Original

Compass Intervention Center

CN1606-025

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June 15, 2016

By hand delivery

Melanie M. Hill
Executive Director
Tennessee Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: Keystone Memphis, LLC, a limited liability company, d/b/a Compass Intervention Center Certificate of Need to establish a children's psychiatric hospital

Dear Ms. Hill:

This letter transmits the original and four copies of the Compass Intervention Center certificate of need application to establish a children's psychiatric hospital in Shelby County, Tennessee. Also enclosed are the affidavit and the filing fee. Please date stamp two copies of this application and return them to me in the enclosed envelope.

The contact person for this application is Jeremy Pitzer, Chief Executive Officer, Compass Intervention Center. His office telephone number is 901-758-2002.

As always, thank you for your courtesies.

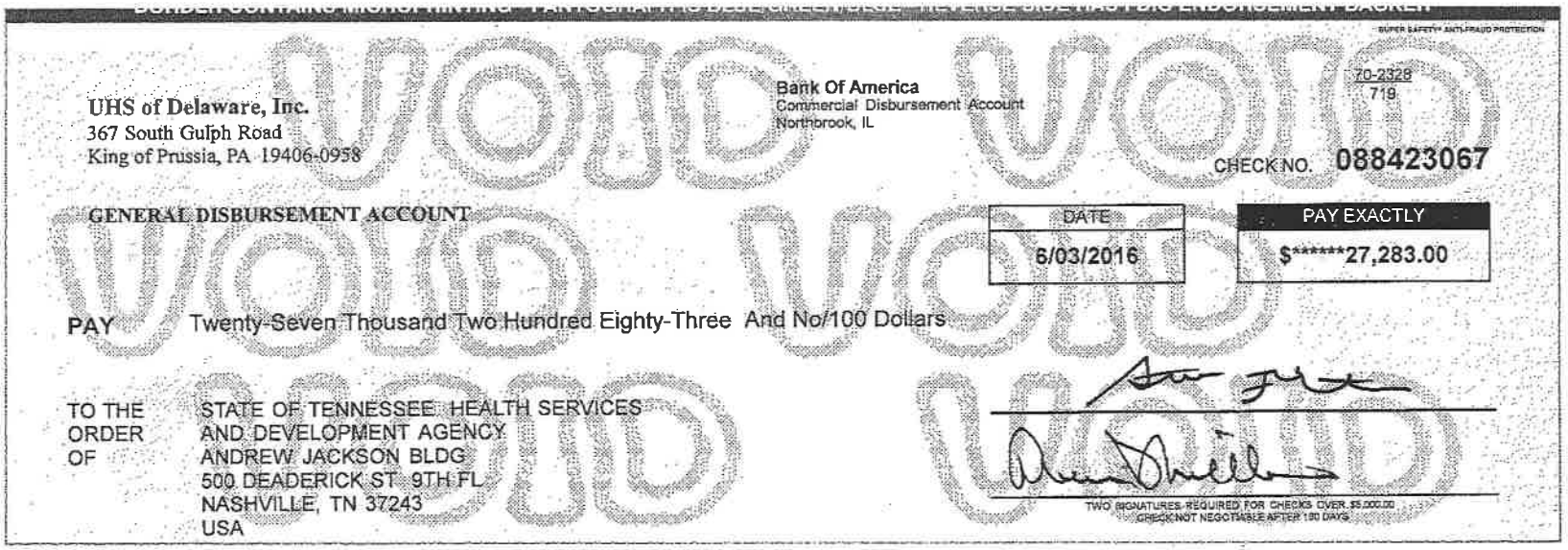
Very truly yours,

Paul W. Ambrosius

PWA:kmn

Enclosures

cc: Jeremy Pitzer, Chief Executive Officer, Compass Intervention Center
Byron R. Trauger, Esq., Trauger & Tuke



UHS of Delaware, Inc.
367 South Gulph Road
King of Prussia, PA 19406-0958

Bank Of America
Commercial Disbursement Account
Northbrook, IL

70-2326
719

CHECK NO. 088423067

GENERAL DISBURSEMENT ACCOUNT

DATE	PAY EXACTLY
6/03/2016	$******27,283.00

PAY Twenty-Seven Thousand Two Hundred Eighty-Three And No/100 Dollars

TO THE ORDER OF
STATE OF TENNESSEE HEALTH SERVICES
AND DEVELOPMENT AGENCY
ANDREW JACKSON BLDG
500 DEADERICK ST 9TH FL
NASHVILLE, TN 37243
USA

TWO SIGNATURES REQUIRED FOR CHECKS OVER $5,000.00
CHECK NOT NEGOTIABLE AFTER 180 DAYS

VOID VOID VOID VOID VOID VOID VOID VOID

⑈088423067⑈ ⑆071923284⑆ 8765316756⑈

1. ***Name of Facility, Agency, or Institution***

Keystone Memphis LLC. d/b/a Compass Intervention Center
Name

7900 Lowrance Road — Shelby
Street or Route — County

Memphis — TN — 38125
City — State — Zip Code

2. ***Contact Person Available for Responses to Questions***

Byron Trauger — Consultant Attorney
Name — Title

Trauger & Tuke Attorneys at Law — brt@tntlaw.net
Company Name — Email address

222 4th Avenue North — Nashville — TN — 37219
Street or Route — City — State — Zip Code

CON Consultant — (615) 256-8585 — (615) 256-7444
Association with Owner — Phone Number — Fax Number

3. ***Owner of the Facility, Agency or Institution***

Keystone Memphis LLC — 901-758-2002
Name — Phone Number

7900 Lowrance Road — Shelby
Street or Route — County

Memphis — TN — 38125
City — State — Zip Code

4. ***Type of Ownership of Control (Check One)***

A. Sole Proprietorship		F. Government (State of TN or Political Subdivision)	
B. Partnership		G.	
C. Limited Partnership		H. Joint Venture	X
D. Corporation (For Profit)		I. Limited Liability Company	
E. Corporation (Not-for-Profit)		Other (Specify)_____	

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

5. ***Name of Management/Operating Entity (If Applicable)***

UHS of Delaware, Inc.
Name

367 South Gulph Road
Street or Route

Montgomery
County

King of Prussia
City

PA
State

19406
Zip Code

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. ***Legal Interest in the Site of the Institution (Check One)***

A.	Ownership	X	D.	Option to Lease	
B.	Option to Purchase		E.	Other (Specify) _____	
C.	Lease of _____ Years				

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

7. ***Type of Institution (Check as appropriate--more than one response may apply)***

A.	Hospital (Specify)_____		I.	Nursing Home	
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty		J.	Outpatient Diagnostic Center	
			K.	Recuperation Center	
C.	ASTC, Single Specialty		L.	Rehabilitation Facility	
D.	Home Health Agency		M.	Residential Hospice	
E.	Hospice		N.	Non-Residential Methadone Facility	
F.	Mental Health Hospital	X			
G.	Mental Health Residential Treatment Facility	X	O.	Birthing Center	
			P.	Other Outpatient Facility (Specify) Mental Health OP, Partial Hospital Mental Health Intensive Day Treatment	X
H.	Mental Retardation Institutional Habilitation Facility (ICF/MR)		Q.	Other (Specify) Alcohol and Drug Residential	X

8. ***Purpose of Review (Check) as appropriate--more than one response may apply)***

A.	New Institution	X	G.	Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation*]	X
B.	Replacement/Existing Facility				
C.	Modification/Existing Facility	X			
D.	Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify)_____		H.	Change of Location	
			I.	Other (Specify)_____	
E.	Discontinuance of OB Services				
F.	Acquisition of Equipment				

9. Bed Complement Data

Please indicate current and proposed distribution and certification of facility beds.

		Current Beds Licensed	*CON	Staffed Beds	Beds Proposed	TOTAL Beds at Completion
A.	Medical					
B.	Surgical					
C.	Long-Term Care Hospital					
D.	Obstetrical					
E.	ICU/CCU					
F.	Neonatal					
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child/Adolescent Psychiatric	0	0	0	48	48
K.	Rehabilitation					
L.	Nursing Facility (non-Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P.	ICF/MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency	30	0	30	0	30
S.	Swing Beds					
T.	Mental Health Residential Treatment	78	0	62	0	78
U.	Residential Hospice					
	TOTAL					

*CON-Beds approved but not yet in service

10. Medicare Provider Number Will apply for Medicare number and validation

Certification Type Hospital

11. Medicaid Provider Number 5441352

Certification Type Current--Psychiatric Residential Treatment Facility, will apply as Hospital

12. If this is a new facility, will certification be sought for Medicare and/or Medicaid? See A.12 next page

13. *Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.* Will this project involve the treatment of TennCare participants? YES **If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted *or plans to contract.***

See A.13 next page

SECTION A: APPLICANT PROFILE

A. 3. Owner of the Facility, Agency or Institution

See Attachment A.3

A. 4. Type of Ownership Control

Keystone Memphis LLC, d/b/a Compass Intervention Center and McDowell Center for Children, is directly and wholly owned by Keystone Education and Youth Services LLC, which is wholly owned by Keys Group Holdings LLC, which is wholly owned by UHS Children's Services, Inc., which is wholly owned by Universal Health Services, Inc. The applicant has no financial interest in any other facility, including those owned by Universal Health Services, Inc. Attached is a list of Tennessee facilities which Universal Health Services, Inc. owns and is the ultimate parent for.

See Attachment A.4

A. 5. Name of Management/Operating Entity

See Attachment A.5

A. 6. Legal Interest in the Site of the Institution

See Attachment A.6

A. 12. If this is a new facility, will certification be sought for Medicare and/or Medicaid?

Compass is currently certified as a Psychiatric Residential Treatment Facility, and the new type of facility will require Compass to seek Medicare validation and certification from Medicaid as a hospital.

A. 13. Identify all TennCare Managed Care Organizations/Behavioral Health Organizations operating in the proposed service area. Will this project involve the treatment of Tenncare participants? YES. If the

response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted or plans to contract.

Discuss any out-of-network relationships in place with MCOs/BHOs in the area.

The three TennCare Managed Care Organizations (BlueCare, UHCCP, and Amerigroup) operate in the proposed service area. Compass has existing contracts with all three MCOs, and will seek to add inpatient hospital services to each contract. Coverkids and Tenncare Select are covered under our existing Bluecare contract. As such, there are no out-of-network relationships with any of the Tenncare MCOs.

SECTION B: PROJECT DESCRIPTION

B. I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of the proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

Brief Description of Proposed Services and Equipment— The Compass Intervention Center proposal includes the construction of a 48 bed child and adolescent inpatient psychiatric facility and additional patient support space. We are excited to say that, upon completion, this will be the only Mental Health Hospital in the state or region dedicated solely to the psychiatric treatment of children and adolescents. This is a one-of-a-kind project and opportunity to advance mental health services for children in Tennessee. The proposed project will be executed at the current facility location of 7900 Lowrance Rd. Memphis, TN 38125, in Shelby County. Additional major components included in this project are the building of space to allow the future growth of outpatient services, 25 additional parking spaces in the northeast section of the property, the renovation and expansion of dietary services, creation of additional outdoor patient areas, and the construction of a new gymnasium.

Ownership Structure—Keystone Memphis LLC, d/b/a Compass Intervention Center, is a Tennessee Limited Liability Company wholly owned by Keystone Education and Youth Services a Tennessee Limited Liability Company, which is wholly owned by Keys Group Holdings a Delaware Limited Liability Company, which is wholly owned by UHS Children's Services, Inc. a Delaware corporation, which is wholly owned by Universal Health Services, Inc. a Delaware corporation.

Service Area—We have identified primary and secondary areas in the proposed service area to include a portions of Tennessee, as well as proximal areas in Arkansas and Mississippi. The primary service area includes 19 Tennessee counties (Shelby, Madison, Tipton, Fayette, Hardeman, Lauderdale, Dyer, McNairy, Chester, Hardin, Crockett, Haywood, Gibson, Lake, Obion, Weakley, Carroll, Henry, and Henderson) in proximity to the proposed project. The primary service area is within an approximately 120 mile radius of Compass and also includes Desoto County Mississippi and Crittenden County Arkansas.
The secondary service area includes 9 counties in Arkansas (Craighead, Cross, Greene, Jackson, Lee, Mississippi, Poinsett, St. Francis, Woodruff). The secondary services area is based upon proximity to Memphis and our mobile assessment services as well as historical referral relationships.

Need— The need for children's inpatient psychiatric beds remains high, with few options in West Tennessee for placement. This proposal arises from both our internal need and the escalating

need in the communities we serve. Lakeside Hospital, the region and state's largest psychiatric facility, has seen explosive census growth over the past several years. According to the Hospital JAR reports Lakeside experienced growth in staffed beds by 67%, patient days by 34% and admissions by 24% from the 2012 to 2014 reporting periods. In the first three months of 2016 Lakeside had to deflect at least 153 child and adolescent patients due to capacity. St. Francis Hospital reported deflecting over 100 psychiatric patients in March 2016 alone. The proposed project would fill this gap in bed availability and ensure all children in the region have access to the mental health services they need. For the Shelby/Memphis region, occupancy as a percentage of staffed beds is over 86%, a strong indicator for the need for additional capacity.

The capacity issues in the region have an effect on the ability of Youth Villages Mobile Crisis and other private providers to safely and appropriately place children. Often, and more frequently during 2015 and 2016, when Lakeside Hospital and St. Francis Hospital are full, there is a domino effect across the state where all mental health hospitals that treat children and adolescents quickly reach capacity or are unable to accept more patients. When this occurs children in need of services may wait in emergency rooms or are put into less-than-ideal safety plans. Some end up going out of state for treatment. We regularly have difficulty and delays placing our patients that need inpatient care, and some end up having to go Mississippi and Kentucky for treatment.

Our internal calls for services and mobile assessment continue to rise at a dramatic rate. In 2015 the call and assessment volume at Compass increased by over 40%, and we have helped fill the community need by providing triage and extra assessment capacity at no charge to the State or community. Our volume continues to increase in 2016, and we project completing over 1000 screening and assessments this year. Over the long-term, about 8% of the referral calls we receive end up meeting criteria for inpatient services. Without consideration of business development activities or impacting other similar services, our own internal need for these beds translates to capacity for an average census of 6.6 or 200 patient days upon opening, This also does not take into account the need existing in the community or the growing need by Mobile Crisis and other community providers in the service area and across the state.

There is overwhelming anecdotal evidence to support need as well. Many times we are unable to locate appropriate inpatient services for the children and adolescents we serve. We have to call every hospital in the state to find that there are no children's beds available anywhere, and this is a common experience shared by Mobile Crisis as well.

The need for this proposed project is widely supported including by community partners, Mobile Crisis, lawmakers, educational institutions and social service agencies.

Existing Resources—Our proposed service area has several psychiatric facilities, however since this proposal is child and adolescent only, there are only three facilities providing similar services: Lakeside Hospital, St. Francis Hospital, and the recently implemented Crestwyn Hospital. Current staffed beds in service often do not meet the community demand for inpatient services.

Project Cost—The proposed project will cost $12,152,661.

Financial Feasibility—The proposed project is financially feasible. The costs to construct are reasonable and will be paid utilizing cash reserves. Universal Health Services, the parent of Compass, will provide the capital resources to complete the project. We have developed a financial proforma that allows us to reasonably recuperate the costs of the project over time while maintaining modest and planful census growth. We plan to reach a positive operating margin 6 months after beginning operations.

Staffing—The proposed project will include 37.9 additional FTEs in year two.

B. II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

B. II. A. Describe the construction, modification and/or renovation of the facility (exclusive of any major medical equipment covered by T.C.A 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc.

See Square Footage Chart on following page.

