During the six-month periods ended June 30, 2022 and 2021, pre-tax compensation costs of $32.8 million and $30.2 million, respectively, was recognized related to outstanding stock options. In addition, during the three-month periods ended June 30, 2022 and 2021, pre-tax compensation cost of approximately $4.7 million and $3.2 million, respectively, was recognized related to restricted stock awards, restricted stock units and performance based restricted stock units. During the six-month periods ended June 30, 2022 and 2021, pre-tax compensation cost of approximately $8.1 million and $6.1 million, respectively, was recognized related to restricted stock awards, restricted stock units and performance based restricted stock units. As of June 30, 2022 there was approximately $191.7 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 3.0 years. There were 1,821,573 stock options granted during the first six months of 2022 with a weighted-average grant date fair value of $45.67 per option. There were an aggregate of 248,684 restricted units granted during the first six months of 2022, including 73,782 performance based restricted stock units, with a weighted-average grant date fair value of $142.97 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 $41.6 million and $37.0 million during the six-month periods ended June 30, 2022 and 2021.

(9) Dispositions and acquisitions

Six-month period ended June 30, 2022:

Acquisitions:

During the first six months of 2022, we spent $12 million on the acquisition of businesses and property.

Divestitures:

During the first six months of 2022, we received $10 million from the sales of assets and businesses.

Six-month period ended June 30, 2021:

Acquisitions:

During the first six months of 2021, there were no acquisitions.

Divestitures:

During the first six 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 $14.7 million, or $.20 per share, during the second quarter of 2022 and $16.8 million, or $.20 per share, during the second quarter of 2021. We declared and paid dividends of $29.4 million, or $.40 per share during the six-month period ended June 30, 2022 and $33.8 million, or $.40 per share, during the six-month period ended June 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 24.3% and 23.8% during the three-month periods ended June 30, 2022, and 2021, respectively, and 24.4% and 23.6% during the six-month periods ended June 30, 2022, and 2021, respectively. The increase in the effective tax rates during the three and six-month periods ended June 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 six-month periods ended June 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 six months ended June 30, 2022 and 2021.

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 six months ended June 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 June 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

The company recognizes revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods or services. 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 six-month periods ended June 30, 2022 and 2021 (in thousands):

	For the three months ended June 30, 2022					
	Acute Care		Behavioral Health		Other	Total	
Medicare	$ 318,166	17%	$ 83,350	6%		$ 401,516	12%
Managed Medicare	306,585	16%	70,877	5%		377,462	11%
Medicaid	184,098	10%	183,911	13%		368,009	11%
Managed Medicaid	162,092	9%	364,171	25%		526,263	16%
Managed Care (HMO and PPOs)	627,475	33%	376,011	26%		1,003,486	30%
UK Revenue	0	0%	173,231	12%		173,231	5%
Other patient revenue and adjustments, net	74,123	4%	125,995	9%		200,118	6%
Other non-patient revenue	202,977	11%	56,374	4%	13,971	273,322	8%
Total Net Revenue	$ 1,875,516	100%	$ 1,433,920	100%	$ 13,971	3,323,407	100%

	For the six months ended June 30, 2022					
	Acute Care		Behavioral Health		Other	Total	
Medicare	$ 655,275	17%	$ 162,862	6%		$ 818,137	12%
Managed Medicare	638,833	17%	134,727	5%		773,560	12%
Medicaid	339,934	9%	359,314	13%		699,248	11%
Managed Medicaid	333,729	9%	698,336	25%		1,032,065	16%
Managed Care (HMO and PPOs)	1,266,370	33%	741,216	26%		2,007,586	30%
UK Revenue	0	0%	349,323	12%		349,323	5%
Other patient revenue and adjustments, net	166,233	4%	246,728	9%		412,961	6%
Other non-patient revenue	387,458	10%	107,881	4%	28,144	523,483	8%
Total Net Revenue	$ 3,787,832	100%	$ 2,800,387	100%	$ 28,144	$ 6,616,363	100%

	For the three months ended June 30, 2021					
	Acute Care		Behavioral Health		Other	Total	
Medicare	$ 308,211	18%	$ 92,727	6%		$ 400,938	13%
Managed Medicare	274,393	16%	61,532	4%		335,925	11%
Medicaid	169,705	10%	227,524	16%		397,229	12%
Managed Medicaid	161,261	9%	334,202	23%		495,463	15%
Managed Care (HMO and PPOs)	588,806	34%	372,146	26%		960,952	30%
UK Revenue	0	0%	172,220	12%		172,220	5%
Other patient revenue and adjustments, net	84,157	5%	128,944	9%		213,101	7%
Other non-patient revenue	167,898	10%	42,202	3%	11,952	222,052	7%
Total Net Revenue	$ 1,754,431	100%	$ 1,431,497	100%	$ 11,952	$ 3,197,880	100%

	For the six months ended June 30, 2021					
	Acute Care		Behavioral Health		Other	Total	
Medicare	$ 643,724	19%	$ 181,219	7%		$ 824,943	13%
Managed Medicare	549,953	16%	119,074	4%		669,027	11%
Medicaid	281,346	8%	380,664	14%		662,010	11%
Managed Medicaid	296,759	9%	668,960	24%		965,719	16%
Managed Care (HMO and PPOs)	1,187,616	34%	720,890	26%		1,908,506	31%
UK Revenue	0	0%	336,886	12%		336,886	5%
Other patient revenue and adjustments, net	178,407	5%	249,227	9%		427,634	7%
Other non-patient revenue	311,168	9%	89,914	3%	15,060	416,142	7%
Total Net Revenue	$ 3,448,973	100%	$ 2,746,834	100%	$ 15,060	$ 6,210,867	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 hospital terms 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 six-month periods ended June 30, 2022 and 2021 are as follows (in thousands):

	Six months ended June 30,	
	2022	2021
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from operating leases	$ 61,964	$ 59,818
Operating cash flows from finance leases	$ 2,000	$ 2,352
Financing cash flows from finance leases	$ 1,798	$ 1,589
Right-of-use assets obtained in exchange for lease obligations:		
Operating leases	$ 27,930	$ 12,322
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 June 30, 2022, we owned and/or operated 361 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;
- 20 free-standing emergency departments, and;
- 7 outpatient centers & 1 surgical hospital.

Behavioral health care facilities (333 inpatient facilities and 13 outpatient facilities):

Located in the U.S.:

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

Located in the U.K.:

- 145 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 56% and 55% during the three-month periods ended June 30, 2022 and 2021, respectively, and 57% and 56% during the six-month periods ended June 30, 2022 and 2021, respectively. Net revenues from our behavioral health care facilities and commercial health insurer accounted for 43% and 45% of our consolidated net revenues during the three-month period ended June 30, 2022 and 2021, respectively, and 42% and 44% during the six-month periods ended June 30, 2022 and 2021, respectively.

Our behavioral health care facilities located in the U.K. generated net revenues of approximately $173 million and $172 million during the three-month periods ended June 30, 2022 and 2021, respectively, and $349 million and $337 million during the six-month periods ended June 30, 2022 and 2021, respectively. Total assets at our U.K. behavioral health care facilities were approximately $1.220 billion as of June 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 during the remainder of 2022. 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 during the remainder of 2022. 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 six months of 2022, are expected to have an unfavorable material impact on our results of operations during the remainder of 2022;
- 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 ARPA's expansion of subsidies to

purchase coverage through a Legislation exchange 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. 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. On July 13, 2021, HHS, the Department of Labor and the Department of the Treasury issued an interim final rule, which begins to implement the legislation. The rule would 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;
- 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/are expected to have 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, 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 and Clinical Staffing Shortage:

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 during the remainder of 2022. 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 during the remainder of 2022.

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 six months of 2022, are expected to have an unfavorable material impact on our results of operations during the remainder of 2022.

Financial results for the three-month periods ended June 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 June 30, 2022 and 2021 (dollar amounts in thousands):

	Three months ended June 30, 2022		Three months ended June 30, 2021	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 3,323,407	100.0%	$ 3,197,880	100.0%
Operating charges:				
Salaries, wages and benefits	1,691,472	50.9%	1,487,935	46.5%
Other operating expenses	867,885	26.1%	769,810	24.1%
Supplies expense	354,993	10.7%	338,033	10.6%
Depreciation and amortization	143,850	4.3%	133,985	4.2%
Lease and rental expense	31,773	1.0%	29,149	0.9%
Subtotal-operating expenses	3,089,973	93.0%	2,758,912	86.3%
Income from operations	233,434	7.0%	438,968	13.7%
Interest expense, net	25,676	0.8%	21,299	0.7%
Other (income) expense, net	(1,972)	(0.1)%	(9,129)	(0.3)%
Income before income taxes	209,730	6.3%	426,798	13.3%
Provision for income taxes	50,949	1.5%	101,522	3.2%
Net income	158,781	4.8%	325,276	10.2%
Less: Income (loss) attributable to noncontrolling interests	(5,281)	(0.2)%	252	0.0%
Net income attributable to UHS	$ 164,062	4.9%	$ 325,024	10.2%

Net revenues increased by 3.9%, or $126 million, to $3.32 billion during the three-month period ended June 30, 2022 as compared to $3.20 billion during the second quarter of 2021. The net increase was primarily attributable to: (i) a $63 million or 2.0% 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) $63 million of other combined net increases.