Established in 1996, Compass Intervention Center has grown over the years into a 108-bed Residential Treatment Facility for Children and Adolescents with serious behavioral health and addiction disorders. Our current facility is almost 30,000 square feet and houses outpatient programs as well. Demand for mental health services continues to outpace our capacity, and it is time for us to grow again.

In order to address the growing need for Psychiatric Services within the service area, Compass Intervention Center proposes to construct a new, approximately 26,900 sq./ft. 48-Bed Psychiatric Unit Addition on the existing Compass Intervention Center (CIC) Campus in Memphis, TN. The Addition shall provide two distinct 24-Bed Inpatient Nursing Units. Both units will provide a variety of Group Therapy and Activity Spaces as well as Exam, Consult, and Treatment Facilities. The new Addition shall also house an approximately 1,000 sf shell space that will allow for future growth of outpatient programs. A 2,850 sq./ft. Activity Therapy/Gymnasium component and approximately 2,250 sq./ft. expansion/renovation of existing Dining services shall be included as part of this Project to serve the increase in patient population.

Safety & security features are based on current best practices within the Behavioral Health Industry. The new Facilities shall provide ample natural light, open circulation & way finding, and a residential and therapeutic atmosphere throughout, with attention given to the fact that this is a children's facility. The entire Facility shall be designed to meet the most current requirements of the Facility Guidelines Institute (FGI) Guidelines for the Design and Construction of Healthcare Facilities and all other applicable Code requirements.

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
Clinical/Support Spaces						13,153	13,153		$420.34	$ 5,528,667
Admissions						1,250	1,250		$464.46	$ 580,596
Shell Space (future PHP)						988	988		$115.38	$ 113,998
Connector Corridor						1,331	1,331		$248.73	$ 331,053
New Gymnasium						3,138	3,138		$195.67	$ 612,116
Dining to Servery Renovation					707		707	229.04		$ 161,932
Gym to Dining Renovation					1,543		1,543	$227.71		$ 351,364
B. Unit/Depart. GSF Sub-Total					2,250	19,860	22,110		$347.34	$ 7,679,726
C. Mechanical/ Electrical GSF						330	330			
D. Circulation /Structure GSF						5,734	5,734			
E. Total GSF					2,250	25,924	28,174		$272.58	$ 7,679,726

6

B. II. B. Identify the number and types of beds increased, decreased, converted, relocated, designated and/or redistributed by this application. Describe the reasons for the change in bed allocations and describe the impact the bed change will have on the existing services.

The plan proposed involves the addition of 48 child and adolescent inpatient psychiatric beds to our existing residential facility. The need for children's inpatient psychiatric beds remains high, with few options in West Tennessee for admission. It has become increasingly difficult to find inpatient services for the children we work with. The inpatient beds will have a positive impact, complementing our existing services and allowing us to provide a full continuum of behavioral health services to appropriately meet the needs of any patient. The proposal decreases pressure on Mobile Crisis and other mental health providers by ensuring less difficulty in locating inpatient beds for patients in need.

While it is difficult to accurately gauge the impact on existing services, we believe the impact to existing services will be minimal as utilization and demand in the service area remain very high. This proposal will benefit the overall healthcare system in the proposed service area and the state by providing much needed capacity for child and adolescent beds. It also presents the opportunity for further coordination and collaboration with other healthcare providers, including those with similar services.

B. II. C. As the applicant describe your need to provide the following health care services (if applicable to this application):

1. **Adult Psychiatric Services**
2. **Alcohol and Drug Treatment for Adolescent (exceeding 28 days)**
3. **Birthing Center**
4. **Burn Units**
5. **Cardiac Catheterization Services**
6. **Child and Adolescent Psychiatric Services**
7. **Extracorporeal Lithotripsy**
8. **Home Health Services**
9. **Hospice Services**
10. **Residential Hospice**
11. **ICF/MR Services**
12. **Long-Term Care Services**
13. **Magnetic Resonance Imaging (MRI)**
14. **Mental Health Residential Services**
15. **Neonatal Intensive Care Unit**

16. Non-Residential Methadone Treatment Centers
17. Open Heart Surgery
18. Positron Emission Tomography
19.Radiation Therapy/Linear Accelerator
20. Rehabilitation Services
21. Swing beds

This proposal to build 48 child and adolescent psychiatric beds is desperately needed and will benefit the service area in several ways.

Improved Distribution of Resources Specific to Children and Adolescents

Table one below shows the distance between Compass Intervention Center and available resources within the identified primary service area for child acute psychiatric care beds. Additionally, the information is further broken down to identify drive time from Compass Intervention Center to other child psychiatric hospitals within the primary market. In the primary service area, average drive time is 15 minutes with average distance being about 9.8 miles from Compass Intervention Center to other child psychiatric hospitals.

Child and Adolescent Psychiatric Beds in Primary Service Area				
Provider	**Type of Facility**	**County and State**	**Miles/ Distance**	**Drive Time**
Crestwyn Behavioral Health	Psychiatric Hospital	Shelby County, TN	4.1 miles	7 minutes
Lakeside Behavioral Health	Psychiatric Hospital	Shelby County, TN	19.5 miles	25 minutes
Saint Francis Hospital	Unit of M/S Hospital	Shelby County, TN	7.3 miles	12 minutes

Crestwyn Behavioral Health is licensed for 15 inpatient psychiatric beds for adolescents ages 13-17. Lakeside Behavioral Health operates 49 inpatient psychiatric beds for children ages 4-17. Saint Francis Hospital has capacity for 35 inpatient psychiatric beds for children ages 4-17. This represents a total of 99 inpatient psychiatric beds for children ages 4-17. With the realization of this proposal, children's beds are better distributed across Shelby County, with our facility in a predominantly African American neighborhood in southeast Memphis.

Bed Availability for Children and Adolescents

Bed availability continues to constrict as occupancy and utilization increase in the region. The need for children's inpatient psychiatric beds remains high, with few options in West Tennessee for placement. This proposal arises from both our internal need and the escalating need in the communities we serve. Lakeside Hospital, the region and state's largest psychiatric facility, has seen explosive census growth over the past several years. According to the Hospital JAR reports Lakeside experienced growth in staffed beds by 67%, patient days by 34% and admissions by 24% from the 2012 to 2014 reporting periods. In the first three months of 2016 Lakeside had to

deflect at least 153 child and adolescent patients due to capacity. St. Francis Hospital reported deflecting over 100 psychiatric patients in March 2016 alone. The proposed project would fill this gap in bed availability and ensure all children in the region have access to the mental health services they need. For the Shelby/Memphis region, occupancy as a percentage of staffed beds is over 86%, a strong indicator for the need for additional capacity.

The capacity issues in the region have an effect on the ability of Youth Villages Mobile Crisis and other private providers to safely and appropriately place children. Often, and more frequently during 2015 and 2016, when Lakeside Hospital and St. Francis Hospital are full, there is a domino effect across the state where all mental health hospitals that treat children and adolescents quickly reach capacity or are unable to accept more patients. When this occurs children in need of services may wait in emergency rooms or are put into less-than-ideal safety plans. Some end up going out of state for treatment. We regularly have difficulty and delays placing our patients that need inpatient care, and some end up having to go Mississippi and Kentucky for treatment.

Our internal calls for services and mobile assessment continue to rise at a dramatic rate. In 2015 the call and assessment volume at Compass increased by over 40%, and we have helped fill the community need by providing triage and extra assessment capacity at no charge to the State or community. Our volume continues to increase in 2016, and we project completing over 1000 screening and assessments this year. Over the long-term, about 5% of the referral calls we receive end up meeting criteria for inpatient services. Without changing anything else, our own internal need for these beds translates to a census of upon opening.

Exclusive Full Continuum of Care for Children and Adolescents

There are no other freestanding acute psychiatric hospitals in the state or region devoted to solely treating children. Adding 48 acute beds, will allow Compass Intervention Center to be the only provider in the region to exclusively treat children and adolescents with psychiatric and substance abuse issues. This will allow for more coordinated and integrated care among various levels of treatment, with all services targeted specifically for children. The inpatient services will complement our existing service lines of residential, partial hospital and intensive outpatient. Furthermore it allows for greater focus on evidenced-based best-practices for the psychiatric treatment of children.

Partnerships

Compass Intervention Center recognizes the importance of partnership, whether it is in the training and development of various disciplines of healthcare professionals, collaboration with other community providers, or providing services to meet specific needs of the population. Compass Intervention Center is partnered with several universities, including University of Tennessee, University of Memphis, University of Mississippi, and Union University to provide high quality clinical internship experiences.

Our partnerships extend into other arenas as well. In 2014 and 2015 we partnered with two local juvenile court systems to provide assessment and diversion services for kids who come into contact with law enforcement. We are excited to participate in proposed grant projects to decrease suicide and provide intensive services to at risk youth. During 2013 and 2014 Compass

participated in the Memphis Community Based Learning Collaborative for Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). TF-CBT is one the most researched and validated treatments for children with trauma, and we have fully committed to the model within the facility. All of our therapists are trained in this evidenced-based best practice, and we have some that are preparing for national certification. These are just a few examples where we put our energy and meaningful effort into partnering in our communities and developing larger systems that are prepared to provide the appropriate services to children in our communities.

B. II. D. Describe the need to change location or replace an existing facility

Not Applicable N/A

B. II. E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $1.5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. **For fixed-site major medical equipment (not replacing existing equipment:**
    - **a. Describe the new equipment, including:**
        1. **Total Cost; (As defined by Agency Rule)**
        2. **Expected Useful Life;**
        3. **List of clinical applications to be provided; and**
        4. **Documentation of FDA approval.**
    - **b. Provide current and proposed schedules of operations.**
2. **For mobile major medical equipment:**
    - **a. List all sites that will be served;**
    - **b. Provide current and/or proposed schedule of Operations;**
    - **c. Provide the lease or contract cost**
    - **d. Provide the fair market value of the equipment; and**
    - **e. List the owner for the equipment.**
3. **Indicate the applicant's legal interest in equipment (i.e., purchase, lease, etc.) In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an**

equipment lease provide a draft lease or contract that at least includes the term of lease and the anticipated lease payments.

Not Applicable N/A. Proposal does not include any major medical equipment.

B. III. A. Attach a copy of the plot plan of the site on 8 ½" X 11" sheet of white paper which must include:

1. **Size of site (in acres)**
2. **Location of structure on the site; and**
3. **Location of the proposed construction.**
4. **Names of streets, roads or highway that cross or border the site. Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.**

See Attachment B. III. A

B. III. B. 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Compass is located in Southeast Memphis near the intersection of Hacks Cross and Winchester, a major bus route. Compass is also less than ½ mile from the Hacks Cross exit of 385, a major artery of traffic from East Memphis to Southeast Memphis and Collierville. Highway 385 also connects to I-40 on the northeast side of the metropolitan area. I-55, I-40, Highway 385, Highway 78 (which turns into I-22), Highway 79 and Highway 51 converge in Memphis making the facility extremely accessible from all areas of Memphis, suburban areas, as well as to the counties in the proposed service areas.

B. IV. Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 ½" X 11" sheet of white paper. NOTE: DO NOT SUBMIT BLUEPRINTS. Simple line drawings should be submitted and need not be drawn to scale.

See Attachment B. IV.

B. V. For a Home Health Agency or Hospice, identify:

1. **Existing service area by county;**

2. **Proposed service area by county;**
3. **A parent or primary service provider;**
4. **Existing branches; and**
5. **Proposed branches.**

Not Applicable N/A.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

NEED

C. Need. 1. Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.

a. Please provide a response to each criterion and standard in Certificate of Need categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

See Project Specific Review Criteria below

b. Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4) (a-c).

Not Applicable N/A

Project Specific Review Criteria—Psychiatric Inpatient Services

A. Need

1. **The population-based estimate of the total need for psychiatric inpatient services is 30 beds per 100,000 general population (using population estimates prepared by the Department of Health and applying the data in Joint Annual Reports).**

   By 2020 there the general population of Shelby County alone is expected to exceed 981,000 people. In the Tennessee portion of the Proposed Service Area (Shelby, Madison, Tipton, Fayette, Hardeman, Lauderdale, Dyer, McNairy, Chester, Hardin, Crockett, Haywood, Gibson, Lake, Obion, Weakley, Carroll, Henry, and Henderson) the total population projection increases by 36,170 to 1,631,641 between 2016 and 2020, representing growth of 2.4%.

   The data above demonstrates consistent population growth in the proposed service area; however this project will serve only children under 18.

   Sources: Tennessee Department of Health CON Age Group Projections 2016-2020.

2. **For adult programs, the age group of 18 years and older should be used in calculating the estimated total number of beds needed.**

   Not Applicable-N/A

3. **For child inpatient under age 13, and if adolescent program the age group of 13-17 should be used.**

   The percentage of the general population that children (0-17) make up in Shelby County is projected at 25.8% (247,503) in 2016 and remains consistent at 25.7% (252,312) in 2020 indicating a 1.9% growth in this population. The average percentage is consistent throughout the proposed service area at 24.2% The average 0-17 population growth in the Tennessee portion of the proposed service area is strong at 2.1% through 2020. The total population in this age range for the Tennessee portion of the proposed service area is expected to grow to 395,172 by 2020.

   Based on this data there is need for 119 beds for children ages 0-17 in the proposed service area.

   Sources: Tennessee Department of Health CON Age Group Projections 2016-2020.

4. **These estimates for total need should be adjusted by the existent staffed beds operating in the area as counted by the Department of Health in the Joint Annual Report.**

   There are total of 99 existing and proposed staffed child and adolescent beds in the proposed service area:

   Lakeside—49
   St. Francis—35
   Crestwyn—15
   Total—99

   According to the Tennessee Department of Mental Health there are 8 Licensed Mental Health Hospitals in the entire West Region. Of this group only Lakeside and Crestwyn currently provide services to children under 18. Delta Medical Center, Methodist Healthcare and St .Francis Hospital provide psychiatric inpatient services as part of Medical-Surgical systems, however only St. Francis currently provides services to children under 18.

Beds by Licensed Mental Health Hospital		
	Adult	0-17
Behavioral Healthcare Center at Martin	16	
Behavioral Healthcare Center at Memphis	16	
Crestwyn	45	15
MMHI	111	
Pathways	10	

Lakeside	212	49
WMHI	187	
Woodridge	16	
Totals	613	64
Psychiatric Beds in Medical-Surgical facilities		
	Adult	0-17
Methodist Healthcare	34	
Delta Medical Center	109	
St. Francis Hospital	67	35
Totals	210	35
Grand Totals	**823**	**99**

Per the current year JAR report, Lakeside hospital reports beds staffed for children under 18 at 49. St. Francis Hospital reports 35 staffed psychiatric beds for children under 18. The Crestwyn opened recently in 2016, so no data is currently available for utilization. Crestwyn is approved for a total of 15 licensed beds for adolescents, and for the purposes of this proposal we assume their ability to staff and fill all 15 beds.

The estimates for need should further take into consideration the reasonable portions of our service area that are out-of-state. Our facility is approximately 14 miles from Arkansas to the West and 4 miles from Mississippi to the South. The contiguous counties, Crittenden County Arkansas and Desoto County Mississippi represent an additional 222,286 people (2015 estimate). Desoto County Mississippi is one of the fastest growing counties in the South with an estimated population growth of 7.5% from 2010-2014. There is only one provider of children's inpatient psychiatric services in Desoto County, Parkwood Hospital, with 52 Child and Adolescent beds serving all of North Mississippi.
The Arkansas counties in our secondary service area represent an additional population base of 293,186 with 23.4 in the 0-17 age range. There are no child and adolescent inpatient providers located in those counties. Based on bed need and current referral patterns, people from these local, but out-of-state areas will continue to come to Memphis to seek treatment.