Income before income taxes (before income attributable to noncontrolling interests) decreased by $217 million to $210 million during the three-month period ended June 30, 2022 as compared to $427 million during the second quarter of 2021. The $217 million net decrease was due to:

- a decrease of $124 million at our acute care facilities, as discussed below in *Acute Care Hospital Services*;
- a decrease of $75 million at our behavioral health care facilities, as discussed below in *Behavioral Health Services*, and;
- $18 million of other combined net decreases.

Net income attributable to UHS decreased by $161 million to $164 million during the three-month period ended June 30, 2022 as compared to $325 million during the second quarter of 2021. This decrease was attributable to:

- a $217 million decrease in income before income taxes, as discussed above;
- an increase of $5 million due to a decrease in income (loss) attributable to noncontrolling interests, and;
- an increase of $51 million resulting from a decrease in the provision for income taxes due primarily to the income tax benefit recorded in connection with the $212 million decrease in pre-tax income.

Financial results for the six-month periods ended June 30, 2022 and 2021:

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

	Six months ended June 30, 2022		Six months ended June 30, 2021	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 6,616,363	100.0%	$ 6,210,867	100.0%
Operating charges:				
Salaries, wages and benefits	3,383,742	51.1%	2,985,708	48.1%
Other operating expenses	1,688,819	25.5%	1,479,518	23.8%
Supplies expense	726,066	11.0%	685,143	11.0%
Depreciation and amortization	287,634	4.3%	265,388	4.3%
Lease and rental expense	63,811	1.0%	60,473	1.0%
Subtotal-operating expenses	6,150,072	93.0%	5,476,230	88.2%
Income from operations	466,291	7.0%	734,637	11.8%
Interest expense, net	47,349	0.7%	43,256	0.7%
Other (income) expense, net	9,229	0.1%	(8,294)	(0.1)%
Income before income taxes	409,713	6.2%	699,675	11.3%
Provision for income taxes	99,911	1.5%	165,329	2.7%
Net income	309,802	4.7%	534,346	8.6%
Less: Income attributable to noncontrolling interests	(8,173)	(0.1)%	231	0.0%
Net income attributable to UHS	$ 317,975	4.8%	$ 534,115	8.6%

Net revenues increased by 6.5%, or $405 million, to $6.62 billion during the three-month period ended June 30, 2022 as compared to $6.21 billion during the second quarter of 2021. The net increase was primarily attributable to: (i) a $275 million or 4.5% increase in net revenues generated from our acute care hospital services and behavioral health services, on a same facility basis, and; (ii) $130 million of other combined net increases.

Income before income taxes (before income attributable to noncontrolling interests) decreased by $290 million to $410 million during the six-month period ended June 30, 2022, as compared to $700 million during the comparable period of 2021. The $290 million net decrease was due to:

- a decrease of $148 million at our acute care facilities, as discussed below in *Acute Care Hospital Services*;
- a decrease of $100 million at our behavioral health care facilities, as discussed below in *Behavioral Health Services*, and;
- $42 million of other combined net decreases.

Net income attributable to UHS decreased by $216 million to $318 million during the six-month period ended June 30, 2022 as compared to $534 million during the first six months of 2021. This decrease was attributable to:

- a $290 million decrease in income before income taxes, as discussed above;
- an increase of $8 million due to a decrease in income (loss) attributable to noncontrolling interests, and;
- an increase of $66 million resulting from a decrease in the provision for income taxes due primarily to the income tax benefit recorded in connection with the $282 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 three and six-month periods ended June 30, 2022 and 2021 included increases to our reserves for self-insured professional and general liability claims amounting to approximately $16 million and $36 million, respectively.

During the three and six-month periods ended June 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 three and six-month periods ended June 30, 2021, approximately $27 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 $9 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 six-month periods ended June 30, 2022 and 2021 (dollar amounts in thousands):

	Three months ended June 30, 2022		Three months ended June 30, 2021		Six months ended June 30, 2022		Six months ended June 30, 2021	
	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,770,546	100.0%	$ 1,713,896	100.0%	$ 3,605,325	100.0%	$ 3,385,732	100.0%
Operating charges:								
Salaries, wages and benefits	792,922	44.8%	691,019	40.3%	1,613,132	44.7%	1,397,830	41.3%
Other operating expenses	469,108	26.5%	412,111	24.0%	906,585	25.1%	805,318	23.8%
Supplies expense	290,067	16.4%	289,111	16.9%	603,204	16.7%	585,589	17.3%
Depreciation and amortization	87,636	4.9%	82,959	4.8%	180,575	5.0%	164,143	4.8%
Lease and rental expense	17,351	1.0%	18,046	1.1%	35,066	1.0%	38,158	1.1%
Subtotal-operating expenses	1,657,084	93.6%	1,493,246	87.1%	3,338,562	92.6%	2,991,038	88.3%
Income from operations	113,462	6.4%	220,650	12.9%	266,763	7.4%	394,694	11.7%
Interest expense, net	478	0.0%	248	0.0%	1,116	0.0%	494	0.0%
Other (income) expense, net	221	0.0%	-	—	422	0.0%	0	—
Income before income taxes	$ 112,763	6.4%	$ 220,402	12.9%	$ 265,225	7.4%	$ 394,200	11.6%

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

During the three-month period ended June 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 $57 million or 3.3%. Income before income taxes (and before income attributable to noncontrolling interests) decreased by $108 million, or 49%, amounting to $113 million, or 6.4% of net revenues during the second quarter of 2022 as compared to $220 million, or 12.9% of net revenues during the second quarter of 2021.

During the three-month period ended June 30, 2022, net revenue per adjusted admission increased by 2.5% while net revenue per adjusted patient day remained unchanged, as compared to the comparable quarter of 2021. During the three-month period ended June 30, 2022, as compared to the comparable prior year quarter, inpatient admissions to our acute care hospitals decreased by 0.9% while adjusted admissions (adjusted for outpatient activity) decreased by 0.7%. Patient days at these facilities increased by 1.7% and adjusted patient days increased by 1.8% during the three-month period ended June 30, 2022 as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities was 4.9 days and 4.8 days during the three-month periods ended June 30, 2022 and 2021, respectively. The occupancy rate, based on the average available beds at these facilities, was 62% during the three-month period ended June 30, 2022 as compared to 63% during the comparable quarter in the prior year.

Our acute care hospitals experienced a significant decline in COVID-related patients during the second quarter of 2022, as compared to the first quarter of 2022. The decrease in COVID-related patient volumes during the second quarter of 2022 was not offset by an equivalent increase in non-COVID-related patients resulting in significant shortfalls in revenues and earnings as compared to our original expectations for the quarter. Although the decreased patient volumes at our acute care hospitals have relieved some of the staffing shortages and related cost escalations previously experienced at those facilities (as discussed above in *COVID-19 and Clinical Staffing Shortage*), recovery from the effects of the labor pressures has been occurring at a somewhat slower pace than expected.

Six-month periods ended June 30, 2022 and 2021:

During the six-month period ended June 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 $220 million or 6.5%. Income before income taxes (and before income attributable to noncontrolling interests) decreased by $129 million, or 33%, amounting to $265 million, or 7.4% of net revenues during the first six months of 2022 as compared to $394 million, or 11.6% of net revenues during the comparable period of 2021.

During the six-month period ended June 30, 2022, net revenue per adjusted admission increased by 2.9% while net revenue per adjusted patient day increased by 1.6%, as compared to the comparable period of 2021. During the six-month period ended June 30, 2022, as compared to the comparable period of 2021, inpatient admissions to our acute care hospitals increased by 0.9% and adjusted admissions (adjusted for outpatient activity) increased by 2.4%. Patient days at these facilities increased by 2.1% and adjusted patient days increased by 3.6% during the six-month period ended June 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 six-month periods ended June 30, 2022 and 2021. The occupancy rate, based on the average available beds at these facilities, was 65% during the six-month period ended June 30, 2022 as compared to 66% during the comparable period of 2021.