Sources: Tennessee Department of Health JAR reports 2014 (current data), Tennessee Department of Mental Health and Substance Abuse Services— Licensure Division, U.S. Census Bureau, Mississippi Department of Health.

B. Service Area

1. **The geographic service area should be reasonable and based on an optimal balance between population density and service proximity or the Community Service Agency.**

   The proposed geographic service area is reasonable. The 19 counties in Tennessee that make up the primary service area are within a less than 2 hour travel time to Memphis, and lacking in other options for children's inpatient psychiatric care. The adjoining counties of Crittenden Arkansas and Desoto Mississippi are effectively part of the greater Memphis area, and citizens regularly travel to Tennessee for healthcare services. We are basing the service area on population based community need in the greater Memphis metro area and surrounding counties, proximity to other similar services as well as existing patterns of patient referral.

   Given that this proposal is unique in our aim to serve only children and adolescents, our service area includes counties in Arkansas that lack in these specific services. The service area closely mirrors the service area for Lakeside hospital based on data for admissions by county.

   *Data based on hospital JAR reports

2. **The relationship of the socio-demographics of the service area, and the projected population to receive services, should be considered. The proposal's sensitivity to and responsiveness to the special needs of the service area should be considered including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, and those needing services involuntarily.**

   Compass Intervention Center is dedicated to providing services that meet the needs of the communities we serve, and this project will be no different. While we provide our services to children across all racial and economic backgrounds, we are committed to providing high quality services to poor and underserved families. Our current and proposed service area includes a mix of rural and urban populations and has high rates of poverty, with some areas having almost 47% of children living below the poverty line. Based on census data the children in our service are made up of approximately 52% African American, 38% White, 6% Hispanic, 3% Asian and 1% other.

   Shelby County, the largest county by population in the proposed service area, has a higher percentage of the population made up of children (26%) compared to the national average of 22%, with approximately 35.5 % living below the poverty line in Shelby County. For comparison the Tennessee average for children under the poverty line is 26.2 %, with a US average of 22.7%

   It is relatively rare for children to need involuntary admission; however we plan to offer this option when the circumstances arise.

   Sources: US Census Bureau, University of Memphis 2015 Poverty Fact Sheet

C. Relationship to Existing Applicable Plans

1. The proposal's relationship to policy as formulated in state, city, county, and/or regional plans and other documents should be a significant consideration.

We did not identify any county or city policies and plan that guide the development of a project of this kind; the backbone for this proposed project has been developed with the State of Tennessee State Health Plan as a guiding document (2014 Update). Specifically this proposal exemplifies the Principles within the Framework for the State Health Plan. Below we highlight some areas where we are in alignment with the goals of the State health Plan.

Principle 1: Healthy Lives

We recognize that each person's health is the result of the interaction of behaviors, social factors, the environment, health care and our genetic endowment. Not only do we work with the children we serve to manage behaviors and mental health symptoms, but we put a lot of energy into family work. The broad goals of the family work includes improving the families' knowledge about mental illness, helping develop workable discharge plans with long-term success in mind, and helping families link with community based resources to support the recovery process. Our extensive relationships with other providers, agencies and managed care organizations, etc., allows for better planning, collaboration and care for patients.

Principle 2: Access

Goal 2d: People in Tennessee are able to obtain appropriate quality health care services to meet their needs: Access to inpatient services for children in Shelby County is a critical issue. More often than not the child and adolescent providers in the area are full or not accepting patients. The need for these services is much higher than the population statistics would indicate. This proposal provides full addresses the much needed capacity for inpatient care.

Principle 3: Economic Efficiencies

Goal 3c: The value of health and health care resources is continually measured, reported, and improving. We track a variety of data to measure outcomes and the quality of the care provided. Our metrics for patient satisfaction, improvement in symptoms, behavioral interventions and variety of other quality improvements demonstrate a measured steady progress over a several year period. This data drives our performance improvement actions and allows us to deploy resources in a targeted manner.

Principle 4: Quality of Care

The underlying concept behind this principle is that providers should be held to the highest standards and that quality of care improves through adoption of best practices. Compass is surveyed multiple times each year through licensure, The Joint Commission,

and Behavioral Health Care Organizations, to name a few. We consistently achieve excellent results and demonstrate a commitment to improving outcomes.

Goal 4a: Priorities for Consideration: Behavioral Health Screenings can be an important factor in achieving successful patient outcomes. All Compass patients are screened at admission for trauma utilizing the CPSS tool (Child Post Traumatic Symptom Scale). We conduct behavioral health screenings or assessments on over 1000 children per year, most of them being referred for appropriate community-based services at lower levels of care.

Goal 4c: The health system uses evidenced based practices and minimizes unnecessary variations in procedures. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is the most researched evidenced-based best practice for the treatment of trauma in children; we deploy TF-CBT with high fidelity to the model.

Principle 5: Workforce

Goal 5c: An adequate health workforce is recruited and retained to care for the health needs of patients and communities. Compass has been very fortunate in the recruitment and retention of our healthcare workforce. In the past two years we have been able to recruit an additional psychiatrist and two psychiatric nurse practitioners. We are consistently able to recruit talented nurses, social workers and health care workers.

2. **The proposal's relationship to underserved geographic areas and underserved population groups as identified in state, city, county and/or regional plans and other documents should be a significant consideration.**

According to the Tennessee Department of Health, the vast majority of the service area is designated as underserved by the U.S. Health Resources and Services Administration. This includes the entire counties of Chester, Crockett, Fayette Gibson, Hardeman, Hardin, Haywood, Lauderdale, McNairy and Tipton counties. Portions of Dyer, Madison and Shelby Counties are also designated as underserved. Our facility is located in Southeast Shelby County in an area that designated as underserved. Every county in the service area is also medically underserved in the Mental Health category, with Shelby County being underserved in the low-income category.

Sources: https://tn.gov/health/article/federal-shortage-areas
http://datawarehouse.hrsa.gov/tools/analyzers/muafind.aspx

3. **The impact of the proposal on similar services supported by state appropriations should be assessed and considered.**

N/A Not Applicable— the two state Mental Health Hospitals in our service area do not accept child or adolescent patients.

4. **The proposal's relationship to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, should be assessed and considered.**

   We plan to accept involuntary patients wherever appropriate, however in the West Region there are a relative few adolescent admissions that are completed in this manner. We do plan to have at least one Admissions staff certified to complete involuntary admissions. We plan to primarily serve shorter-term acute patients, though there will likely be occasions where long-term patients are served.

5. **The degree of projected financial participation in the Medicare and TennCare programs should be considered.**

   We are projecting active participation with all three TennCare MCOs. The projections are based on current utilization, referrals and trends, as well as population demographics including growth and Tenncare participation. TennCare represents $948,070 and $1,360,520 of net revenue in Years One and Two respectively. We do not expect any participation in Medicare.

D. Relationship to Existing Similar Services in the Area

1. **The area's trends in occupancy and utilization of similar services should be considered.**

   It is difficult to fully quantify utilization and occupancy specific to the child and adolescent psychiatric beds in the area. Crestwyn Hospital data is not yet available and St. Francis does not break out unit specific occupancy and average daily census in the JAR reports. That said, occupancy and utilization remain very high in the Memphis/Shelby Region. Overall occupancy on staffed beds for Mental Health Hospitals in the Memphis/Shelby Region is exceptional at 86.8% (highest in the state for the Mental Health Hospital category). The Memphis/Shelby Region also demonstrated a 14.6% increase in admissions over the prior year, which increased from 8,738 to 10,018. Lakeside Hospital, which gives us the best analogue on occupancy and utilization for the Region has demonstrated strong growth and high demand for services. In 2013 Lakeside met the high community need for services by running an occupancy of 116.5% on staffed beds and demonstrated 11-12% growth in Admissions/Discharges and Average Daily Census categories from 2013-2014.

   Source: 2013-Current JAR data, Reports 2, 2A from "Report for Hospitals"

2. **Accessibility to specific special need groups should be an important factor.**

   Compass is committed to providing high-quality services to children and adolescents regardless of payor source or the ability to pay for services. Access to appropriate services for the child and adolescent population is difficult to find at times, and we

consistently find that regional providers are at capacity/not accepting admissions. We also do not shy away from complex cases often involving multiple state or private agencies/providers. The project adds needed capacity in a specific demographic, relieving pressure on current similar providers and providing regional crisis teams with a needed resource.

E. Feasibility

The ability of the applicant to meet Tennessee Department of Mental Health licensure requirements (related to personnel and staffing for psychiatric inpatient facilities) should be considered.

We are fully aware of the licensure requirements for this type of facility, and are fully able to meet all Licensure requirements. We currently provide 24-hour Psychiatric and general Medical coverage and 24-hour direct nursing supervision, and this will continue with the addition of inpatient services. We are committed to meeting and exceeding the requirements for Direct Care staff which per current licensure regulation is at least two staff on duty, on site, per ward, per shift, with at least one RN. With our existing services and Human Resources processes in place, we expect a good amount of internal and external interest in Direct Care and other positions.

C. Need. 2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

This proposal represents a critical step in the long-range plan for Compass. First, by providing for inpatient services, it allows for a full and flexible continuum of care to address the mental health needs of any child, even as those needs change. This continuum encompasses less restrictive options as well as those for the most acute and chronic patients who are most in need of services. The proposal also importantly allows for future growth of less restrictive options like intensive outpatient and partial hospital and which brings with it the increased ability to utilize step-down treatment options. Providing comprehensive mental health services in one location will improve the long-term success of treatment by improving coordination of care and communication of important patient information.

C. Need. 3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the state of Tennessee clearly marked to reflect the service area. Please submit the map on 8 ½" X 11" sheet of white paper marked only with ink detectible by a standard photocopier (i.e., no highlighters, pencils, etc.).

We have identified primary and secondary service areas within the proposed service area. The primary service area includes 19 Tennessee counties (Shelby, Madison, Tipton, Fayette, Hardeman, Lauderdale, Dyer, McNairy, Chester, Hardin, Crockett, Haywood, Gibson, Lake, Obion, Weakley, Carroll, Henry, and Henderson) in proximity to the proposed project. The primary service area is within an approximately 120 mile radius of Compass and also includes Desoto County Mississippi and Crittenden County Arkansas. The primary service area is reasonable in that it is based upon proximity to the facility including the denser population center in the greater Memphis area, existing relationships with referral sources (higher numbers of admissions from counties within the service area), and upon lack of availability of similar services in much of the service area. The service area mirrors the service area for Lakeside hospital based on data for admissions by county.

The secondary service area includes 9 counties in Arkansas (Craighead, Cross, Greene, Jackson, Lee, Mississippi, Poinsett, St. Francis, Woodruff). The secondary services area is based upon proximity to Memphis and our mobile assessment services as well as historical referral relationships.
The secondary service area is reasonable in that it is based on **current** mobile assessment services we provide, and we have long-standing referral relationships with providers in secondary services area. Our mobile assessors currently provide services in these areas, and it is reasonable to expect that there will be need for the proposed inpatient services as well.

The table on the following page indicates the distribution of admissions by county, and the data clearly supports the reasonableness of the service area: Almost 90% of our Tennessee admissions from 2013 to 2015 originated in the counties identified in the proposed service area.

See Attachment C.NEED. 3, The Proposed Service Area Maps

Tennessee Admissions by County					
	2013	2014	2015	Total	
Bedford	0	0	1	1	0.1%
Benton	0	0	1	1	0.1%
Bledsoe	0	1	1	2	0.3%
Blount	0	1	0	1	0.1%
Bradley	0	0	1	1	0.1%
Carroll	0	2	2	4	0.6%
Chester	2	0	0	2	0.3%
Coffee	0	1	0	1	0.1%
Crockett	2	1	0	3	0.4%
Davidson	2	6	8	16	2.4%
Decatur	1	2	0	3	0.4%
Dickson	0	0	1	1	0.1%
Dyer	3	7	2	12	1.8%
Fayette	8	10	14	32	4.7%
Franklin	0	0	1	1	0.1%
Gibson	3	4	5	12	1.8%
Greene	0	0	1	1	0.1%
Hamblen	0	1	0	1	0.1%
Hamilton	1	2	1	4	0.6%
Hardeman	3	5	7	15	2.2%
Hardin	3	8	5	16	2.4%
Haywood	4	4	7	15	2.2%
Henderso	3	4	3	10	1.5%
Henry	0	2	0	2	0.3%
Hickman	2	0	0	2	0.3%
Jefferson	0	0	3	3	0.4%
Knox	0	4	7	11	1.6%
Lauderdal	3	3	3	9	1.3%
Madison	44	49	41	134	19.7%
Maury	0	1	3	4	0.6%
McMinn	0	0	1	1	0.1%
McNairy	2	2	2	6	0.9%
Montgom	5	4	14	23	3.4%
Moore	0	0	1	1	0.1%
Rhea	0	0	1	1	0.1%
Robertsor	0	0	3	3	0.4%
Rutherfor	2	5	9	16	2.4%
Shelby	75	101	83	259	38.1%
Smith	0	0	1	1	0.1%
Sullivan	0	1	1	2	0.3%
Sumner	0	2	7	9	1.3%
Tipton	11	6	8	25	3.7%
Warren	1	0	2	3	0.4%
Washingt	0	0	2	2	0.3%
Weakley	0	1	0	1	0.1%
Williamsc	0	0	4	4	0.6%
Wilson	0	0	2	2	0.3%
Totals	180	240	259	679	100.0%

*Shaded rows indicate counties with admissions in the proposed service area.

C. Need. 4.

a. Describe the demographics of the population to be served by this proposal.

The population served by this proposal is children and adolescents up through age 17, who are experiencing serious mental health disturbances (examples: suicidality, homicidality, psychosis), and who are not able to be safely or effectively managed in a less restrictive level of care. We will accept patients who are voluntary and involuntary. The proposed service area is a mix of urban, suburban and rural cities/counties, so our population demographics are very diverse. The population demographics of the service are, both rural and urban, has a higher than average percentage of low-income families.

b. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Compass is committed to serving all children in need and we have high utilization of services by underserved and low-income families. Our location in southeast Memphis is a primarily African American neighborhood that is underserved in terms of mental health services. Approximately 60% of the children we treat are African American. On average 70% of the children we treat children have Medicaid, and we expect this higher-than-average trend to continue with the expansion of services. We continue to develop our relationships with Mobile Crisis (Youth Villages), who are charged with the responsibility for West Tennessee and most of the state to screen children and adolescents with TennCare for psychiatric admission.

Our ongoing business development activities focus on community engagement, building partnerships within our community, and providing services to the entire population we serve. We offer mobile assessment services based out of the Nashville area and Little Rock, AR.

C. Need. 5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its/utilization and/or occupancy individually.

Inpatient bed projects must include the following data: admissions and discharges, patient days, occupancy. Other projects should use the most appropriate measures, e.g. cases, procedures, visits, admissions, etc.

According to the Tennessee Department of Mental Health there are 8 Licensed Mental Health Hospitals in the entire West Region. Of this group only Lakeside and Crestwyn currently provide services to children under 18. Delta Medical Center, Methodist Healthcare and St .Francis Hospital provide psychiatric inpatient services as part of Medical-Surgical systems, however only St. Francis currently provides services to children under 18.This proposal is unique in that we will only treat children and adolescents. As such, this proposal will not have any impact on the operations of adult-only facilities and we cannot consider them similar within this criterion.