All Acute Care Hospitals

The following table summarizes the results of operations for all our acute care operations during the three and six-month periods ended June 30, 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 June 30, 2022		Three months ended June 30, 2021		Six months ended June 30, 2022		Six months ended June 30, 2021	
	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,875,516	100.0%	$ 1,754,431	100.0%	$ 3,787,832	100.0%	$ 3,448,973	100.0%
Operating charges:								
Salaries, wages and benefits	829,040	44.2%	691,880	39.4%	1,672,946	44.2%	1,399,098	40.6%
Other operating expenses	532,504	28.4%	453,063	25.8%	1,014,582	26.8%	869,070	25.2%
Supplies expense	302,728	16.1%	289,225	16.5%	624,155	16.5%	585,704	17.0%
Depreciation and amortization	95,004	5.1%	83,306	4.7%	189,538	5.0%	164,668	4.8%
Lease and rental expense	20,482	1.1%	18,046	1.0%	41,334	1.1%	38,158	1.1%
Subtotal-operating expenses	1,779,758	94.9%	1,535,520	87.5%	3,542,555	93.5%	3,056,698	88.6%
Income from operations	95,758	5.1%	218,911	12.5%	245,277	6.5%	392,275	11.4%
Interest expense, net	478	0.0%	248	0.0%	1,116	0.0%	494	0.0%
Other (income) expense, net	221	0.0%	-	—	422	0.0%	0	—
Income before income taxes	$ 95,059	5.1%	$ 218,663	12.5%	$ 243,739	6.4%	$ 391,781	11.4%

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

During the three-month period ended June 30, 2022, as compared to the comparable prior year quarter, net revenues from our acute care hospital services increased by $121 million, or 6.9%, due to: (i) the $57 million, or 3.3% increase in same facility revenues, as discussed above, and; (ii) $64 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 $124 million, or 57%, to $95 million, or 5.1% of net revenues during the second quarter of 2022, as compared to $219 million, or 12.5% of net revenues during the second quarter of 2021. The $124 million decrease in income before income taxes from our acute care hospital services resulted from the $108 million, or 49% decrease in income before income taxes at our hospitals, on a same facility basis, as discussed above, and $16 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.

Six-month periods ended June 30, 2022 and 2021:

During the six-month period ended June 30, 2022, as compared to the comparable prior year period, net revenues from our acute care hospital services increased by $339 million, or 9.8%, due to: (i) the $220 million, or 6.5% increase in same facility revenues, as discussed above, and; (ii) $119 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 $148 million, or 38%, to $244 million, or 6.4% of net revenues during the first six months of 2022, as compared to $392 million, or 11.4% of net revenues during the first six months of 2021. The $148 million decrease in income before income taxes from our acute care hospital services resulted from the $129 million, or 33% decrease in income before income taxes at our hospitals, on a same facility basis, as discussed above, and $19 million of other combined net decreases related primarily to the start-up losses incurred at the recently opened hospital located in Reno, Nevada.

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 six-month periods ended June 30, 2022 and 2021:

Uncompensated care:

Amounts in millions	Three Months Ended				Six Months Ended			
	June 30, 2022	%	June 30, 2021	%	June 30, 2022	%	June 30, 2021	%
Charity care	$ 205	33%	$ 179	34%	$ 420	38%	$ 346	36%
Uninsured discounts	419	67%	350	66%	674	62%	609	64%
Total uncompensated care	$ 624	100%	$ 529	100%	$ 1,094	100%	$ 955	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		Six Months Ended	
	June 30, 2022	June 30, 2021	June 30, 2022	June 30, 2021
Estimated cost of providing charity care	$ 22	$ 19	$ 45	$ 37
Estimated cost of providing uninsured discounts related care	46	38	73	66
Estimated cost of providing uncompensated care	$ 68	$ 57	$ 118	$ 103

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

Same Facility—Behavioral Health

	Three months ended June 30, 2022		Three months ended June 30, 2021		Six months ended June 30, 2022		Six months ended June 30, 2021	
	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,410,799	100.0%	$ 1,404,142	100.0%	$ 2,745,331	100.0%	$ 2,690,119	100.0%
Operating charges:								
Salaries, wages and benefits	768,174	54.4%	709,170	50.5%	1,513,980	55.1%	1,407,398	52.3%
Other operating expenses	274,237	19.4%	263,135	18.7%	539,928	19.7%	507,500	18.9%
Supplies expense	52,343	3.7%	49,278	3.5%	101,939	3.7%	99,791	3.7%
Depreciation and amortization	45,154	3.2%	46,323	3.3%	89,885	3.3%	91,413	3.4%
Lease and rental expense	10,685	0.8%	9,736	0.7%	21,409	0.8%	20,987	0.8%
Subtotal-operating expenses	1,150,593	81.6%	1,077,642	76.7%	2,267,141	82.6%	2,127,089	79.1%
Income from operations	260,206	18.4%	326,500	23.3%	478,190	17.4%	563,030	20.9%
Interest expense, net	1,141	0.1%	989	0.1%	1,606	0.1%	1,327	0.0%
Other (income) expense, net	(643)	(0.0)%	(5)	(0.0)%	(758)	(0.0)%	408	0.0%
Income before income taxes	$ 259,708	18.4%	$ 325,516	23.2%	$ 477,342	17.4%	$ 561,295	20.9%

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

During the three-month period ended June 30, 2022, as compared to the comparable prior year quarter, net revenues from our behavioral health services, on a same facility basis, increased by $7 million or 0.5%. Income before income taxes (and before income attributable to noncontrolling interests) decreased by $66 million, or 20%, amounting to $260 million or 18.4% of net revenues during the second quarter of 2022 as compared to $326 million or 23.2% of net revenues during the second quarter of 2021.

During the three-month period ended June 30, 2022, net revenue per adjusted admission increased by 2.6% while net revenue per adjusted patient day increased by 1.8%, as compared to the comparable quarter of 2021. During the three-month period ended June 30, 2022, as compared to the comparable prior year quarter, inpatient admissions and adjusted admissions to our behavioral health care hospitals each decreased by 0.1%. Patient days and adjusted patient days at these facilities each increased by 0.7% during the three-month period ended June 30, 2022 as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities was 13.6 days and 13.4 days during the three-month periods ended June 30, 2022 and 2021, respectively. The occupancy rate, based on the average available beds at these facilities, was 72% during each of the three-month periods ended June 30, 2022 and 2021.

Six-month periods ended June 30, 2022 and 2021:

During the six-month period ended June 30, 2022, as compared to the comparable prior year period, net revenues from our behavioral health services, on a same facility basis, increased by $55 million or 2.1%. Income before income taxes (and before income attributable to noncontrolling interests) decreased by $84 million, or 15%, amounting to $477 million or 17.4% of net revenues during the first six months of 2022 as compared to $561 million or 20.9% of net revenues during the first six months of 2021.

During the six-month period ended June 30, 2022, net revenue per adjusted admission increased by 4.2% while net revenue per adjusted patient day increased by 3.4%, as compared to the comparable period of 2021. During the six-month period ended June 30, 2022, as compared to the comparable prior year period, inpatient admissions to our behavioral health care hospitals decreased by 1.2% and adjusted admissions decreased by 1.0%. Patient days at these facilities decreased by 0.5% and adjusted patient days decreased by 0.3% during the six-month period ended June 30, 2022 as compared to the comparable prior year period. The average length of inpatient stay at these facilities was 13.5 days and 13.4 days during the six-month periods ended June 30, 2022 and 2021, respectively. The occupancy rate, based on the average available beds at these facilities, was 71% and 72% during the six-month periods ended June 30, 2022 and 2021, respectively.

As discussed above in *COVID-19 and Clinical Staffing Shortage*, the nationwide shortage of nurses and other clinical staff and support personnel has been a significant operating issue facing us and other healthcare providers. At certain of our behavioral health care facilities, we have been unable to fill all vacant positions and, consequently, have been required to limit patient volumes which had a material unfavorable impact on our results of operations during the first six months of 2022. Conditions related to the COVID-19 pandemic and its unfavorable impact on our staffing and related impact on our behavioral health care patient volumes could continue to materially affect our financial performance during the remainder of 2022.

All Behavioral Health Care Facilities

The following table summarizes the results of operations for all our behavioral health care services during the three and six-month periods ended June 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 June 30, 2022		Three months ended June 30, 2021		Six months ended June 30, 2022		Six months ended June 30, 2021	
	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,433,920	100.0%	$ 1,431,497	100.0%	$ 2,800,387	100.0%	$ 2,746,834	100.0%
Operating charges:								
Salaries, wages and benefits	773,966	54.0%	713,623	49.9%	1,527,852	54.6%	1,417,598	51.6%
Other operating expenses	299,782	20.9%	285,689	20.0%	598,249	21.4%	554,986	20.2%
Supplies expense	52,655	3.7%	49,552	3.5%	102,832	3.7%	100,561	3.7%
Depreciation and amortization	45,863	3.2%	47,183	3.3%	91,942	3.3%	93,665	3.4%
Lease and rental expense	10,973	0.8%	9,685	0.7%	21,793	0.8%	21,368	0.8%
Subtotal-operating expenses	1,183,239	82.5%	1,105,732	77.2%	2,342,668	83.7%	2,188,178	79.7%
Income from operations	250,681	17.5%	325,765	22.8%	457,719	16.3%	558,656	20.3%
Interest expense, net	1,366	0.1%	1,193	0.1%	2,731	0.1%	2,346	0.1%
Other (income) expense, net	(643)	(0.0)%	(5)	(0.0)%	(758)	(0.0)%	408	0.0%
Income before income taxes	$ 249,958	17.4%	$ 324,577	22.7%	$ 455,746	16.3%	$ 555,902	20.2%

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

During the three-month period ended June 30, 2022, as compared to the comparable prior year quarter, net revenues generated from our behavioral health services increased by $2 million, or 0.2%.

Income before income taxes decreased by $75 million, or 23.0%, to $250 million or 17.4% of net revenues during the second quarter of 2022, as compared to $325 million or 22.7% of net revenues during the second quarter of 2021. The decrease in income before income taxes at our behavioral health facilities during the second quarter of 2022, as compared to the second quarter of 2021, was primarily attributable to the $66 million, or 20% decrease in income before income taxes experienced at our behavioral health facilities on a same facility basis, as discussed above, as well as $9 million of other combined net decreases consisting primarily of the startup losses incurred at various facilities opened during the past year.

Six-month periods ended June 30, 2022 and 2021:

During the six-month period ended June 30, 2022, as compared to the comparable prior year period, net revenues generated from our behavioral health services increased by $54 million, or 1.9% due primarily to the above-mentioned $55 million, or 2.1% increase in net revenues on a same facility basis.

Income before income taxes decreased by $100 million, or 18.0%, to $456 million or 16.3% of net revenues during the first six months of 2022, as compared to $556 million or 20.2% of net revenues during the first six months of 2021. The decrease in income before income taxes at our behavioral health facilities during the first six months of 2022, as compared to the compared period of 2021, was primarily attributable to the $84 million, or 15% decrease in income before income taxes experienced at our behavioral health facilities on a same facility basis, as discussed above, as well as $16 million of other combined net decreases consisting primarily of the startup losses incurred at various facilities opened during the past year.

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.

The various provisions in the Legislation that directly or indirectly affect Medicare and Medicaid reimbursement are scheduled to take 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 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 ends 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 July, 2022, CMS issued its OPPS proposed rule for 2023. The hospital market basket increase is 3.1% and the productivity adjustment reduction is -0.4% for a net market basket increase of 2.7%. Notably, the CMS proposed rule did not reflect the *American Hospital Association v. Becerra* Supreme Court decision. Given the timing of that decision, CMS was unable to adjust the proposed payment rates and budget neutrality calculations before issuing this proposed rule. For calendar year 2023, CMS had formally proposed a payment rate of average sales price minus 22.5% for drugs and biologicals acquired through the 340B Program, consistent with prior CMS policy. However, CMS indicated it anticipates applying a rate of average sale price plus 6% to such drugs and biologicals in the final rule for calendar year 2023, in light of the Supreme Court's recent decision. CMS is still evaluating how to apply the Supreme Court's recent decision related to prior calendar years (i.e. 2018 to 2022). CMS provided an impact file for its anticipated 340B payment policy option as addenda to the proposed rule. 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 2022 will aggregate to a net decrease of -0.6% which includes a -3.9% decrease 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 2020, 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. HHSC has a pool size of $4.7 billion. On March 25, 2022, CMS approved the CHIRP program retroactive to September 1, 2021. Actual impact is expected to become known during the second quarter of 2022 upon finalization of CHIRP program details including the collection of the necessary inter-governmental transfers by the state used to finance the non-federal share of the 2023 CHIRP payments as well as interaction with other state payment programs. As a result of CMS' approval of CHIRP, our results of operations for the six-month period ended June 30, 2022 include approximately $12 million of estimated CHIRP revenues (which were recorded during the first quarter of 2022, net of associated provider taxes) attributable to the period September 1, 2021 through December 31, 2021. Our results of operations for the three and six-month periods ended June 30, 2022 included incremental CHIRP related revenue of approximately $22 million for the period retroactive to September 1, 2021.

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. The impact of this program is 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 during the three and six-month periods ended June 30, 2022 and $30 million during the three and six-month period ended June 30, 2021.

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 six-month periods ended June 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		Six Months Ended	
	June 30, 2022	June 30, 2021	June 30, 2022	June 30, 2021
Texas UC/UPL:				
Revenues	$ 60	$ 41	$ 126	$ 67
Provider Taxes	(17)	(13)	(46)	(19)
Net benefit	$ 43	$ 28	$ 80	$ 48
Texas DSRIP:				
Revenues	$ 27	$ 44	$ 27	$ 44
Provider Taxes	(9)	(14)	(9)	(14)
Net benefit	$ 18	$ 30	$ 18	$ 30
Various other state programs:				
Revenues	$ 113	$ 149	$ 217	$ 234
Provider Taxes	(36)	(35)	(78)	(75)
Net benefit	$ 77	$ 114	$ 139	$ 159
Total all Provider Tax programs:				
Revenues	$ 200	$ 234	$ 370	$ 345
Provider Taxes	(62)	(62)	(133)	(108)
Net benefit	$ 138	$ 172	$ 237	$ 237

We estimate that our aggregate net benefit from the Texas and various other state Medicaid supplemental payment programs will approximate $452 million (net of Provider Taxes of $266 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 six-month periods ended June 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 2022 DSH fiscal year (covering the period of October 1, 2021 through September 30, 2022).

In connection with these DSH programs, included in our financial results was an aggregate of approximately $13 million during each of the three-month periods ended June 30, 2022 and 2021, and approximately $24 million and $23 million during the six-month periods ended June 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 $49 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 $43 million as of June 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.

In connection with this program, included in our financial results was approximately $6 million during each of the three-month period ended June 30, 2022 and 2021, and approximately $11 million during each of the six-month periods ended June 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, 2021	Approved through December 31, 2021; Paid through December 31, 2021
Managed Care-Pass-Through Payment	Approved through December 31, 2021	Approved through June 30, 2019; Paid in advance of approval through December 31, 2021
Managed Care-Directed Payment	Approved through December 31, 2021	Approved through June 30, 2019; Paid in advance of approval through June 30, 2020

In connection with the existing program, included in our financial results was approximately $13 million and $11 million during the three-month periods ended June 30, 2022 and 2021, respectively, and $27 million and $24 million during the six-month periods ended June 30, 2022 and 2021, respectively. We estimate that our reimbursements pursuant to this program will approximate $52 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.

In April, 2020, the California Department of Health Care Services ("DHCS") notified hospital providers that participate in the Medicaid managed care directed payment program that DHCS would recalculate directed payments for the period of July 1, 2017 through September 30, 2018 ("SFY 2018") to remedy an identified data error. In August, 2020, as a follow-up to that notification, DHCS issued its corrected directed payment calculations. The updated calculation resulted in a favorable adjustment to the above program year and also resulted in increased expected supplemental payment amount for program years subsequent to the recalculated SFY 2018 rate period. The California Hospital Fee amounts noted above include our portion of the state corrected data.

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 $13 million and $55 million during the three-month periods ended June 30, 2022 and 2021, respectively, and approximately $30 million and $55 million during the six-month periods ended June 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 $35 million during the year ended December 31, 2022, all of which we expect to record during the fourth quarter. Additional Medicaid managed regions in the state may participate in the program during the 2022 DPP year which, if implemented, would increase our reimbursements received pursuant to the 2022 DPP.

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. We do not expect this interim 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 proposed 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 proposed rule discussed above, and as a result of the on-going COVID-19 pandemic, CMS has proposed to 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 proposed rule discussed above, CMS proposed to 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 July 15, 2022 for ninety (90) days. As a result, states would be eligible for the enhanced FMAP through the end of federal fiscal quarter ending December 31, 2022 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 six-month period ended June 30, 2022. Our results of operations for the six-month period ended June 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 $1 million and $14 million during the three-month periods ended June 30, 2022 and 2021, respectively, and $18 million and $32 million during the six-month periods ended June 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 ends on June 30, 2022.
  - Our financial results included revenues recorded in connection with this Medicare sequestration relief program amounting to $6 million and $11 million during the three-month periods ended June 30, 2022 and 2021, respectively, and $17 million and $22 million during the six-month periods ended June 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 $3 million during each of the three-month periods ended June 30, 2022 and 2021, and approximately $19 million during each of the six month periods ended June 30, 2022 and 2021. 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 $26 million and $21 million during the three-month periods ended June 30, 2022 and 2021, respectively, and $47 million and $43 million during the six-month periods ended June 30, 2022 and 2021, respectively (amounts in thousands):