Lakeside Hospital— Lakeside has full service child and adolescent inpatient programs within a large behavioral health system. Lakeside reported 261 staffed beds in the most recent JAR report, with 25 of those dedicated solely to adolescent patients. Lakeside reports a capacity of 55 children and adolescents and Lakeside occupancy and utilization have been increasing over past several years. Lakeside Hospital consistently demonstrates growth and high demand for services. In 2012 and 2013 Lakeside met the high community need for services by running an occupancy of over 100% on staffed beds and demonstrated 27.9% growth in Admissions/Discharges and 31% growth in Patient Days from 2012-2014.

	2012	2013	2014
Admissions/Discharges	6,606	7,525	8,453
Patient Days	63,508	74,858	83,256
Occupancy of Staffed Beds	111.2%	116.5%	87.4%

Crestwyn Hospital—recently opened 60-bed facility, with only 15 of 60 beds being adolescent (45 beds for adult and geriatric services). Per their recently implemented CON, Crestwyn does not plan to treat children. The impact of proposed project would be minimal considering differing primary service lines. There is no utilization/occupancy data to draw from yet.

St. Francis—full service Med-Surg facility that also provides inpatient services to children and adolescents and adults. St. Francis has a reported capacity of 35 on their child and adolescent floor. Admission/Discharge and Patient Days data below are specific to child and adolescent psychiatric population which was not broken out in their 2012 report and Occupancy data is based on the whole hospital.

	2012	2013	2014
Admissions/Discharges	Not Available	869	825
Patient Days	Not Available	6200	6359
Occupancy of Staffed Beds	71.7%	73.4%	74.0%

Source Current: JAR reports 2012-2014, Report 2A, St. Francis Hospital Individual JAR Reports 2012-2014

C. Need. 6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally provide details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources and identification for all assumptions.

Historical Utilization			
	2013	2014	2015
Admissions	281	260	256
Patient Days	32603	32217	32241
ADC	89.3	88.3	88.3
Occupancy	97%	96%	96%

Projected Utilization (New Beds)		
	Year One	Year Two
Admissions	478	688
Patient Days	3356	4816
ADC	9.2	13.2
Occupancy	19.2%	27.5%

Projected Utilization (Combined)		
	Year One	Year Two
Admissions	738	948
Patient Days	36479	37939
ADC	99.7	103.7
Occupancy	71.20%	74.10%

The methodology used to project future utilization associated with this project comes from a few sources. First, projections are based on recent Compass data points. Over 2014-2015, we had an average daily census of 1.7 patients who were hospitalized during their residential treatment with Compass or met criteria for inpatient admission. Occasionally, we are not able to secure inpatient services for current residents and are forced to continue to manage them in the residential setting. During that same time period of 2014-2015, an average of 8.3% of patients assessed were determined to need inpatient treatment. Based on a projected ALOS of 7 days, this translates to an additional 3 ADC upon opening. We anticipate additional interest and referrals to our program simply because it is a specialty children's mental health hospital, which is not found elsewhere in the service area or region.

Demand and need for mental health services remains extremely high in the proposed service area and from Compass specifically. The occupancy on staffed Mental Health beds is over 86% beds for the region. Our residential occupancy has been above 96% of staffed beds on an annual basis for over three years, and there is sustained pressure on existing services. Inquiry calls for services and assessments increased by 40% during 2015, and we have added assessment staff to manage the additional need. Our projections for utilization growth are conservative and well justified by trends in the region and state over the past several years.

Finally, we based increased utilization on data points associated with key stakeholders like Mobile Crisis and other hospitals. The number of Mobile Crisis assessments, which are required for all TennCare participants prior to hospitalization, continue to rise annually. Though it varies by region and agency, crisis services consistently maintain admirable deflection rates of 65-70%, leaving 30-35% of patients screened referred to inpatient services. As the number of crisis screenings continues to rise each year, the number of patients appropriate for inpatient services will continue to rise at a steady and predictable rate.

ECONOMIC FEASIBILITY

C. Economic Feasibility. 1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

- **All Projects should have a project cost of at least $3,000 on Line F (Minimum CON Filing Fee). CON Filing fee should be calculated from Line D. (See Application Instructions for Filing Fee).d**
- **The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure**

or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.

- **The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful like of the equipment; federal, state and local taxes and other governmental assessments; and installation charges, excluding capital expenditures for physical plan renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.**
- **For projects that include construction, modification, and/or renovation; documentation must be provided from a contractor and or architect that support the estimated construction costs.**

See Project Costs Chart on following page.

See Attachment C. Economic Feasibility.1

PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:		
	1.	Architectural and Engineering Fees	$844,500
	2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	50,000
	3.	Acquisition of Site	N/A
	4.	Preparation of Site	779,000
	5.	Construction Costs	7,679,726
	6.	Contingency Fund	1,102,307
	7.	Fixed Equipment (Not included in Construction Contract)	90,000
	8.	Moveable Equipment (List all equipment over $50,000)	827,135
	9.	Other (Specify) paving repair, soil remediation, permits testing, owner's risk	752,710
B.	Acquisition by gift, donation, or lease:		
	1.	Facility (inclusive of building and land)	N/A
	2.	Building only	N/A
	3.	Land only	N/A
	4.	Equipment (Specify)_____	N/A
	5.	Other (Specify) _____	N/A
C.	Financing Costs and Fees:		
	1.	Interim Financing	N/A
	2.	Underwriting Costs	N/A
	3.	Reserve for One Year's Debt Service	N/A
	4.	Other (Specify) _____	N/A
D.	Estimated Project Cost (A+B+C)		$12,125,378
E.		CON Filing Fee	27,283
F.		Total Estimated Project Cost (D+E)	
		TOTAL	$12,152,661

C. Economic Feasibility. 2. Identify the funding sources for this project.

Please check the applicable item(s) below and briefly summarize how the project will be financed. (Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2)

__ A. Commercial Loan—Letter form lending institution or guarantor stating favorable initial contract, proposed loan amount, expected interest rates, anticipated term of the loan and any restrictions or conditions.

__ B. Tax-exempt bonds—Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance.

__ C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.

__ D. Grants—Notification of intent form for grant application or notice of grant award; or

_X E. Cash Reserves—Appropriate documentation from Chief Financial Officer

__ F. Other—identify and document funding from all other sources.

See Attachment C, Economic Feasibility -2.

C. Economic Feasibility.3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services Development Agency.

The proposed construction costs of $7,679,726 ($272.58 sq. /ft.) are consistent with the published Hospital Construction Costs for years 2013-2015 and the CON for the recently implemented Crestwyn hospital project at $244.85 sq. /ft. The proposed renovated costs are on target with the

Median and the overall cost per-square-foot falls between the Median and 3rd quartile. Based on this data the costs are reasonable.

Hospital Construction Costs Per Square Foot, Years: 2013-2015			
	Renovated Construction	**New Construction**	**Total Construction**
1st Quartile	$160.66/ sq. ft.	$244.85/ sq. ft.	$196.62/ sq. ft.
Median	$223.91/ sq. ft.	$308.43/ sq. ft.	$249.67/ sq. ft.
3rd Quartile	$297.82/ sq. ft.	$374.32/ sq. ft.	$330.50/ sq. ft.

Source: CON approved applications for years 2013- 2015

C. Economic Feasibility.4. Complete Historical and Projected Data Charts on the following two pages. Do not modify the Charts provided or submit Chart substitutions! Historical Data Chart represents revenue and expense information for the last three (3) years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the Proposal Only (i.e., if the application is for additional beds include anticipated revenue from the proposed beds only, not from all beds in the facility).

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

	Year 2013	Year 2014	Year 2015
A. Utilization Data (Specify unit of measure) Patient Days	32,603	32,217	32,241
B. Revenue from Services to Patients			
1. Inpatient Services	$32,940,883	$32,430,381	$32,500,775
2. Outpatient Services	97,200	205,200	313,600
3. Emergency Services	-	-	-
4. Other Operating Revenue (Specify) Physicians Fees, Medical Records Admin. Misc.	2,441	2,048	2,727
Gross Operating Revenue	$33,040,524	$32,637,629	$32,817,102
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$20,905,188	$20,549,545	$20,221,109
2. Provision for Charity Care	-	-	-
3. Provisions for Bad Debt	(102,870)	91,230	164,685
Total Deductions	$20,802,318	$20,640,775	$20,385,794
NET OPERATING REVENUE	$12,238,206	$11,996,854	$12,431,308
D. Operating Expenses			
1. Salaries and Wages	$4,382,932	$4,556,722	$4,692,219
2. Physician's Salaries and Wages	471,650	487,000	508,410
3. Supplies	894,209	991,027	852,438
4. Taxes	418,760	416,292	412,874
5. Depreciation	214,759	225,549	252,145
6. Rent	30,591	37,832	35,484
7. Interest, other than Capital	-	-	-
8. Management Fees:			
a. Fees to Affiliates	248,400	287,640	330,480
b. Fees to Non-Affiliates	-	-	-
9. Other Expenses (Specify) Benefits, Purchased Services, Maintenance, Insurance, Travel, Other Misc.	1,235,760	1,439,982	1,541,554
Total Operating Expenses	$7,897,061	$8,442,044	$8,625,604
E. Other Revenue (Expenses) – Net (Specify)	$-	$-	$-
NET OPERATING INCOME (LOSS)	$4,341,145	$3,554,810	$3,805,704
F. Capital Expenditures			
1. Retirement of Principal	$-	$-	$-
2. Interest	2,450,081	2,464,791	2,482,990
Total Capital Expenditures	$2,450,081	$2,464,791	$2,482,990
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$1,891,064	$1,090,019	$1,322,714

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year One	Year Two
A.	Utilization Data (Specify unit of measure) Patient Days	3356	4816
B.	Revenue from Services to Patients		
1.	Inpatient Services	$ 6,040,800	$ 8,668,800
2.	Outpatient Services	676,800	936,000
3.	Emergency Services	--	--
4.	Other Operating Revenue (Specify) Physicians Fees, Medical Records, Admin. Misc.	85,025	121,600
	Gross Operating Revenue	$ 6,802,625	$ 9,726,400
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$ 4,214,361	$ 6,029,784
2.	Provision for Charity Care	704,185	144,913
3.	Provisions for Bad Debt	132,626	189,290
	Total Deductions	$ 5,051,172	$ 6,363,987
NET OPERATING REVENUE		$ 1,751,453	$ 3,362,413
D.	Operating Expenses		
1.	Salaries and Wages	$ 1,226,673	$ 1,655,644
2.	Physician's Salaries and Wages	304,180	421,280
3.	Supplies	103,030	147,852
4.	Taxes	157,212	185,335
5.	Depreciation	680,572	680,572
6.	Rent	6,000	6,000
7.	Interest, other than Capital	--	--
8.	Management Fees:		
a.	Fees to Affiliates	--	--
b.	Fees to Non-Affiliates	--	--
9.	Other Expenses (Specify) Benefits, Purchased Services, Maintenance, Insurance, Travel, Other Misc.	452,353	561,594
	Total Operating Expenses	$ 2,903,020	$ 3,658,277
E.	Other Revenue (Expenses) -- Net (Specify)	$ --	$ --
NET OPERATING INCOME (LOSS)		$ (1,178,567)	$ (295,864)
F.	Capital Expenditures		
1.	Retirement of Principal	-- $	-- $
2.	Interest	--	--
	Total Capital Expenditures	$ --	$ --
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$ (1,178,567)	$ (295,864)

C. Economic Feasibility. 5. Please identify the projects average gross charge, average deduction from operating revenue, and average net charge.

Average Charges and Deductions PPD		
	Year One	Year Two
Average Gross Charge	1824	1824
Average Revenue Deduction	1183	1183
Average Net Charge	641	641

C. Economic Feasibility. 6.

A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Current charges will not be impacted by the implementation of this proposal. While charges are periodically adjusted from time to time, there are no plans to change current charges in association with this proposal. The anticipated revenue from the proposal is $1,751,453 in Year One and $3,362,413 in Year Two, and as a new service line, the revenues from the proposal will not have any impact on existing charges. (See following current and proposed fee schedules).

Current Schedule of Charges	
Residential Treatment	$1,000.00
Partial Hospital 4-8hrs	$600.00
Intensive Outpatient	$400.00
Psychiatric Evaluation	$185.00
History and Physical	$100.00

Proposed Schedule of Charges	
Inpatient Hospital	$1,800.00
Residential Treatment	$1,000.00
Partial Hospital 4-8hrs	$600.00
Intensive Outpatient	$400.00
Psychiatric Evaluation	$185.00
History and Physical	$100.00
Initial Hospital Care (30 min)	$195.00
Initial Hospital Care (50 min)	$200.00
Initial Hospital Care (70 min)	$205.00
Subsequent Care (15 min)	$80.00
Subsequent Care (25 min)	$140.00
Subsequent Care (35 min)	$95.00
Discharge Day Management < 30 min	$95.00
Discharge Day Management > 30 min	$125.00

B. Compare the proposed charges to those of similar facilities in the service area/adjoining services areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) codes.

Our proposed charges were developed in comparison to the charges of other facilities in the service area, including the recently implemented Crestwyn project, and other regional UHS facilities.

C. Economic Feasibility. 7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

Based on the conservative projected utilization rates, the proposal is cost-effective in that we will obtain a positive monthly operating margin within 6 months of beginning operations and positive project-to-date operating margin within approximately 30 months.

C. Economic Feasibility. 8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

As indicated in the included financial reports (also See Attachment C, Economic Feasibility-10), our parent company Universal Health Services, Inc. has sufficient financial resources to ensure the viability of this proposal. Our conservative utilization projections have us showing a positive monthly margin within 6 months of beginning operations. It should also be noted that existing operations generate a margin which helps ensure financial viability.

C. Economic Feasibility. 9. Discuss the projects participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of Tenncare, Medicare, or other state and federal sources for the proposal's first year of operation.

Through this proposal, which is serving only children and adolescents, we expect no participation in Medicare and limited medically indigent patients. The first year of this proposal does include a substantial percentage of charity care associated with starting operations. Compass currently participates in TennCare and is contracted with all three MCOs to provide behavioral health services. We also currently participate in Arkansas Medicaid and will seek participation in Mississippi Medicaid upon implementation of this proposal.

Revenue by State or Federal Program		
	Revenue in Year One	Percentage of Total Revenue
TennCare	$948,070	54%
AR Medicaid	$284,421	16.2%

C. Economic Feasibility. 10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial

information for the corporation, partnership or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

See Attachment C, Economic Feasibility-10.

C. Economic Feasibility. 11. Describe all alternatives to this project which were considered and discuss the advantages of each alternative including but not limited to:

A. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

The development of inpatient psychiatric service included in this proposal cannot be duplicated or provided in a different non-hospital setting. Facility Admission Criteria as well as Medically Necessity standards for TennCare and commercials insurers require this service to be distinct from less restrictive community based treatments and driven by severity and acuity of symptoms. We are committed to ensuring that state resources are used wisely by linking consumers with the appropriate services onsite or in the community. Through this proposal Compass will be able to provide a continuum of care that ranges from outpatient services to inpatient psychiatric care.

B. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent possible.

Prior to initiating this proposal we explored the option of converting RTC beds to inpatient beds. However, due to the variations in physical plant requirements between Residential Treatment and Inpatient Hospital we would have had to demolish the existing facility to the foundation, making it not financially feasible to convert. The proposal is the superior alternative in that it allows for state-of-the art

facilities to be constructed specifically for the child and adolescent patient population utilizing industry best practices and design.

See also Attachment C. Economic Feasibility. 1.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

C. Contribution to the Orderly Development of Health Care. 1

List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health care services.