	Three Months Ended June 30, 2022	Three Months Ended June 30, 2021	Six Months Ended June 30, 2022	Six Months Ended June 30, 2021
Revolving credit & demand notes (a.)	$ 3,977	$ 504	$ 6,312	$ 1,000
Tranche A term loan facility (a.)	9,507	6,999	15,533	14,116
Tranche B term loan facility (a.)	-	2,291	-	4,589
$400 million, 5.00% Senior Notes due 2026 (b.)	-	5,000	-	10,000
$800 million, 2.65% Senior Notes due 2030 (c.)	5,357	5,357	10,713	10,757
$700 million, 1.65% Senior Notes due 2026 (d.)	2,931	-	5,863	-
$500 million, 2.65% Senior Notes due 2032 (e.)	3,345	-	6,690	-
Accounts receivable securitization program (f.)	10	7	20	767
Subtotal-revolving credit, demand notes, Senior Notes, term loan facilities and accounts receivable securitization program	25,127	20,158	45,131	41,229
Amortization of financing fees	1,117	1,026	2,222	2,118
Other combined interest expense	1,706	1,538	3,611	2,875
Capitalized interest on major projects	(2,211)	(1,013)	(3,539)	(1,652)
Interest income	(63)	(410)	(76)	(1,314)
Interest expense, net	$ 25,676	$ 21,299	$ 47,349	$ 43,256

(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 ($140 million of borrowings outstanding as of June 30, 2022); (ii) a tranche A term loan facility with $2.37 billion of outstanding borrowings as of June 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, and amended in July, 2022 to extend the maturity date to September, 2022. There are no outstanding borrowings as of June 30, 2022.

Interest expense increased approximately $4 million during the three-month period ended June 30, 2022 as compared to the three-month period ended June 30, 2021, due primarily to a net $5 million increase in aggregate interest expense on our revolving credit, demand notes, senior notes, term loan facilities and accounts receivable securitization program resulting from an increase in the aggregate average outstanding borrowings ($4.41 billion during the three months ended June 30, 2022 as compared to $3.56 billion during the three months ended June 30, 2021). Our weighted average cost of borrowings pursuant to these facilities was 2.24% during each of the three-month periods ended June 30, 2022 and 2021. 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 2.4% during each of the three-month period ended June 30, 2022 and 2021.

Interest expense increased approximately $4 million during the six-month period ended June 30, 2022, as compared to the six-month period ended June 30, 2021, primarily due to a net $4 million increase on our revolving credit, demand notes, senior notes, term loan facilities and accounts receivable securitization program resulting from an increase in the aggregate average outstanding borrowings ($4.33 billion during the six months ended June 30, 2022 as compared to $3.69 billion during the six months ended June 30, 2021), partially offset by a decrease in our weighted average cost of borrowings pursuant to these facilities (2.06% and 2.22% during the six-month periods ended June 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 2.17% and 2.34% during the six-month periods ended June 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 six-month periods ended June 30, 2022 and 2021 (dollar amounts in thousands):

	Three months ended		Six months ended	
	June 30, 2022	June 30, 2021	June 30, 2022	June 30, 2021
Provision for income taxes	$ 50,949	$ 101,522	$ 99,911	$ 165,329
Income before income taxes	209,730	426,798	409,713	699,675
Effective tax rate	24.3%	23.8%	24.4%	23.6%

The provision for income taxes decreased $51 million during the three-month period ended June 30, 2022, as compared to the second quarter of 2021, due primarily to the income tax benefit recorded in connection with the $212 million decrease in pre-tax income.

The provision for income taxes decreased $65 million during the six-month period ended June 30, 2022, as compared to the comparable period of 2021, due primarily to the income tax benefit recorded in connection with the $282 million decrease in pre-tax income.

Liquidity

Net cash provided by operating activities

Net cash provided by operating activities was $478 million during the six-month period ended June 30, 2022 and $119 million during the first six months of 2021. The net increase of $359 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 $199 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 and provision for asset impairment;
- an unfavorable change of $102 million from other working capital accounts due primarily to the timing of disbursements for accrued expenses, accounts payable and accrued compensation, and;
- $35 million of other combined net unfavorable changes.

Days sales outstanding ("DSO"): Our DSO are calculated by dividing our net revenue by the number of days in the six-month periods. The result is divided into the accounts receivable balance at June 30th of each year to obtain the DSO. Our DSO were 50 days and 52 days at June 30, 2022 and 2021, respectively.

Net cash used in investing activities

During the first six months of 2022, we used $326 million of net cash in investing activities as follows:

- $408 million spent on capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities;
- $85 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;
- $12 million spent on the acquisition of businesses and property, and;
- $10 million received from the sales of assets and businesses.

During the first six months of 2021, we used $484 million of net cash in investing activities as follows:

- $482 million spent on capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities;
- $21 million spent in connection with net cash outflows from forward exchange contracts that hedge our investment in the U.K. against movements in exchange rates;
- $21 million received from the sale of our equity interest in a business, and;
- $1 million spent on the purchase and implementation of information technology applications.

Net cash used in financing activities

During the first six months of 2022, we used $124 million of net cash in financing activities as follows:

- generated $700 million of additional borrowings pursuant to the new tranche A term loan facility which commenced in June, 2022;
- spent $565 million to repurchase shares of our Class B Common Stock in connection with: (i) open market purchases pursuant to our stock repurchase program ($546 million), and; (ii) income tax withholding obligations related to stock-based compensation programs ($19 million);
- spent $227 million on net repayments of debt as follows: (i) $203 million related to our revolving credit facility; (ii) $21 million related to our tranche A term loan facility, and; (iii) $3 million related to other debt facilities;
- spent $30 million to pay quarterly cash dividends of $.20 per share during each of the first and second quarters;
- spent $5 million to pay profit distributions related to noncontrolling interests in majority owned businesses;
- generated $7 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans;
- spent $2 million to pay financing costs, and;
- spent $1 million in connection with the purchase of ownership interests from minority members.

During the first six months of 2021, we used $662 million of net cash in financing activities as follows:

- spent $279 million on net repayments of debt as follows: (i) $225 million in connection with our accounts receivable securitization program; (ii) $50 million related to our term loan A facility; (iii) $3 million related to our previously outstanding term loan B facility, and; (iv) $1 million related to other debt facilities;
- generated $7 million of proceeds related to other debt facilities;
- spent $34 million to pay cash dividends of $.20 per share during each of the first and second quarters;
- received $11 million in connection with the sale of ownership interest to minority members;
- spent $368 million to repurchase shares of our Class B Common Stock in connection with: (i) open market purchases pursuant to our stock repurchase program ($350 million), and; (ii) income tax withholding obligations related to stock-based compensation programs ($18 million);
- spent $6 million to pay profit distributions related to noncontrolling interests in majority owned businesses, and;
- generated $6 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans;

Expected capital expenditures during remainder of 2022

During the full year of 2022, we expect to spend approximately $800 million to $850 million on capital expenditures which includes expenditures for capital equipment, construction of new facilities, and renovations and expansions at existing hospitals. During the first six months of 2022, we spent approximately $408 million on capital expenditures. During the remaining six months of 2022, we expect to spend approximately $392 million to $442 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 June 30, 2022, this facility had $140 million of borrowings outstanding and $1.056 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 $2.368 billion of outstanding borrowings as of June 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 June 30, 2022, the applicable margins were 0.375% for ABR-based loans and 1.375% 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 June 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. Substantially all other material terms and conditions remained unchanged. There were no borrowings outstanding pursuant to the Securitization as of June 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 June 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 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 June 30, 2022 and December 31, 2021 reflect financial liabilities, which are included in debt, of approximately $82 million as of each date.

At June 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 June 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 $1.056 billion of available borrowing capacity as of June 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.

Off-Balance Sheet Arrangements

During the three months ended June 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 June 30, 2022 we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds which totaled $168 million consisting of: (i) $159 million related to our self-insurance programs, and; (ii) $9 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 June 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 June 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 second 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 second 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 June 30, 2022, we had an aggregate available repurchase authorization of $1.21 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 June 30, 2022, we have repurchased approximately 1.61 million shares at an aggregate cost of approximately $195.62 million (approximately $121.67 per share) pursuant to the terms of our stock repurchase program. In addition, during the three-month period ended June 30, 2022, 27,309 shares were repurchased in connection with income tax withholding obligations resulting from stock-based compensation programs.

During the period of April 1, 2022 through June 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)
April, 2022	$ -	186,056	315	$ 0.01	160,000	$ 123.37	$ 19,740	—	$ 1,388,334
May, 2022	$ -	1,046,001	636	$ 0.01	1,045,171	$ 123.62	$ 129,203	—	$ 1,259,131
June, 2022	$ -	402,965	1,443	$ 0.01	402,542	$ 115.95	$ 46,673	—	$ 1,212,458
Total April through June, 2022	$ -	1,635,022	2,394	$ 0.01	1,607,713	121.67	$ 195,616		

Dividends

During the quarter ended June 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	Second Supplemental Indenture, dated as of June 23, 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 2030 Notes, previously filed as Exhibit 4.1 to the Company's Current Report on Form 8-K dated June 23, 2022, is incorporated herein by reference.
4.2	First Supplemental Indenture, dated as of June 23, 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 2026 Notes and the 2032 Notes, previously filed as Exhibit 4.2 to the Company's Current Report on Form 8-K dated June 23, 2022, is incorporated herein by reference.
10.1	Ninth Amendment and Increased Facility Activation Notice dated as of June 23, 2022, to Credit Agreement, dated as of November 15, 2010 and as amended and restated as of March 15, 2011, September 21, 2012, May 16, 2013, August 7, 2014, June 7, 2016, October 23, 2018, August 24, 2021 and September 10, 2021, among the Company, JP Morgan Chase Bank, N.A., as administrative agent and other financial institutions or entities from time to time parties thereto, including the amendment and restatement thereof, effective as of June 23, 2022, attached as Exhibit A thereto and referred to herein as the Senior Secured Credit Facility previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated June 23, 2022, is incorporated herein by reference.
10.2	Universal Health Services, Inc. Amended and Restated 2020 Omnibus Stock and Incentive Plan, previously filed as Exhibit 99.1 to the Company's Registration Statement on Form S-8 (File No. 333-265495) dated June 9, 2022, is incorporated herein by reference.
10.3	Ninth Amendment to Amended and Restated Credit and Security Agreement, dated as of April 22, 2022. previously filed as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the Quarter Ended March 31, 2022, is incorporated herein by reference.
10.4	Form of Restricted Stock Units Award Agreement for Directors.
10.5	Tenth Amendment to Amended and Restated Credit and Security Agreement, dated as of July 22, 2022.
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 June 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: August 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)

Granted To:	###PARTICIPANT_NAME###
Address:	###HOME_ADDRESS###
Grant Date:	###GRANT_DATE###
Granted Amount:	###TOTAL_AWARDS###
Grant Type:	###DICTIONARY_AWARD_NAME###
RSU No:	###EMPLOYEE_GRANT_NUMBER###
Plan:	AMENDED AND RESTATED 2020 OMNIBUS STOCK AND INCENTIVE PLAN

UNIVERSAL HEALTH SERVICES, INC.
AMENDED AND RESTATED 2020 OMNIBUS STOCK AND INCENTIVE PLAN

RESTRICTED STOCK UNITS AWARD AGREEMENT

This Restricted Stock Units Award Agreement (the "***Award Agreement***"), made as of the date specified above (the "***Grant Date***"), by and between Universal Health Services, Inc., a Delaware corporation (the "***Company***"), and ###PARTICIPANT_NAME### (the "***Participant***"), residing at the address ###HOME_ADDRESS### set forth above.

W I T N E S S E T H:

WHEREAS, pursuant to the Universal Health Services, Inc. Amended and Restated 2020 Omnibus Stock and Incentive Plan, as amended to the Grant Date (the "***Plan***"), the Company desires to grant to the Participant an award of Restricted Stock Units, each of which is a bookkeeping entry representing the equivalent in value of one (1) Share, as hereinafter provided. Unless otherwise defined herein, capitalized terms shall have the meanings assigned under the Plan.

NOW, THEREFORE, in consideration of the premises and of the mutual promises hereinafter contained, the parties hereto agree as follows:

1. **The Award**. The Company hereby awards to the Participant Restricted Stock Units under the Plan, the provisions of which are incorporated herein by reference. Subject to the terms of this Award Agreement and the Plan, each Restricted Stock Unit represents a right to receive one (1) share of Common Stock (a "***Share***") on the applicable vesting date. The number of Restricted Stock Units subject to this Award, the applicable vesting schedule for the Restricted Stock Units, the dates on which the Shares underlying the Restricted Stock Units will be issued, and the remaining terms and conditions are set forth above and in this Award Agreement. Unless and until the Restricted Stock Units have vested in accordance with the vesting schedule set forth in Section 2 below, the Participant will have no right to settlement of such Restricted Stock Units. Prior to settlement of any vested Restricted Stock Units, such Restricted Stock Units will represent an unsecured obligation.

2. **Vesting Schedule**. Except as otherwise provided in this Award Agreement, the Restricted Stock Units shall vest in one installment on the earlier of one year from the date hereof or the date of the Company's 2023 annual meeting of stockholders.

3. **Termination of Service**.

3.1 **General Rule**. In the event that, prior to the vesting date, the Participant ceases to provide services to the Company (or any Subsidiary or Affiliate) in the capacity of a Director or Consultant (collectively referred to herein as "***Service***") for any reason, with or without cause, the Participant shall forfeit all Restricted Stock Units which are not, as of the time of such termination, vested (and Dividend Equivalents, if any), and the Participant shall not be entitled to any payment therefor.

3.2 **Determination of Termination Date**. For purposes of this Award Agreement, the Participant's date of cessation of Service shall mean the date upon which the Participant ceases active performance of services for the Company, a Subsidiary or Affiliate, as determined by the Company, and shall be determined solely by this Award Agreement. Thus, in the event of termination of the Participant's Service (regardless of the reason for such termination and whether or not later found to be invalid), unless otherwise expressly provided in this Award Agreement or determined by the Company, the Participant's right to vest in the Restricted Stock Units under the Plan, if any, will terminate as of such date and will not be extended by any notice period). The Committee shall have the exclusive discretion to determine when the Participant is no longer actively performing Service for purposes of the grant of Restricted Stock Units (including whether the Participant may still be considered to be providing services while on a leave of absence).

4. **Settlement of the Award**.

4.1 **Issuance of Shares of Common Stock**. Subject to the provisions of Section 4.3, Section 5 and Section 7.2 below, the Company shall issue to the Participant on the vesting date, or as soon as practicable thereafter (but in no event later than 60 days after the vesting date), with respect to each Restricted Stock Unit that becomes vested on such date, one (1) Share. Shares issued in settlement of Restricted Stock Units shall not be subject to any restriction on transfer other than any such restriction as may be required pursuant to Section 4.3.

4.2 **Beneficial Ownership of Shares; Certificate Registration**. The Participant hereby authorizes the Company, in its sole discretion, to deposit for the benefit of the Participant with a Company-designated brokerage firm or, at the Company's discretion, any other broker with which the Participant has an account relationship of which the Company has notice, any or all Shares acquired by the Participant pursuant to the settlement of the Award. Except as provided by the preceding sentence, a certificate for the Shares as to which the Award is settled shall be registered in the name of the Participant.

4.3 **Restrictions on Grant of the Award and Issuance of Shares**. The grant of the Award and issuance of shares of Common Stock upon settlement of the Award shall be subject to compliance with all applicable requirements of U.S. federal, state or foreign law with respect to such securities. No Shares may be issued hereunder if the issuance of such Shares would constitute a violation of any applicable U.S. federal, state or foreign securities laws or other laws or regulations or the requirements of any stock exchange or market system upon which the Common Stock may then be listed. The inability of the Company to obtain from any regulatory body having jurisdiction the authority, if any, deemed by the Company's legal counsel to be necessary to the lawful issuance of any Shares subject to the Award shall relieve the Company of any liability in respect of the failure to issue such Shares as to which such requisite authority shall not have been obtained. As a condition to the settlement of the Award, the Company may require the Participant to satisfy any qualifications that may be necessary or appropriate, to evidence compliance with any applicable law or regulation, and to make any representation or warranty with respect thereto as may be requested by the Company. Further, regardless of whether the transfer or issuance of the Shares to be issued pursuant to the Restricted Stock Units has been registered under the Securities Act or

has been registered or qualified under the securities laws of any State, the Company may impose additional restrictions upon the sale, pledge, or other transfer of the Shares (including the placement of appropriate legends on stock certificates and the issuance of stop-transfer instructions to the Company's transfer agent) if, in the judgment of the Company and the Company's counsel, such restrictions are necessary in order to achieve compliance with the provisions of the Securities Act, the securities laws of any State, or any other law.

4.4 **Fractional Shares**. The Company shall not be required to issue fractional Shares upon the settlement of the Award.

5. **Tax Withholding and Advice**.

5.1 **In General**. The Participant acknowledges that, regardless of any action taken by the Company, the ultimate liability for all income tax, social insurance, payroll tax, fringe benefits tax, payment on account or other tax-related items related to the Participant's participation in the Plan and legally applicable to the Participant ("***Tax-Related Items***"), is and remains the Participant's responsibility. The Participant further acknowledges that the Company (i) makes no representations or undertakings regarding the treatment of any Tax-Related Items in connection with any aspect of the Restricted Stock Unit, including, but not limited to, the grant, vesting or settlement of the Restricted Stock Units, the subsequent sale of Shares acquired pursuant to such settlement and the receipt of any dividends; and (ii) does not commit to and are under no obligation to structure the terms of the grant or any aspect of the Restricted Stock Units to reduce or eliminate the Participant's liability for Tax-Related Items or achieve any particular tax result.