Current Healthcare Related Contracts and Agreements

NAME	CONTRACT TYPE
Aetna	Managed Health
Amerigroup	Managed Health
Arkansas Medicaid	Managed Health
Atrium Pharmacy	Pharmacy
Ballet Memphis Corporation	Therapy Services
Baptist College of Health Sciences	School Affiliation
BHSG	Managed Health
Blue Care	Managed Health
Blue Cross Blue Shield of Tennessee	Managed Health
Centerstone of America	MOU
Cigna	Managed Health
eTransconic Transcription, LLC	Transcription Services
Magellan	Managed Health
Marquis Mobile Dentist	Mobile Dental Services
Medical Waste Services	Medical Waste Disposal
Methodist LeBonheur Healthcare	Medical
Passport Health Communications, Inc.	Benefit Verification
Radiographics, Inc.	Portable Diagnostics
Saint Francis Hospital	Therapy Services
Saint Francis Hospital	Transfer Agreement
Tricare South	Managed Health
Union University	School Affiliation
United Health Care (UBH/Optum)	Managed Health

University Of Memphis	School Affiliation
University Of Mississippi	School Affiliation
University Of Tennessee at Knoxville	School Affiliation
Value Options/Tricare	Managed Health

C. Contribution to the Orderly Development of Health Care. 2

Describe the positive and/or negative effects of the proposal on the healthcare system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the services area of the project.

This proposal will benefit the overall healthcare system in the proposed service area and the state by providing much needed capacity for child and adolescent beds. The proposal decreases pressure on Mobile Crisis and other mental health providers by ensuring less difficulty in locating inpatient beds for patients in need. While similar services exist in our service area, there is still need for additional beds, and therefore we do not foresee measureable negative impact to existing providers. Our utilization projections are based on admissions generated internally, and take into account the steady growth in overall hospital utilization trends across the region and state. We will continue to work with other hospitals and agencies to provide a comprehensive mental health system.

C. Contribution to the Orderly Development of Health Care. 3

Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to the prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

As an existing facility, we expect to realize overlap between some existing employees and additional employees hired as part of this proposal. For example, the current Director of Nursing will have responsibility over the nursing department staff associated with the proposed project. The following table breaks out the various clinical FTEs as of Year two of the proposal.

Year 2 FTE Grid	
Position	**FTE**
Nursing Admin	2.0
Nursing (RN)	7.0
Nursing (Tech)	8.4
Partial Hospital	1.5
Activities Therapy	1.4
Social Work	2.0
Total Patient Care FTE	22.3

In comparing our current wages to data from the Tennessee Department of Labor, Compass demonstrates highly competitive pay for clinical positions. In the table below our starting rates are compared with the Starting, Median and Experienced rates as published on the website for the Tennessee Department of Labor.

Clinical Staff Type	Wage Type	Starting	Median	Experienced	Compass Rate
Social Worker	Annual	$30,928	$47,840	$58,017	$38,000
Psychiatric Tech	Hourly	$10.47	$11.30	$13.10	$10.25
RN	Hourly	$21.32	$27.10	$30.47	$24.00
Recreational Therapy	Annual	$25,417	$38,998	$51,392	$35,000

*Tennessee Department of Labor Occupational and Employment Wage Rates 2014

C. Contribution to the Orderly Development of Health Care. 4

Discuss the availability and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

As an existing entity Compass currently has processes in place for the development of human resources. We currently have 120 employees and 8 contracted professional staff. We will not have any difficulty hiring and training the additional employees needed to implement this project. Compass has successfully recruited professional staff over the last three years including an MD, a psychologist and two Nurse Practitioners.

C. Contribution to the Orderly Development of Health Care. 5
Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping and staff education.

It is verified that we understand all licensing certification as required by the State of Tennessee for Medical/Clinical staff, including without limitation regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping and staff education. As an existing behavioral health facility, Compass already has processes and policies in place for all of the above required items and will make any modifications required with the addition of inpatient services.

C. Contribution to the Orderly Development of Health Care. 6
Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies).

Compass currently has a robust clinical internship and field placement program for graduate and undergraduate students in several fields including Social Work, Counseling, Psychology, Recreational Therapy and Occupational Therapy. We have field placement agreements with The University of Tennessee (Knoxville and Martin Campuses), University of Mississippi, University of Memphis and Union University. Each year between 10 and 20 students complete field placement experiences with Compass Intervention Center. Through this proposal, expansion of our services will allow for an even greater scope and extent of student learning, including the possibility of working with medical schools and their students.

C. Contribution to the Orderly Development of Health Care. 7

a. Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, The Department of Mental Health and Developmental

Disabilities, the Division of Mental Retardation, and/or any applicable Medicare standards.

Compass is currently licensed with the Tennessee Department of Mental Health and Substance Abuse Services, and will be seeking the additional Mental Health Hospital license from the agency. It is verified that Compass has fully reviewed and understands the applicable licensure requirements of the Tennessee Department of Mental Health and Substance Abuse Services, and Medicare Conditions of Participation and other relevant standards. As an existing behavioral health facility, Compass has a long-standing relationship with the department of Mental Health and Substance Abuse Services and fully complies with all requirements of licensure.

b. Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure: Compass is currently licensed by the State of Tennessee Department of Mental Health and Substance Abuse Services in the categories of Alcohol and Drug Residential Treatment for Children and Youth, Mental Health Outpatient Facility, Mental Health Partial Hospitalization Facility, Mental Health Residential Treatment for Children and Youth, and Mental Health Intensive Day Treatment for Children and Adolescents. Upon approval and implementation of the project we plan to add Inpatient Psychiatric Beds to our license.

Certification: Compass is currently certified by TennCare as a residential treatment facility, and will jointly pursue validation and certification by Medicare and TennCare as a Psychiatric Inpatient Hospital.

Accreditation: Compass is currently accredited by the Joint Commission under the Behavioral Health Manual. Compass was last surveyed in March 2015 with exemplary results. Upon approval and implementation of the project we will seek the additional accreditation under the Joint Commission Hospital manual as well, and each subsequent future survey will be completed on both the Hospital and Behavioral Health manuals.

c. If an existing institution please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.

Compass is currently in good standing with the Tennessee Department of Mental Health and Substance Abuse Services Licensure Division and the Joint Commission.

See Attachment C. Contribution to the Orderly Development of Health Care. 7-c.

d. For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

All deficiencies cited in the last onsite inspection have been have been addressed thorough an approved plan of correction.

See Attachment C. Contribution to the Orderly Development of Health Care. 7-d.

C. Contribution to the Orderly Development of Health Care. 8

Document and explain any final orders or judgments entered in any state or county by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

Not Applicable N/A

C. Contribution to the Orderly Development of Health Care. 9

Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project.

Not Applicable N/A

C. Contribution to the Orderly Development of Health Care. 10

If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients

treated, the number and type of procedures performed and other data as required.

Once this proposal is approved Compass will fully provide utilization data and other necessary data to the Tennessee Health Services and Development Agency and/or other reviewing agency.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

Please see following Affidavit and the notice of intent as published in the Commercial Appeal.

The Commercial Appeal
Affidavit of Publication

STATE OF TENNESSEE
COUNTY OF SHELBY

Personally appeared before me, Patrick Maddox, a Notary Public, Marianne Sheridan, of MEMPHIS PUBLISHING COMPANY, a corporation, publishers of The Commercial Appeal, morning and Sunday paper, published in Memphis, Tennessee, who makes oath in due form of law, that she is Legal Clerk of the said Memphis Publishing Company, and that the accompanying and hereto attached advertisement was published in the following editions of The Commercial Appeal, to-wit:

June 10, 2016

Marianne Sheridan

Subscribed and sworn to before me this 10th day of June, 2016.

Notary Public

My commission expires January 20, 2020.

PATRICK MADDOX
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF SHELBY

DEVELOPMENT SCHEDULE

Tennessee Code Annotated 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of issuance and after such time shall expire; provided that the Agency may, in granting the Certificate of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**

2. **If the response to the preceding question indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph, please state below any request for an extended schedule and document the "good cause" for such an extension.**

If approved we will complete the project within the prescribed period of validity. Please see the Project Completion Forecast Chart on the Following Page.

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-1609(c): 9/28/2016

Assuming the CON approval becomes the final agency action on that **date;** indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

Phase	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed	--	August 2016
2. Construction documents approved by the Tennessee Department of Health	135	February 2017
3. Construction contract signed	120	January 2017
4. Building permit secured	150	February 2017
5. Site preparation completed	230	May 2017
6. Building construction commenced	240	May 2017
7. Construction 40% complete	310	August 2017
8. Construction 80% complete	390	October 2017
9. Construction 100% complete (approved for occupancy	470	January 2018
10. *Issuance of license	510	February 2018
11. *Initiation of service	600	May 2018
12. Final Architectural Certification of Payment	515	February 2018
13. Final Project Report Form (HF0055)	545	March 2018

* **For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

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Attachment A.3. Owner of the Facility, Agency or Institution

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

JEREMY PITZER
7900 LOWRANCE RD
MEMPHIS, TN 38125-2838

May 31, 2016

Request Type: Certificate of Existence/Authorization
Request #: 0204027

Issuance Date: 05/31/2016
Copies Requested: 1

Document Receipt

Receipt # : 002720989 Filing Fee: $20.00

Payment-Check/MO - JEREMY PITZER, MEMPHIS, TN $20.00

Regarding: **KEYSTONE MEMPHIS, LLC**
Filing Type: Limited Liability Company - Domestic
Formation/Qualification Date: 09/14/2000
Status: Active
Duration Term: Perpetual
Business County:

Control # : 395685
Date Formed: 09/14/2000
Formation Locale: TENNESSEE
Inactive Date:

CERTIFICATE OF EXISTENCE

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that effective as of the issuance date noted above

KEYSTONE MEMPHIS, LLC

* is a Limited Liability Company duly formed under the law of this State with a date of incorporation and duration as given above;

* has paid all fees, taxes and penalties owed to this State (as reflected in the records of the Secretary of State and the Department of Revenue) which affect the existence/authorization of the business;

* has filed the most recent annual report required with this office;

* has appointed a registered agent and registered office in this State;

* has not filed Articles of Dissolution or Articles of Termination. A decree of judicial dissolution has not been filed.

Tre Hargett
Secretary of State

Processed By: Sheila Keeling

Verification #: 017564933

Attachment A.4. Typer of Ownership Control

Secretary of State
Division of Business Services
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, Tennessee 37243

DATE: 02/26/01
REQUEST NUMBER: 4133-2273
TELEPHONE CONTACT: (615) 741-2286
FILE DATE/TIME: 02/26/01 1433
EFFECTIVE DATE/TIME: 02/28/01 1630
CONTROL NUMBER: 0395685

TO:
BOULT, CUMMINGS, CONNERS & BERRY, PLC
P.O. BOX 198062

NASHVILLE, TN 37219

Davidson County CHARTER
Recvd: 03/02/01 08:20 5pgs
Fees:7.50 Taxes:0.00

20010302-0019528

RE:
KEYSTONE MEMPHIS, LLC
ARTICLES OF CONVERSION - LIMITED LIABILITY COMPANY

CONGRATULATIONS UPON THE FORMATION OF THE LIMITED LIABILITY COMPANY IN THE STATE OF TENNESSEE WHICH IS EFFECTIVE AS INDICATED ABOVE.

A LIMITED LIABILITY COMPANY ANNUAL REPORT MUST BE FILED WITH THE SECRETARY OF STATE ON OR BEFORE THE FIRST DAY OF THE FOURTH MONTH FOLLOWING THE CLOSE OF THE LIMITED LIABILITY COMPANY'S FISCAL YEAR. ONCE THE FISCAL YEAR HAS BEEN ESTABLISHED, PLEASE PROVIDE THIS OFFICE WITH WRITTEN NOTIFICATION. THIS OFFICE WILL MAIL THE REPORT DURING THE LAST MONTH OF SAID FISCAL YEAR TO THE LIMITED LIABILITY COMPANY AT THE ADDRESS OF ITS PRINCIPAL OFFICE OR TO A MAILING ADDRESS PROVIDED TO THIS OFFICE IN WRITING. FAILURE TO FILE THIS REPORT OR TO MAINTAIN A REGISTERED AGENT AND OFFICE WILL SUBJECT THE LIMITED LIABILITY COMPANY TO ADMINISTRATIVE DISSOLUTION

WHEN CORRESPONDING WITH THIS OFFICE OR SUBMITTING DOCUMENTS FOR FILING, PLEASE REFER TO THE LIMITED LIABILITY COMPANY CONTROL NUMBER GIVEN ABOVE.

PLEASE BE ADVISED THAT THIS DOCUMENT MUST BE FILED IN THE OFFICE OF THE REGISTER OF DEEDS IN THE COUNTY WHEREIN A LIMITED LIABILITY COMPANY HAS ITS PRINCIPAL OFFICE IF SUCH PRINCIPAL OFFICE IS IN TENNESSEE.

FOR: ARTICLES OF CONVERSION - LIMITED LIABILITY COMPANY

ON DATE: 02/26/01

FROM:
BOULT, CUMMINGS, CONNERS & BERRY
P. O. BOX 198062

NASHVILLE, TN 37219-0000

	FEES	
RECEIVED:	$300.00	$0.00
TOTAL PAYMENT RECEIVED:		$300.00

RECEIPT NUMBER: 000002818989
ACCOUNT NUMBER: 00000413

Riley C Darnell

RILEY C. DARNELL
SECRETARY OF STATE

52

SS-4458

Attachment A.4. Typer of Ownership Control

41.3.3 2:2:75

Appendix 1

Articles of Organization of Keystone Memphis, LLC

The undersigned person, on behalf of the limited liability company under the Tennessee Limited Liability Company Act, adopts the following as the Articles of Organization for such limited liability company:

1. The name of the limited liability company is Keystone Memphis, LLC (the "LLC").

2. The street address, zip code and county of the initial registered office of the LLC in the State of Tennessee shall be 414 Union Street, Suite 1600, Nashville, Tennessee 37219, County of Davidson.

3. The name of the initial registered agent of the LLC, located at the registered office set forth above, is Andrea C. Barach, Esq..

4. The name and address of the organizer of the LLC is:

Andrea C. Barach, Esq.
c/o Boult, Cummings, Conners & Berry, PLC
414 Union Street, Suite 1600
Nashville, TN 37219

5. The street address, zip code and county of the principal executive office of the LLC shall be is 1114 17th Avenue South, Suite 204, Nashville, County of Davidson, Tennessee 37212.

6. The LLC will be member-managed.

7. The LLC has one (1) member at the time of organization.

8. The existence of the LLC is to begin upon the filing of the Articles of Organization.

9. The duration of the LLC shall be perpetual.

10. To the maximum extent permitted by the provisions of T.C.A. § 48-243-101, as amended from time to time (provided, however, that if an amendment to such act limits or restricts in any way the indemnification rights permitted by law as of the date hereof, such amendment shall apply only to the extent mandated by law and only to activities of persons subject to indemnification under this paragraph which occur subsequent to the effective date of such amendment), the LLC shall indemnify and advance expenses to any person, his heirs, executors and administrators, for the defense of any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative and whether formal or informal, including counsel fees actually incurred as a result of such action, suit or proceeding or any appeal thereof, and against all fines (including any excise tax assessed with respect to an employee benefit plan), judgments, penalties and amounts paid in settlement thereof, provided that such proceeding or action be instituted by reason of the fact that such person is or was a member of the LLC. Any repeal or modification of the provisions of this paragraph directly or by the LLC's adoption of an amendment to these Articles of Organization that is inconsistent with the provisions of this paragraph, shall not adversely affect any right or protection set forth herein existing in favor of a particular individual at the time of such repeal or modification.

Dated: February 28, 2001.