5.2 **Tax Advice**. The Participant represents, warrants and acknowledges that the Company has made no warranties or representations to the Participant with respect to the income tax, social contributions or other tax consequences of the transactions contemplated by this Award Agreement, and the Participant is in no manner relying on the Company or the Company's representatives for an assessment of such tax consequences. THE PARTICIPANT UNDERSTANDS THAT THE TAX AND SOCIAL SECURITY LAWS AND REGULATIONS ARE SUBJECT TO CHANGE. THE PARTICIPANT IS HEREBY ADVISED TO CONSULT WITH HIS OR HER OWN PERSONAL TAX, LEGAL AND FINANCIAL ADVISORS REGARDING THE PARTICIPANT'S PARTICIPATION IN THE PLAN BEFORE TAKING ANY ACTION RELATED TO THE PLAN. NOTHING STATED HEREIN IS INTENDED OR WRITTEN TO BE USED, AND CANNOT BE USED, FOR THE PURPOSE OF AVOIDING TAXPAYER PENALTIES.

6. **Authorization to Release Necessary Personal Information**.

The Participant hereby explicitly and unambiguously consents to the collection, use and transfer, in electronic or other form, of the Participant's personal data as described in this Award Agreement and any other Award grant materials ("Data") by and among, as applicable, the Company and its Subsidiaries and Affiliates for the exclusive purpose of implementing, administering and managing the Participant's participation in the Plan.

The Participant understands that the Company may hold certain personal information about the Participant, including, but not limited to, the Participant's name, home address and telephone number, date of birth, social insurance number or other identification number, salary or other compensation information, nationality, job title, any Shares or directorships held in the Company, details of all Restricted Stock Units or any other entitlement to Shares awarded, canceled, exercised, vested, unvested or outstanding in the Participant's favor, for the exclusive purpose of implementing, administering and managing the Plan.

The Company may retain the services of an equity compensation plan recordkeeper (the "Recordkeeper") to facilitate administration of the Plan. In such event, the Participant understands that Data will be transferred to the Recordkeeper or such other stock plan service provider as may be selected by the Company in the future, which is assisting the Company with the implementation, administration and management of the Plan. The Participant understands that the recipients of the Data may be located in the United States or elsewhere, and that the recipient's country (e.g., the United States) may have different data privacy laws and protections than the Participant's country. The Participant understands that if he or she resides outside the United States, he or she may request a list with the names and addresses of any potential recipients of the Data by contacting the Company's stock administration department. The Participant authorizes the Company, the Recordkeeper and any other possible recipients which may assist the Company (presently or in the future) with implementing, administering and managing the Plan to receive, possess, use, retain and transfer the Data, in electronic or other form, for the sole purposes of implementing, administering and managing the Participant's participation in the Plan. The Participant understands that Data will be held only as long as is necessary to implement, administer and manage the Participant's participation in the Plan. The Participant understands that if he or she resides outside the United States, he or she may, at any time, view Data, request additional information about the storage and processing of Data, require any necessary amendments to Data or refuse or withdraw the consents herein, in any case without cost, by contacting the Company's stock administration department. Further, the Participant understands that he or she is providing the consents herein on a purely voluntary basis. If the Participant does not consent, or if the Participant later seeks to revoke his or her consent, his or her e status or service and career with the Company will not be adversely affected; the only adverse consequence of refusing or withdrawing the Participant's consent is that the Company would not be able to grant the Participant Restricted Stock Units or other equity awards or administer or maintain such awards. Therefore, the Participant understands that refusing or withdrawing his or her consent may affect the Participant's ability to participate in the Plan. For more information on the consequences of the Participant's refusal to consent or withdrawal of consent, the Participant understands that he or she may contact the Company's stock administration department.

7. **Effect of Change in Control on Award**.

In the event of a Change in Control, the vesting of the Restricted Stock Units shall be accelerated in full and the total number of Restricted Stock Units subject to the Award shall be deemed vested effective as of immediately prior to the date of the Change in Control, provided that the Participant's Service has not terminated prior to such date, and such vested Restricted Stock Units shall be settled in accordance with Section 4.1. This Award Agreement shall not in any way affect the right of the Company to adjust, reclassify, reorganize or otherwise change its capital or business structure or to merge, consolidate, dissolve, liquidate, sell or transfer all or any part of its business or assets.

8. **Adjustments for Changes in Capital Structure**.

The number of Restricted Stock Units awarded pursuant to this Award Agreement is subject to adjustment as provided in Article 10 of the Plan. Upon the occurrence of an event described in Article 10 of the Plan, any and all new, substituted or additional securities or other property to which a holder of a Share issuable in settlement of the Award would be entitled shall be immediately subject to the Award Agreement and included within the meaning of the term "Shares" for all purposes of the Award. The Participant shall be notified of such adjustment and such adjustment shall be binding upon the Company and the Participant.

9. **No Entitlement to or Claims for Compensation**.

In accepting the Award, the Participant acknowledges, understands and agrees that:

(a) the Plan is established voluntarily by the Company, it is discretionary in nature and it may be modified, amended, suspended or terminated by the Company at any time, to the extent permitted by the Plan;

(b) the grant of the Restricted Stock Units is voluntary and occasional and does not create any contractual or other right to receive future grants of Restricted Stock Units, or benefits in lieu of Restricted Stock Units, even if Restricted Stock Units have been granted in the past;

(c) all decisions with respect to future Awards of Restricted Stock Units or other grants, if any, will be at the sole discretion of the Company;

(d) the Restricted Stock Unit grant and the Participant's participation in the Plan shall not create a right to continue to serve as a director of the Company or be interpreted as forming an employment or services contract with the Company or any Subsidiary or Affiliate and shall not interfere with the ability of the Company or any Subsidiary or Affiliate, as applicable, to terminate the Participant's service relationship (if any);

(e) the Participant is voluntarily participating in the Plan;

(f) the Restricted Stock Units and the Shares subject to the Restricted Stock Units are not intended to replace any pension rights or compensation;

(g) the Restricted Stock Units and the Shares subject to the Restricted Stock Units, and the income and value of same, are not part of normal or expected compensation for purposes of calculating any severance, resignation, termination, redundancy, dismissal, end-of-service payments, bonuses, long-service awards, pension or retirement or welfare benefits or similar payments;

(h) the future value of the underlying Shares is unknown, indeterminable and cannot be predicted with certainty;

(i) no claim for or entitlement to compensation or damages shall arise from forfeiture of the Restricted Stock Units (or any portion thereof) (and Dividend Equivalents, if any) resulting from the termination of the Participant's service relationship (for any reason whatsoever whether or not later found to be invalid), and in consideration of the grant of the Restricted Stock Units, to which the Participant acknowledges he or she is otherwise not entitled, the Participant irrevocably agrees never to institute any such claim against the Company, or any of its Subsidiaries or Affiliates, waives his or her ability, if any, to bring any such claim, and releases the Company, its Subsidiaries and Affiliates from any such claim; if, notwithstanding the foregoing, any such claim is allowed by a court of competent jurisdiction, then, by participating in the Plan, the Participant shall be deemed irrevocably to have agreed not to pursue such claim and agrees to execute any and all documents necessary to request dismissal or withdrawal of such claim; and

(i) unless otherwise provided in the Plan or determined by the Company in its discretion, the Restricted Stock Units and the benefits evidenced by this Award Agreement do not create any entitlement to have the Restricted Stock Units or any such benefits transferred to, or assumed by, another company, nor to be exchanged, cashed out or substituted for, in connection with any corporate transaction affecting the shares of the Company..

10. **Rights as a Stockholder; Dividend Equivalents**.

10.1 The Participant shall have no rights as a stockholder with respect to any Shares which may be issued in settlement of this Award until the date of the issuance of a certificate for such Shares or the deposit of such Shares in a brokerage account (as evidenced by the appropriate entry on the books of the Company or of a duly authorized transfer agent of the Company). No adjustment shall be made for dividends, distributions or other rights for which the record date is prior to the date the Shares are issued, except as provided in Section 8 or Section 10.2.

10.2 The Participant shall accumulate an unvested right to payment of Dividend Equivalents on the Shares underlying Restricted Stock Units with respect to any cash dividends paid on the Shares that have a record date on or after the date of this Award Agreement. Such Dividend Equivalents will be in an amount of cash per Restricted Stock Unit equal to the cash dividend paid with respect to one Share. The Dividend Equivalents, if any, will be credited to a bookkeeping account in the name of the Participant. The Participant shall be entitled to payment of accumulated Dividend Equivalents with respect to the number of Restricted Stock Units equal to the number of Shares ultimately issued to the Participant pursuant to this Award Agreement. Dividend Equivalents shall be subject to any required tax withholding, and shall be paid to the Participant as soon as administratively possible following the date that the Shares are issued to the Participant, but in no event later than March 15th of the year following the year in which such vesting occurs. The Participant shall not be entitled to Dividend Equivalents with respect to dividends with a record date prior to the date of this Award Agreement. The Dividend Equivalent amounts will be subject to the same vesting, forfeiture and other terms and conditions applicable to the corresponding Restricted Stock Units.