Andrea C. Barach, Esq., Sole Organizer

Attachment A.4. Typer of Ownership Control

FILED

RECEIVED
01 FEB 23 PM 2:35
SECRETARY OF STATE

4133 2212 73

Articles of Conversion

Keystone Memphis, Inc. (Control No. 0395685)

into

Keystone Memphis, LLC

February 28, 2001

To the Secretary of State of the State of Tennessee:

Pursuant to the provisions of Section 48-21-111 of the Tennessee Business Corporation Act, as amended, the undersigned domestic corporation adopts the following articles of conversion for the purpose of converting into a limited liability company:

1. The name of the limited liability company shall be Keystone Memphis, LLC (the "LLC").

2. The initial registered office of the LLC is 414 Union Street, Suite 1600, Nashville, Tennessee 37219.

3. The initial registered agent at the initial registered office is Andrea C. Barach, Esq.

4. The organizer is Andrea C. Barach, Esq., and her address is 414 Union Street, Suite 1600, Nashville, County of Davidson, Tennessee 37219.

5. The LLC will be member managed.

6. As of the effective date of these articles, the LLC will have one (1) member.

7. The principal executive office of the LLC is 1114 17th Avenue South, Suite 204, Nashville, County of Davidson, Tennessee 37212.

8. The LLC was converted from a corporation.

9. The former corporation's name and principal business address were Keystone Memphis, Inc., 1114 17th Avenue South, Suite 204, Nashville, County of Davidson, Tennessee 37212.

10. The Plan of Conversion is attached hereto as Exhibit A.

11. The existence of the LLC shall begin upon the effective date of the filing of these articles, which date shall be February 28, 2001.

KEYSTONE MEMPHIS, INC.

By: _____
Name: H. Neil Campbell
Title: President

Attachment A.4. Typer of Ownership Control

4-1-3-3 12:24

Exhibit A

Plan of Conversion of Keystone Memphis, Inc. into Keystone Memphis, LLC

This Plan of Merger is prepared and submitted pursuant to the provisions of Section 48-21-111 of the Tennessee Business Corporation Act, as amended.

1. The names of limited liability company into which the corporation will be converted is Keystone Memphis, LLC.

2. On the effective date of the conversion, each share of common stock of the corporation issued and outstanding immediately prior to the effective date of the conversion will be canceled and extinguished such that each shareholder of the corporation shall thereafter hold the same number of units of membership interests of Keystone Memphis, LLC as such shareholder held shares in the corporation.

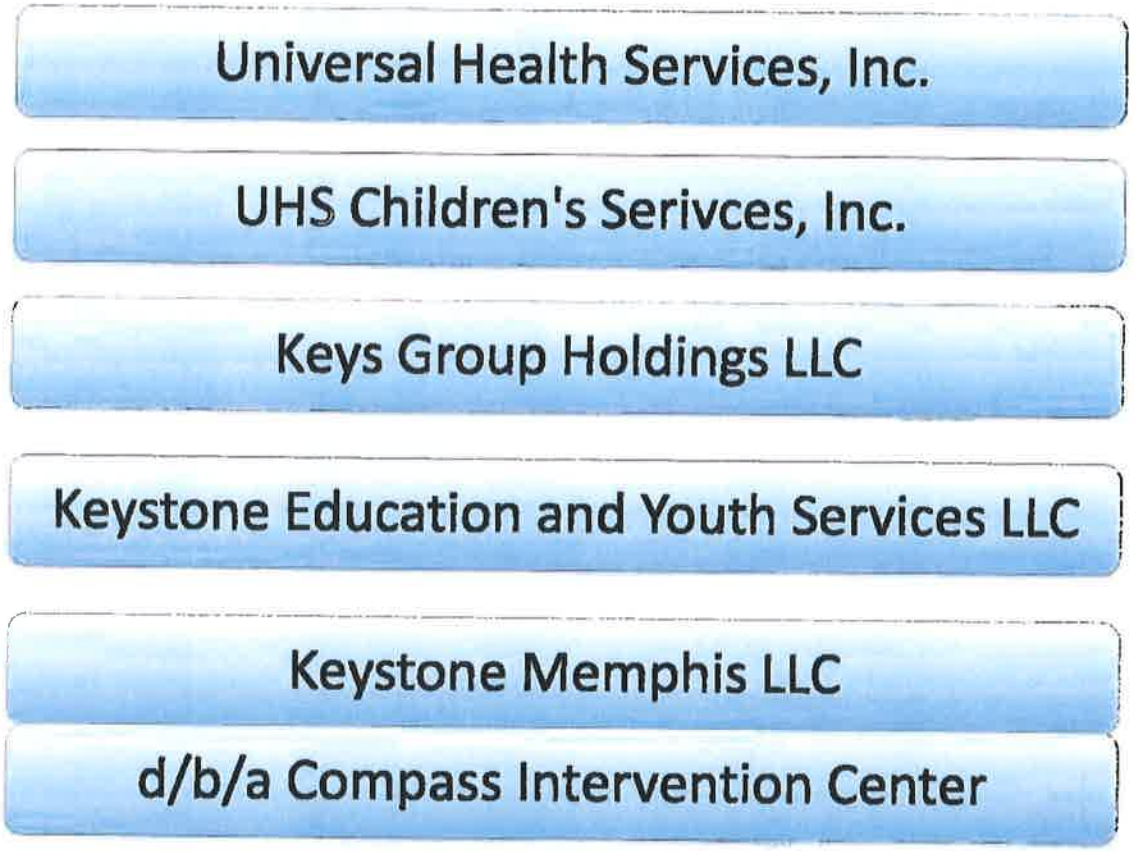
3. The effective date of this Plan of Conversion and the date upon which the conversion contemplated by this Plan of Conversion shall become effective shall be February 28, 2001.

4. The contents of the articles of organization that shall be the articles of organization of Keystone Memphis, LLC are set forth on Appendix 1 attached hereto.

5. Notification of the approval of this conversion will be deemed to be execution of the operating agreement attached hereto as Appendix 2 by Keystone Education and Youth Services, Inc., who will be the sole initial member of Keystone Memphis, LLC.

Attachment A.4

Ownership Structure Organizational Chart



Attachment A.4

Ownership of Other Healthcare Facilities in Tennessee

Facility Name, Facility Type, Address	Licensure/Certification
Cedar Grove Residential Treatment Center (RTC) 1640 Lascassas Pike Murfreesboro, TN 37130	Active Medicaid Certification 4121518 TDMHSAS License In Good Standing
Lakeside Behavioral Health System (Mental Health Hospital) 2911 Brunswick Road Memphis, TN 38133	Active Medicare and Medicaid Certification 444004 TDMHSAS License in Good Standing
McDowell Center for Children 711 Highway 51 Bypass South Dyersburg, TN 38024	Active Medicaid Certification 5441342 TDMHSAS License In Good Standing
Mountain Youth Academy (RTC) 332 Hospital Road P.O. Box 58 Mountain City, TN 37683	Active Medicaid Certification 5441347 TDMHSAS License in Good Standing
Natchez Trace Youth Academy (RTC) 415 Seven Hawks Lane Waverly, TN 37185	Active Medicaid Certification 5441259 TDMHSAS License In Good Standing
Oak Plains Academy (RTC) 1751 Oak Plains Road Ashland City, TN 37015	Active Medicaid Certification 5441152 TDMHSAS License In Good Standing
Rolling Hills Hospital (Mental Health Hospital) 2014 Quail Hollow Circle Franklin, TN 3706	Active Medicare and Medicaid Certification 444007 TDMHSAS License in Good Standing

Attachment A.5. Name of Management/ Operating Entity

MANAGEMENT AGREEMENT

This Management Agreement ("Agreement") is made as of January 1, 2016, by and between UHS of Delaware, Inc., a Delaware corporation ("Manager") and Keystone Memphis, LLC d/b/a Compass Intervention Center ("Facility").

BACKGROUND:

A. Facility owns and operates a behavioral health facility located in the State of Tennessee.

B. Manager, among other things, is in the business of providing comprehensive administrative, management, information and other services to behavioral health care entities and facilities as more specifically described in this Agreement (collectively, the "Services").

C. Facility hereby engages Manager to provide the Services and Manager agrees to provide such Services pursuant to the terms and conditions set forth in this Agreement.

NOW THEREFORE, in consideration of the mutual covenants and agreements herein contained, and intending to be legally bound hereby, Facility and Manager agree as follows:

AGREEMENT:

1. **Incorporation of Background; Defined Terms**. The "Background" provisions set forth above (including, but not limited to all defined terms set forth therein) are true and correct and are hereby incorporated by reference into this Agreement and made a part hereof as if set forth in their entirety.

2. **Appointment and Relationship of the Parties**

A. Appointment. Facility hereby engages Manager and Manager hereby agrees to be engaged to serve as the manager of the Facility and provide the Services to Facility during the Term of this Agreement.

B. Term. This Agreement shall commence at 12:01 a.m. on January 1, 2016 (the "Effective Date") and end of December 31, 2016 ("Initial Term"). Thereafter, this Agreement shall automatically renew for successive one (1) year terms until terminated pursuant to Section 9, below (collectively, the "Renewal Terms") (the Initial Term and any Renewal Term thereafter shall be collectively referred to herein as the "Term").

C. Independent Relationship. The relationship between Manager and Facility is that of independent contracting parties and neither Manager nor Facility, nor their respective employees, servants, agents or representatives shall be considered the employee, servant, agent or representative of the other, except with respect to duties specifically delegated to Manager under this Agreement. Each party shall be responsible solely for and shall comply with all Federal, state, county and municipal laws and regulations pertaining to employment taxes,

income withholding, unemployment compensation contributions and other employment related statutes applicable to that party.

D. No Patient Referrals. The parties agree that the benefits to Facility hereunder do not require, are not payment for, and are not in any way contingent upon the admission, referral, or any other arrangement for the provision of any item or services offered by Manager to the patients of Facility. The parties to this Agreement agree that no payments made hereunder are made in return for, or to induce any person to:

(1) Refer an individual to anyone for the furnishing or arranging for the furnishing of items or services for which payment may be made in whole or in part under Medicare or Medicaid; or

(2) Purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under Medicare or Medicaid.

3. Duties and Responsibilities of Manager

A. General Duties and Responsibilities. Manager is authorized to provide management services to the Facility in accordance with the terms and conditions of this Agreement and to provide the Services in a manner consistent with the prudent and workmanlike management, operation, maintenance and supervision of facilities similar to Facility.

B. Services. Without limiting the provisions of Section 3.A., above, Manager shall provide the following Services for the Facility:

(1) Preparation of Budgets. Manager shall assist Facility in the preparation of annual capital and operating budgets reflecting in reasonable detail the anticipated revenues and expenses and sources and uses of capital for enhancement, remediation/repair or growth of Facility and its clinical operations. While Manager shall provide assistance in the preparation of an annual budget, Facility acknowledges that they are solely and independently responsible for the preparation of an annual budget.

(2) Service Development. At least annually, Manager shall review, analyze and make recommendations related to the expansion of Facility's service lines and need for capital expenditures and improvements.

(3) Inventory and Supplies. Manager shall cause to be ordered and purchased inventory and supplies, and such other ordinary or appropriate materials which are necessary for the operation of Facility (collectively, the "Supplies). The cost of such Supplies shall be borne by Facility and shall not be included in the Management Fee (as defined in Section 6).

(4) Systems and Procedures. Manager shall develop and implement all systems and procedures required for the efficient operations of Facility. The systems and procedures shall include, without limitation:

(a) the billing system;
(b) the collection system;
(c) the disbursement system;
(d) the payroll system;
(e) the insurance claim system;
(f) the management information system; and
(g) the patient safety improvement system.

(5) Records and Confidentiality. Manager shall maintain or cause to be maintained a comprehensive system of records, books and accounts for Facility, which records, books and accounts shall, to the extent possible, be maintained on the premises of Facility. Manager shall, in connection with the performance of the Services, maintain the confidentiality of all financial information of Facility as well as protected health information of Facility's patients in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations (collectively, "HIPAA"). Manager shall comply with the terms of the Business Associate Agreement with Facility as attached hereto on Exhibit A.

(6) Compliance with Laws. Manager shall assist Facility in connection with any and all actions as may be necessary to comply with all laws, rules, regulations, interpretive guidelines, accreditation standards, orders and requirements of any Federal, state, county or municipal authority or accrediting body (collectively, "Applicable Laws") relating to Facility. Manager shall comply with all Applicable Laws in connection with its performance of the Services under this Agreement.

(7) Marketing. Manager, following consultation with Facility, shall design and implement an adequate and appropriate public relations program on behalf of Facility, with appropriate emphasis on public awareness of the availability of services from Facility. The public relations program shall be conducted in compliance with all Applicable Laws governing the operation of Facility.

(8) Managed Care. Manager shall review and, upon Facility request, negotiate, all managed care contracts on behalf of Facility.

(9) Property, Plant and Equipment. Manager shall arrange for the proper maintenance and repair of Facility's property, plant and equipment. The costs related to any maintenance and repairs shall be borne by Facility.

(10) Personnel and Benefits.

(a) Manager shall provide human resources management services for the successful operation of Facility. Such services may include but not be limited to: consulting on employment and labor issues; providing model policies and best practices; and negotiating contracts for benefits and other

services. Manager does not control day to day employment policies, practices or decisions relating to employees employed by Facility.

(b) Manger shall provide Facility with the following personnel necessary for the management of the Facility: (a) Chief Executive Officer; (b) Chief Financial Officer; (c) Chief Operating Officer and (d) Chief Nursing Officer (collectively, "Key Personnel"). Manager shall negotiate and contract with all Key Personnel for services to be provided at Facility. Salaries and benefits of Key Personnel shall be included in the Management Fee. Such Key Personnel shall provide specific duties on behalf of the Facility consistent with their respective job descriptions and shall have authority to execute contracts on behalf of Facility consistent with the parameters set forth in this Agreement.

(c) Manager shall contract for and supervise the preparation and filing of all necessary forms for disability insurance, hospitalization and group life insurance, unemployment insurance for Facility's employees (collectively "Benefits"), withholding and social security taxes and all other forms required by any Federal, state, municipal or other governmental authority or by any labor union agreement. The costs related to such Benefits shall be borne by Facility.

(11) Insurance.

(a) Manager shall cause to be purchased all forms of insurance required by Applicable Laws or deemed necessary or advisable to adequately to protect Facility and its properties, whether owned or leased by it, including, but not limited to public liability insurance, fire and extended coverage insurance and burglary and theft insurance.

(b) Manager shall also cause to be purchased professional liability insurance on behalf of Facility in form and such amounts as required by Applicable Laws.

(c) All insurance coverage shall be placed with such companies, in such amounts, and with such beneficial interest appearing therein as shall be acceptable to Facility. Manager shall supervise the prompt investigation and filing of full timely written reports to the insurance companies as to all accidents and claims for damages relating to the ownership, operation and maintenance of Facility's properties and business and shall supervise the preparation of any and all reports required by any insurance company in connection therewith. All such reports shall be timely filed with the insurance company as required under the terms of insurance policy involved. Manager is authorized to settle any and all claims against insurance companies arising out of any policies, including

the execution of proofs of loss, the adjustment of losses, signing of receipts, and the collections of money.

(d) The costs related to the maintenance of all insurance coverage set forth in this Section 3.B.11, including, but not limited to premiums and deductibles, shall be borne by Facility.

(12) Legal Actions. Manager shall assist and advise Facility regarding any and all legal actions or proceedings. If necessary, Manager shall engage and manage outside counsel on behalf of Facility. The costs of all such legal actions or proceedings shall be borne by Facility.

(13) Contract Negotiation. In addition to assisting in the negotiation of managed care contracts for Facility, Manager shall, at the request of Facility, negotiate on behalf of and in the name of Facility such agreements as Manager deems necessary or advisable for the furnishing of goods and services necessary for the operation of Facility, including, without limitation, professional services agreements maintenance agreements, and real and personal property lease agreements (collectively, "Facility Agreements"). Compensation to third parties for Services provided under Facility Agreements shall be borne by Facility.