11. **Miscellaneous Provisions**.

11.1 **Amendment**. The Committee may amend this Award Agreement at any time; provided, however, that no such amendment may adversely affect the Participant's rights under this Award Agreement without the consent of the Participant, except to the extent such amendment is desirable or necessary to comply with applicable law, including, but not limited to, Section 409A of the Code, as further provided in the Plan. No amendment or addition to this Award Agreement shall be effective unless in writing.

11.2 **Nontransferability of the Award**. Prior to the issuance of Shares on the applicable settlement date, no right or interest of the Participant in the Award nor any Restricted Stock Units subject to the Award shall be in any manner pledged, encumbered, or hypothecated to or in favor of any party other than the Company or a Subsidiary or Affiliate or shall become subject to any lien, obligation, or liability of such Participant to any other party other than the Company, or a Subsidiary or Affiliate. Except as otherwise provided by the Committee, no Award shall be assigned, transferred or otherwise disposed of other than by will or the laws of descent and distribution. All rights with respect to the Award shall be exercisable during the Participant's lifetime only by the Participant or the Participant's guardian or legal representative.

11.3 **Further Instruments and Imposition of Other Requirements**. The parties hereto agree to execute such further instruments and to take such further action as may reasonably be necessary to carry out the intent of this Award Agreement. The Company reserves the right to impose other requirements on Participant's participation in the Plan, on the Restricted Stock Units and on any Shares acquired under the Plan, to the extent the Company determines it is necessary or advisable in order to comply with local law or facilitate the administration of the Plan. Furthermore, the Participant acknowledges that the laws of the country in which the Participant is working at the time of grant, vesting or settlement of the Restricted Stock Units or the sale of Shares received pursuant to this Award Agreement (including any rules or regulations

governing securities, foreign exchange, tax, labor, or other matters) may subject the Participant to additional procedural or regulatory requirements that the Participant is and will be solely responsible for and must fulfill.

11.4 **Binding Effect**. This Award Agreement shall inure to the benefit of the successors and assigns of the Company and, subject to the restrictions on transfer set forth herein, be binding upon the Participant and the Participant's heirs, executors, administrators, successors and permitted assigns.

11.5 **Notices**. Any notice required to be given or delivered to the Company under the terms of this Award Agreement shall be in writing and addressed to the Company at its principal corporate offices. Any notice required to be given or delivered to the Participant shall be in writing and addressed to the Participant at the address maintained for the Participant in the Company's records or at the address of the local office of the Company or of a Subsidiary or Affiliate at which the Participant works.

11.6 **Construction of Award Agreement**. This Award Agreement, and the Restricted Stock Units evidenced hereby (i) are made and granted pursuant to the Plan and are in all respects limited by and subject to the terms of the Plan, and (ii) constitute the entire agreement between the Participant and the Company on the subject matter hereof and supersede all proposals, written or oral, and all other communications between the parties related to the subject matter. All decisions of the Committee with respect to any question or issue arising under this Award Agreement or the Plan shall be conclusive and binding on all persons having an interest in the Restricted Stock Units.

11.7 **Governing Law**. The interpretation, performance and enforcement of this Award Agreement shall be governed by the laws of the State of Delaware, U.S.A. without regard to the conflict-of-laws rules thereof or of any other jurisdiction.

11.8 **Arbitration; Choice of Forum**. BY ACCEPTING THIS AWARD, THE PARTICIPANT UNDERSTANDS AND AGREES THAT THE ARBITRATION AND CHOICE OF FORUM PROVISIONS SET FORTH IN SECTION 14.14 OF THE PLAN, WHICH ARE EXPRESSLY INCORPORATED HEREIN BY REFERENCE AND WHICH, AMONG OTHER THINGS, PROVIDE THAT ANY DISPUTE, CONTROVERSY OR CLAIM BETWEEN THE COMPANY AND THE PARTICIPANT ARISING OUT OF OR RELATING TO OR CONCERNING THE PLAN OR THIS AWARD AGREEMENT SHALL BE FINALLY SETTLED BY ARBITRATION IN PHILADELPHIA, PENNSYLVANIA, PURSUANT TO THE TERMS THEREOF, SHALL APPLY.

11.9 **Section 409A**. Notwithstanding any other provision of the Plan or this Award Agreement, the Plan and this Award Agreement shall be interpreted in accordance with, and incorporate the terms and conditions required by, Section 409A of the Code (together with any Department of Treasury regulations and other interpretive guidance issued thereunder, including without limitation any such regulations or other guidance that may be issued after the date hereof). The vesting and settlement of Restricted Stock Units awarded pursuant to this Award Agreement (and Dividend Equivalents, if any) are intended to qualify for the "short-term deferral" exemption from Section 409A of the Code and the terms of this Award Agreement shall be interpreted in compliance with this intention. The Company reserves the right, to the extent the Company deems necessary or advisable in its sole discretion, to unilaterally amend or modify the Plan and/or this Award Agreement or adopt other policies and procedures (including amendments, policies and procedures with retroactive effect), or take any other actions, including amendments or actions that would result in a reduction in benefits payable under the Award, as the Committee determines are necessary or appropriate to ensure that the Restricted Stock Units (and Dividend Equivalents, if any) qualify for exemption from or comply with Section 409A of the Code or mitigate any additional tax, interest and/or penalties or other adverse tax consequences that may apply under Section 409A of the Code; *provided*, *however*, that the Company makes no representations that the Restricted Stock Units (and

Dividend Equivalents, if any) will be exempt from Section 409A of the Code and makes no undertaking to preclude Section 409A of the Code from applying to these Restricted Stock Units (and Dividend Equivalents, if any).

11.10 **Administration**. The Committee shall have the power to interpret the Plan and this Award Agreement and to adopt such rules for the administration, interpretation and application of the Plan as are consistent therewith and to interpret, amend or revoke any such rules. All actions taken and all interpretations and determinations made by the Committee in good faith shall be final and binding upon the Participant, the Company and all other interested persons. No member of the Committee or the Board shall be personally liable for any action, determination or interpretation made in good faith with respect to the Plan, this Award Agreement or the Restricted Stock Units.

11.11 **Counterparts**. This Award Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

11.12 **Severability**. If any provision of this Award Agreement is held to be unenforceable for any reason, it shall be adjusted rather than voided, if possible, in order to achieve the intent of the parties to the extent possible. In any event, all other provisions of this Award Agreement shall be deemed valid and enforceable to the full extent possible.

11.13 **Language**. If the Participant has received this Award Agreement or any other document related to the Plan in a language other than English and the meaning of the translated version is different from the English version, the English version will control.

11.14 **Electronic Delivery**. The Company may, in its sole discretion, decide to deliver any documents related to current or future participation in the Plan by electronic means. The Participant hereby consents to receive such documents by electronic delivery and agrees to participate in the Plan through an online or electronic system established and maintained by the Company or a third party designated by the Company.

11.15 **Waiver**. The Participant acknowledges that the Company's waiver of a breach of any provision of this Award Agreement shall not operate or be construed as a waiver of any other provision of this Award Agreement, or of any subsequent breach by the Participant or any other participant.

11.16 **Clawback/Recovery**. The Restricted Stock Units shall be subject to the Clawback/Recovery provisions contained in Section 14.17 of the Plan.

By his or her signature below or by electronic acceptance or authentication in a form authorized by the Company (including by electronically accepting this Award Agreement through his or her Shareworks account with Morgan Stanley), the Participant agrees to be bound by the terms and conditions of the Plan and this Award Agreement. The Participant has reviewed this Award Agreement and the Plan in their entirety, has had an opportunity to obtain the advice of counsel prior to executing this Award Agreement and fully understands all provisions of this Award Agreement and the Plan. The Participant hereby agrees to accept as binding, conclusive and final all decisions or interpretations of the Committee upon any questions arising under the Plan or relating to the Restricted Stock Units.

UNIVERSAL HEALTH SERVICES, INC.

By:/s/ Steve Filton

Print Name: Steve Filton

Title:Executive Vice President and CFO

PARTICIPANT

By: _____

Print Name: ###PARTICIPANT_NAME###

EXHIBIT 10.5

TENTH AMENDMENT
TO
AMENDED AND RESTATED CREDIT AND SECURITY AGREEMENT

This TENTH AMENDMENT TO AMENDED AND RESTATED CREDIT AND SECURITY AGREEMENT (this "Amendment"), dated as of July 22, 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) September 20, 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

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: August 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: August 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 June 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
August 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 June 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
August 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.