(14) Collections and Disbursements; Operating Accounts. Manager shall be responsible for the billing and collection for services provided by Facility. All monies collected shall be deposited in such commercial bank or banks as Manager from time to time designates, in demand, deposit or savings accounts opened for and on behalf of Facility (such accounts hereinafter referred to as the "Operating Accounts"), and from the revenues so collected and deposited on behalf of Facility, Manager will supervise the regular and punctual payment of all Operating Expenses (as defined herein). All interest accruing on the Operating Accounts shall serve to increase such accounts. In the event of any shortfall in the amounts available from such revenues and Operating Accounts to pay the Operating Expenses, it shall be the obligation of Facility to pay such amounts from the Reserve Account (as defined herein) or otherwise. Nothing in this Agreement shall require Manager to advance Operating Expenses or any other funds on behalf of Facility. "Operating Expenses" shall mean all expenses and costs incurred incident to the day to day conduct of Facility and all other amounts otherwise due and payable to any person or entity in connection with the operation and management of Facility or the discharge of any of Manager's duties under the terms of this Agreement.

(15) Taxes. All taxes and assessments properly levied with respect to the Facility shall be paid by Manager in the name and for the account of Facility from the Operating Accounts.

C. Events Excusing Performance. Manager shall not be liable to Facility for failure to perform any of the Services required herein in the event of strikes, lock-outs, calamities, acts of God, unavailability of supplies or other events over which Manager has no control for so long as such events continue, and for a reasonable period of time thereafter.

4. Cooperation of Facility. Facility shall provide Manager with all information necessary for Manager's performance of the Services hereunder.

5. Revenues and Reserve Account

All revenues generated by or with respect to Facility shall accrue solely to Facility and shall be its property. Manager shall establish a separate account (hereinafter the "Reserve Account") which shall be separate from the Operating Accounts and shall be a demand, deposit or savings account at such financial institution or institutions as Manager from time to time designates and into which Manager shall deposit such amounts from the revenues of Facility as it deems appropriate. All interest accruing on the Reserve Account shall serve to increase the Reserve Account. Funds may be disbursed out of the Reserve Account from time to time under the direction of Manager as may be required for purposes of operating Facility, including, without limitation, meeting Facility's working capital, capital improvement or contingency needs.

6. Financial Arrangements

A. Management Fee. Facility and Manager agree that the compensation set forth in this Section 6 is being paid to Manager in consideration of the Services rendered and substantial commitment made by Manager hereunder and that the Management Fee (as defined in subsection B, below) is fair, reasonable and consistent with fair market value.

B. Annual Management Fee.

(1) For each year of the Term of this Agreement, Facility shall pay to Manager, as compensation for services rendered hereunder, a monthly fee based upon a pro rata portion of the Manager's aggregate operating costs ("Management Fee").

(2) Facility agrees that if the United States or the Commonwealth of Pennsylvania or any of their subdivisions having jurisdiction shall levy, assess, or charge any tax, assessment or imposition in the nature of a sales, use or service tax, charge or assessment upon the management fee, then the Facility shall pay (or reimburse Manager for) such tax, assessment or imposition.

C. Reimbursement. In addition to the Management Fee described above, and in recognition of the fact that certain costs and expenses paid or incurred by Manager will be paid or incurred in the best interests of and on behalf of Facility, Facility hereby agrees to reimburse Manager for all of the costs and expenses paid or incurred by Manager on behalf of Facility. Without limiting the generality of the foregoing, Facility agrees to reimburse Manager for any travel, meals or lodging costs reasonably incurred by Manager in connection with the provision of the Services under this Agreement.

D. Payments. Facility shall establish a depository account (the "Account") in Facility's name at a bank or lending institution of Facility's choice. Such Account shall be the sole and exclusive property of Facility. Facility shall issue a revocable instruction to the

financial institution to sweep the amounts deposited into the Account on a daily basis to pay the Management Fee into an account established at such financial institution by Manager, which shall be the sole and exclusive property of Manager ("Concentration Account"). Facility hereby agrees that all such amounts deposited into the Account shall be transferred pursuant to such instruction to the Concentration Account in connection with Facility obligations pursuant to this Agreement. Manager acknowledges that Facility's instructions given to the applicable financial institution pursuant to this Section 6.D. shall be revocable at the sole and exclusive direction of Facility. Manager shall make disbursements of any and all moneys deposited in the Concentration Account strictly in accordance with the terms of this Agreement.

7. Records

A. During the Term of this Agreement, and for two (2) years thereafter, Facility or its designees shall have reasonable access during normal business hours to the financial records of Manager, including, but not limited to, records of collections, expenses and disbursements as kept by Manager in performing the Services under this Agreement, and Facility may copy any or all such records at its own expense.

B. During the Term of this Agreement, and for seven (7) years thereafter, Manager and its designees shall have reasonable access during normal business hours, including the right to make and retain copies at its own expense, to the records (including medical records) maintained by Facility to defend any claim regarding services rendered pursuant to this Agreement.

8. Indemnification

Facility shall indemnify Manager, Manager's Key Personnel and all agents, employees and representatives of Manager against any and all claims, damages, costs, fees and expenses (including settlements, judgments, court costs and attorneys' fees, regardless of the outcome of such claim or action) (collectively, "Damages") resulting from (i) the Services provided to Facility under this Agreement, except if such Damages are caused by the willful misconduct or gross negligence of Manager; (ii) the operation of Facility, including, but not limited to, services provided by Facility to patients; and (iii) Facility's obligations under Facility Agreements.

9. Termination of this Agreement

A. Termination by Facility and Manager. This Agreement may be terminated at any time upon the mutual written consent of Facility and Manager.

B. Termination by Facility. Facility may terminate this Agreement as follows:

(1) In the event of the filing of a petition in voluntary bankruptcy or an assignment for the benefit of creditors by Manager, or upon other action taken or suffered, voluntarily or involuntarily, under any Federal or state law for the benefit of debtors by Manager, except for the filing of a petition in involuntary bankruptcy against Manager which is dismissed

within thirty (30) days thereafter, Facility may give notice of the immediate termination of this Agreement.

(2) In the event Manager shall materially default in the performance of any Services set forth in this Agreement and such default shall continue for a period of sixty (60) days after written notice thereof has been given to Manager by Facility, Facility may give notice of the immediate termination of this Agreement.

(3) At any time, without cause, upon ninety (90) days' written notice to Manager.

C. Termination by Manager. Manager may terminate this Agreement as follows:

(1) In the event of the filing of a petition in voluntary bankruptcy or an assignment for the benefit of creditors by Facility, or upon other action taken or suffered, voluntarily or involuntarily, under any Federal or state law for the benefit of debtors by Facility, except for the filing of a petition in involuntary bankruptcy against Facility which is dismissed within thirty (30) days thereafter, Manager may give notice of the immediate termination of this Agreement.

(2) In the event that Facility shall materially default in the performance of any duty or obligation imposed upon it by this Agreement, and such default shall continue for a period of sixty (60) days after written notice thereof has been given to Facility by Manager, or Facility shall fail to remit the payments due as provided in Section 6 hereof and such failure to remit shall continue for a period of thirty (30) days after written notice thereof, Manager may give notice of the immediate termination of this Agreement.

(3) In the event Facility takes any action to voluntarily dissolve or wind-up its affairs or liquidate a substantial portion of its assets or in the event a proceeding shall have been instituted in a court having jurisdiction seeking the appointment of a receiver, liquidator, assignee, custodian, trustee, sequestrator (or similar official) of Facility or for any substantial part of its assets, or for the winding up or liquidation of its affairs, and such proceeding shall remain undismissed or unstayed and in effect for a period of thirty (30) consecutive days or such court shall enter a decree or order granting the relief sought in such proceeding, Manager may give notice of the immediate termination of this Agreement.

(4) At any time, without cause, upon ninety (90) days' written notice to Facility.

10. General Provisions

A. Assignment. Except with respect to an assignment by Manager to any subsidiary or affiliate of Manager, neither Manager nor Facility shall have the right to assign their respective rights and obligations hereunder without the written consent of the other parties hereto.

B. Notices. All notices required or permitted by this Agreement shall be in writing and shall be deemed given if sent postage prepaid, certified mail, return receipt requested to the address set forth below:

To Manager: UHS of Delaware, Inc.
c/o Universal Health Services, Inc.
367 South Gulph Road
P.O. Box 61558
King of Prussia, PA 19406-0958
Attention: General Counsel

To Facility: Compass Intervention Center
7900 Lowrance Road
Memphis, TN 38125
Attention: CEO/CFO

Copies to: UHS of Delaware, Inc.
367 South Gulph Road
P.O. Box 61558
King of Prussia, PA 19406-0958
Attention: General Counsel

or such other address as either party shall notify the other in accordance with the provisions of this Section.

C. Binding on Successors. This Agreement shall be binding upon the parties hereto, and their successors and assigns.

D. Waiver of Provisions. Any waiver of any terms and conditions hereof must be in writing, and signed by the parties hereto. The waiver of any of the terms and conditions of this Agreement shall not be construed as a waiver of any other terms and conditions hereof.

E. Governing Law. The validity, interpretation and performance of this Agreement shall be governed by and construed in accordance with the laws of the Commonwealth of Pennsylvania, notwithstanding any conflicts of law provisions to the contrary.

F. Severability. The provisions of this Agreement shall be deemed severable and if any portion shall be held invalid, illegal or unenforceable for any reason, the remainder of this Agreement shall be effective and binding upon the parties.

G. Additional Documents. Each of the parties hereto agrees to execute any document or documents that may be reasonably requested from time to time by the other party to implement or complete such party's obligations pursuant to this Agreement.

H. Confidentiality. No party shall disseminate or release to any third party any information regarding any provision of this Agreement, or any financial information regarding

any other party (past, present or future) that was obtained in the course of the negotiations of this Agreement or in the course of the performance of this Agreement, without the written approval of the party to which the information pertains.

I. Remedies Cumulative. No remedy set forth in this Agreement or otherwise conferred upon or reserved to any party shall be considered exclusive of any other remedy available to any party, but the same shall be distinct, separate and cumulative and may be exercised from time to time as often as occasion may arise or as may be deemed expedient.

J. Language Construction. The language of this Agreement shall be construed, in all cases, according to its fair meaning, and not for or against any party hereto. The parties acknowledge that each party and its counsel have reviewed and revised this Agreement and that the normal rule of construction to the effect that any ambiguities are to be resolved against the drafting party shall not be employed in the interpretation of this Agreement.

K. No Obligation to Third Parties. None of the obligations and duties of Manager or Facility under this Agreement shall in any way or in any manner be deemed to create any obligation of Manager or Facility to, or any rights in, any person or entity not a party to this Agreement.

L. Amendments. This Agreement may be amended, but only in writing, signed by the parties hereto.

M. Entire Agreement. This Agreement, including all Exhibits thereto, contains the entire agreement of the parties related to the subject matter hereof. This Agreement supersedes and replaces in its entirety any existing management services agreement between Manager and Facility.

N. Counterparts and Facsimiles. This Agreement may be executed in two (2) or more counterparts, each of which shall be deemed an original, but all of which shall constitute one in the same agreement. Furthermore, this Agreement may be executed by the facsimile or scanned signature of any party hereto, it being agreed that the facsimile or scanned signature of any party hereto shall be deemed an original for all purposes.

O. Electronic Signature. Signature below for Manager's Senior Vice President may be done via electronic signature. Pursuant to the *Electronic Signatures in Global and National Commerce Act (E-SIGN)*, S. 761 (106th Congress, 2000) a federal law, effective October 1, 2000, this document is deemed to have the same legal integrity as documents bearing an ink or "wet" signature. All parties to this Agreement acknowledge and represent that the affixed electronic signature carries the same legal weight and authority as the written signature, and Manager represents that the electronic signature has been executed by the individual named below.

Attachment A.5. Name of Management/ Operating Entity

Manager represents that the electronic signature has been executed by the individual named below.

IN WITNESS WHEREOF, the parties have executed this Agreement and caused the same to be duly delivered on their behalf as of the day and year first above written.

MANAGER: **FACILITY:** Compass Intervention Center

UHS OF DELAWARE, INC.

Steve Filton. Senior Vice President

By: Jeremy Pitzer

Attachment A.5. Name of Management/ Operating Entity

EXHIBIT A

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is entered into by and between Compass Intervention Center ("Business Associate") and UHS of Delaware, Inc., a Delaware Corporation ("Covered Entity") as of the commencement date ("Effective Date") of the Management Agreement ("Master Agreement").

RECITALS

The purpose of this Agreement is to enable the parties to comply with the applicable requirements of HIPAA, the HIPAA Regulations and the HITECH Act (defined below) that involve Protected Health Information ("PHI") (including but not limited to Electronic Protected Health Information ("ePHI")) that is accessed, maintained, transmitted, used or disclosed by Business Associate (and/or any agent or Subcontractor of Business Associate that creates, receives, maintains or transmit PHI on behalf of Business Associate or Covered Entity) in connection with services performed on behalf of Covered Entity pursuant to any oral or written agreement(s) for the provision of services to Covered Entity that has been or may be entered into ("Services Agreement").

NOW THEREFORE, the parties agree as follows.

DEFINITIONS

Terms used, but not defined below, shall have the meaning as set forth in HIPAA, the HIPAA Regulations, HITECH provisions of the American Recovery and Reinvestment Act of 2009 ("Stimulus Act"), Title XIII and related regulations.

"Administrative Safeguards" means safeguards consisting of administrative actions, policies and procedures designed to protect the privacy of PHI from intentional or unintentional use or disclosure in violation of HIPAA and other legal requirements, and to manage the selection, development, implementation, and maintenance of security measures to protect Electronic PHI, as well as managing the conduct of the workforce relating to the protection of that information.

"Availability" means the property that data or information is accessible and useable upon demand by an authorized person, as set forth at 45 C.F.R. § 164.304.

"Breach" means the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such information. For the purposes of reporting to the Covered Entity under this Agreement, Business Associate shall presume that any unauthorized acquisition, access, use or disclosure of PHI is a "Breach." A Breach excludes:

(i) Any unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of the Covered Entity or Business Associate, if such acquisition, access or use was made in good faith and within the scope of authority and such information is not further acquired, accessed, used or disclosed in a manner not permitted under HIPAA, the HIPAA Regulations, or HITECH;

(ii) Any inadvertent disclosure by a person who is authorized to access PHI at a facility operated by Covered Entity or Business Associate to another person authorized to access PHI at the same facility, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under HIPAA, the HIPAA Regulations, or HITECH; or

(iii) A disclosure of PHI where Covered Entity or Business Associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

"Breach Notification Regulations" means the rules set forth primarily at set forth primarily at 45 C.F.R. Part 164, Subpart D.

"Business Associate" means the entity so designated in the preamble to this Agreement.

"Confidentiality" means the property that data or information is not made available or disclosed to unauthorized persons or processes, as set forth at 45 C.F.R. § 164.304.

"Covered Entities" or **"Covered Entity"** means the entity or entities as designated in the preamble to this Agreement.

"Days" means a calendar day unless a provision specifies "business days."

"Discovery" or **"Discovery of a Breach"** means that Business Associate, or an employee, officer or agent of Business Associate, has acquired actual knowledge of a Breach or by the exercise of reasonable diligence should have acquired knowledge of a Breach.

"Electronic Protected Health Information," "Electronic PHI." or **"ePHI"** means PHI in electronic form. All references to "Protected Health Information" or "PHI" in this Agreement include ePHI.

"Encrypted" or "Encryption" means the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key, as set forth at 45 C.F.R. § 164.304.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996 Pub. L. No. 104-191.

"HIPAA Regulations" means the Privacy Regulations, the Security Regulations, the Breach Notification Regulations and such other applicable regulations set forth in 45 C.F.R. Parts 160 and 164.

"HITECH" or **"HITECH Act"** means the Health Information Technology for Economic and Clinical Health Act privacy and security provisions of the Stimulus Act and implementing regulations.

"Identifiers" means the identifiers listed in the HIPAA Privacy Rule at 45 C.F.R. Section 164.514(b)(2), which include, among other identifiers: name, address, zip code, all elements of dates other than the year that directly relating to an individual (such as birthdate, admission date, discharge date, date of death), telephone numbers, email address, fax numbers, social security numbers, medical record numbers, vehicle identifiers, license numbers, and all other identifiers of an individual, or of the individual's relatives, employers, or household members described in Section 164.514(b)(2).

"Individual" means the person who is the subject of PHI and shall include a person who qualifies as a personal representative under 45 C.F.R. Section 164.502(g).

"Integrity" means the property that data or information have not been altered or destroyed in an unauthorized manner, and that data from one system is consistently and accurately transferred to other systems, as set forth at 45 C.F.R. § 164.304.

"Physical Safeguards" means safeguards consisting of physical measures, policies, and procedures to protect electronic information systems and related buildings and equipment, from natural and environmental hazards and unauthorized intrusion.

"Protected Health Information" or **"PHI"** means individually identifiable health information created or received by Business Associate from or on behalf of a Covered Entity that relates to the past, present, or future physical or mental health or condition of an Individual, the provision of health care to an Individual, or the past, present, or future payment for the provision of health care to an Individual, as set forth at 45 C.F.R. § 160.103. PHI can be oral, written, electronic, or recorded in any other form. All references to "Protected Health Information" or "PHI" in this Agreement include Electronic Protected Health Information (ePHI).

"Privacy Regulations" means the rules set forth primarily at 45 C.F.R. Part 160 and Part 164, Subparts A and E.

"Required by Law" means a mandate contained in law that compels an entity to make a use or disclosure of PHI and that is enforceable in a court of law, as set forth at 45 C.F.R. § 164.103. Required by Law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

"Secretary" or **"HHS Secretary"** means the Secretary of the Department of Health and Human Services ("HHS").

"Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system, as set forth at 45 C.F.R. § 164.304. The term "Security Incident" is very broad and includes attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations.

"Security Measures" relates to the means (process and technology) by which a Covered Entity and/or Business Associate protect the privacy and security of information, as set forth at 45 C.F.R. § 164.304. Security Measures keep information secured, and decrease the means of tampering, destruction, or inappropriate access. Security encompasses all of the administrative, physical, and technical safeguards in an information system.

"Security Regulations" means the rules set forth primarily at 45 C.F.R. Part 160 and Part 164, Subparts A and C.

"Subcontractor" means a person or entity to whom the Business Associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of the Business Associate, whether by written agreement or otherwise.

"Technical Safeguards" means safeguards consisting of technology and the policy and procedures for the use of the technology that protect ePHI and control access.

"Unsecured PHI" means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the HHS Secretary in the guidance issued under section 13402(h)(2) of HITECH on the HHS Web site.

1. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

1.1 Business Associate agrees not to use or disclose PHI ("PHI") except as permitted or required by this Agreement or as Required by Law. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement.

1.2 Business Associate and its agents or Subcontractors, if any, shall only request, use and disclose the minimum amount of PHI necessary to accomplish the purpose of the request, use or disclosure in accordance with HIPAA, the HIPAA Regulations and HITECH.

1.3 Business Associate agrees to use appropriate safeguards and comply with the applicable requirements of the HIPAA Regulations, including 45 CFR Subpart C with respect to ePHI and Subpart E of 45 CFR with respect to PHI. This shall include, without limitation, using appropriate Security Measures and developing, implementing, maintaining and using appropriate and reasonable Administrative, Physical, and Technical Safeguards for the privacy and security of PHI to insure the Integrity, Confidentiality and Availability of, and to prevent non-permitted uses and disclosures of PHI that it creates, receives, maintains, or transmits on behalf of Covered Entity. Business Associate further acknowledges and agrees that pursuant to HITECH it will implement and document its Security Measures and will comply with 45 C.F.R. sections 164.306 (Security Standards), 164.308 (Administrative Safeguards), 164.310 (Physical Safeguards), 164.312 (Technical Safeguards), 164.314 (Organizational Safeguards), and 164.316 (Policy and Procedures and documentation requirements), and all other applicable requirements of HIPAA, the HIPAA Regulations, HITECH and other applicable privacy and security laws. Business Associate agrees to adopt the technology and methodology standards provided in guidance issued by the HHS Secretary pursuant to HITECH.

1.4 Business Associate agrees to take prompt action to correct any deficiencies and to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of an access, use, disclosure, modification or destruction of PHI by Business Associate, its agents or Subcontractors, if any, in violation of the requirements of this Agreement.

1.5 Business Associate agrees to promptly notify Covered Entity within forty-eight (48) hours of any access, use, disclosure, modification or destruction of PHI not provided for by this Agreement or that is in violation of the requirements of this Agreement, and to provide Covered Entity or its designee such information as may be

reasonably requested by Covered Entity to investigate the violation. Business Associate shall report to Covered Entity any Security Incident of which it becomes aware. If Business Associate has been requested orally or in writing by law enforcement officials that notification of affected Individuals of a Breach may impede a criminal investigation, Business Associate shall so inform Covered Entity.

1.6 Business Associate further agrees to provide a report in writing to Covered Entity within ten (10) days of, and to cooperate with Covered Entity in investigating and resolving, any of the following as they relate to PHI under this Agreement:

(i) Any unauthorized access, use, disclosure, modification or destruction of PHI of which Business Associate becomes aware;

(ii) Any Security Incident of which Business Associate becomes aware;

(iii) The receipt of a request from an Individual (or their authorized personal representative) for access to, amendment to, an accounting of disclosures of, a copy or electronic copy of, or a restriction on the use or disclosure of PHI; or

(iv) Any Breach or potential Breach of Unsecured PHI of which Business Associate becomes aware. In such event, Business Associate will document its investigation and provide such additional information as may reasonably be requested to enable Covered Entity to determine the extent to which the PHI has been compromised. Notice to affected Individuals will be made by or at the direction of Covered Entity at Business Associate's expense.

The written report from Business Associate required by this Section shall set forth the following:

(i) A brief description of what happened, including the date of any unauthorized access, use, disclosure, modification or destruction, and, if known, the date of Discovery, the number of individuals affected, the time period involved, and the nature and extent of any harm resulting from the violation;

(ii) A description of the type(s) of PHI and Identifiers involved (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, and other types of information were involved);

(iii) Information regarding whether and to what extent the PHI was Unsecured PHI, Encrypted, or was rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the HHS Secretary in the guidance issued under section 13402(h)(2) of HITECH on the HHS Web site;

(iv) A description of the manner in which the PHI could be identified or, if known, how and whether the PHI could be re-identified;

(v) To the extent possible, the name of each Individual whose PHI has been, or is reasonably believed to have been accessed, used, disclosed, modified or destroyed;

(vi) To the extent possible, the name of the unauthorized person and entity who used the PHI or to whom the disclosure was made;

(vii) To the extent possible, whether the unauthorized person or entity is another covered entity, business associate, employee of Business Associate, Subcontractor or entity affiliated with Business Associate;

(viii) Whether any opportunity existed for an unauthorized person to acquire, view, transfer or otherwise compromise the PHI;

(ix) Whether the PHI was actually acquired, viewed, transferred or otherwise compromised by an unauthorized person;

(x) Any steps Individuals should take to protect themselves from potential harm resulting from the unauthorized access, use, disclosure, modification or destruction of PHI; and

(xi) A description of what the Business Associate is doing to investigate, mitigate harm to Individuals, and protect against any further unauthorized access, use, disclosure, modification or destruction of PHI.

1.7 Business Associate agrees that any Subcontractor that creates, receives, maintains, or transmits PHI on behalf of the Business Associate or Covered Entity will enter into in an enforceable written HIPAA-compliant business associate agreement requiring that the Subcontractor:

(a) agrees to comply with the HIPAA Privacy Regulations, HIPAA Security Regulations, HITECH law, and other applicable laws and regulations related to privacy and security of PHI, including ePHI;

(b) agrees to the same restrictions, reporting and contracting obligations, and conditions that apply in this Agreement to Business Associate with respect to PHI including, by way of example and without limitation, that the Subcontractor develop, implement, maintain and use appropriate and reasonable Security Measures and Administrative, Physical, and Technical Safeguards for the privacy and security of PHI to insure the Integrity, Confidentiality and Availability of, and prevent non-permitted access, use, disclosure, modification or destruction of PHI, including ePHI; that the Subcontractor enter into business associate agreements with its subcontractors that create, receive, maintain or transmit PHI on behalf of Subcontractor, Business Associate or Covered Entity; and that the Subcontractor adopt a HIPAA compliance program and policies and procedures.

If Business Associate becomes aware of a pattern of activity or practice of a Subcontractor that constitutes a material breach of their written business associate agreement, Business Associate shall take reasonable steps to cure the breach or end the violation, as applicable, and if such steps are unsuccessful, terminate the contract.

1.8 Business Associate agrees to provide access to and copies of PHI maintained in a Designated Record Set to Covered Entity or, when requested in writing by Covered Entity, to an Individual in order for Covered entity to meet the requirements of 45 C.F.R. §164.524. Business Associate shall provide access to and copies of PHI in a reasonable time, not to exceed fifteen (15) days (unless the parties reasonably agree otherwise in writing) and in a reasonable manner. If requested by Covered Entity or an Individual, Business Associate shall provide access to ePHI to Covered Entity or, when requested in writing by Covered Entity, to an Individual in the electronic form and format requested by Covered Entity or by the Individual, as applicable, if it is readily producible and, if not, in a readable electronic form and format as agreed by the Covered Entity or Individual, as applicable.

1.9 Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by

Business Associate, on behalf of Covered Entity available to the Secretary, in the time and manner designated by the Secretary, for purposes of the Secretary determining compliance with the HIPAA Regulations. Upon receipt of a request from the Secretary, Business Associate shall notify Covered Entity in writing unless such notification would be contrary to law.

1.10 Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that Covered Entity determines is required to enable Covered Entity to comply with 45 C.F.R. §164.526. Except for good cause shown in writing to Covered Entity, Business Associate shall act upon Covered Entity's request for an amendment within thirty (30) days of receipt Covered Entity's request.

1.11 Business Associate agrees to identify, track and document disclosures of PHI and other information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. §164.528. Business Associate agrees to provide the information collected to Covered Entity or to an Individual when requested by Covered Entity, in writing and not later than thirty (30) days after receiving a request under this subsection, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. §164.528. Upon written request, Business Associate shall furnish to Covered Entity a copy of its policies or procedures that it has, and will maintain, that describe how it carries out its obligations under this subsection.

1.12 Business Associate agrees that if it has a legal obligation to disclose any PHI, it will notify Covered Entity as soon as reasonably practicable after it learns of such obligation, sufficiently in advance of the proposed release date such that the rights of Covered Entity and the Individual to whom the PHI relates would not be prejudiced. If Covered Entity or the Individual objects to the release of such PHI, Business Associate will allow Covered Entity and/or the Individual to exercise any legal rights or remedies Covered Entity and/or the Individual might have to object to the release of the PHI, and Business Associate agrees to provide such assistance as Covered Entity or the Individual may reasonably request in connection therewith.

2. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

2.1 General Use and Disclosure Provision. Business Associate agrees to use or disclose PHI only as permitted or required for the purpose of performing its obligations under the Services Agreement, provided such use or disclosure of PHI would not violate the HIPAA Regulations if done by Covered Entity, including the minimum necessary requirements in the HIPAA Regulations and Subpart E of 45 CFR Part 164, or violate the terms of this Agreement.

2.2 Specific Use and Disclosure Provisions:

(i) Except as otherwise limited in this Agreement, Business Associate may use and disclose PHI for the proper management and administration of the Business Associate or to carry out its legal responsibilities, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law, or for the purpose for which it was

disclosed to the person, and the person notified the Business Associate of any instances of which it is aware in which the Confidentiality of the information has been breached.

(ii) Only when specifically authorized by Covered Entity in writing separate from this Agreement or in accordance with a specific provision of the Services Agreement, Business Associate may use PHI: (a) to provide data aggregation services to Covered Entity as permitted by 45 C.F.R. §164.504(e)(2)(i)(B); or (b) to create de-identified health information in accordance with 45 C.F.R. §164.514.

(iii) Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. §164.502(j)(1).

3. OBLIGATIONS OF COVERED ENTITY

3.1 Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices, prepared for compliance with 45 C.F.R. §164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

3.2 Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

3.3 Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. §164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

3.4 Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Regulations if done by Covered Entity.

4. TERM AND TERMINATION

4.1 Term. The term of this Agreement shall be effective as of the Effective Date, and shall terminate after the exercise of any of the termination provisions set forth below and when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity and no copies of PHI are retained, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

4.2 Termination by Covered Entity. Covered Entity may immediately terminate this Agreement and any Services Agreement if Covered Entity makes the determination that Business Associate has breached a material term of this Agreement. Alternatively, Covered Entity may provide Business Associate with thirty (30) days written notice of the existence of an alleged material breach and afford Business Associate an opportunity to cure upon mutually agreeable terms. Nonetheless, in the event that mutually agreeable terms cannot be achieved within thirty (30) days, Business Associate must cure said breach to the satisfaction of the Covered Entity. Failure to cure in the manner set forth in this Section is grounds for the immediate termination of this

Agreement and any Services Agreement. Nothing contained herein shall be deemed to require Covered Entity to terminate this Agreement if termination is not feasible.

4.3 Termination by Business Associate. If Business Associate makes the determination that a condition material to the performance of this Agreement has changed under any Services Agreement or this Agreement, or that Covered Entity has breached a material term of this Agreement, Business Associate may provide (30) days notice of its intention to terminate this Agreement and the Services Agreement. Business Associate agrees, however, to cooperate with Covered Entity find a mutually satisfactory resolution to the matter prior to terminating and further agrees that, notwithstanding this provision, it shall not terminate this Agreement so long as any Services Agreement is in effect.

4.4 Automatic Termination. This Agreement will automatically terminate without any further action of the parties upon the termination or expiration of the last Service Agreement in effect between the parties.

4.5 Effect of Termination. Upon any termination pursuant to this Section or otherwise, Business Associate shall return or destroy all PHI pursuant to 45 C.F.R. §164.504(e)(2)(ii)(J) if it is feasible to do so, and shall not retain any copies of the PHI. If return or destruction is not feasible, Business Associate will notify Covered Entity in writing, including: (i) a statement that Business Associate has determined that it is infeasible to return or destroy the PHI, and (ii) the specific reason(s) for such determination, which reason(s) must be agreed to by Covered Entity. Business Associate further agrees to extend any and all protections, limitations and restrictions contained in this Agreement to Business Associate's use and/or disclosure of any PHI retained after the termination of this Agreement, and to limit any further uses and/or disclosures to the purposes that make the return or destruction of the PHI infeasible. Business Associate further agrees to recover any PHI in the possession of its Subcontractors or agents and to return or destroy the PHI as set forth in this Section; if infeasible, Business Associate must provide a written explanation to Covered Entity and require the Subcontractors and agents to agree to extend any and all protections, limitations and restrictions contained in this Agreement to the Subcontractors' and/or agents' use and/or disclosure of any PHI retained after the termination of this Agreement, and to limit any further uses and/or disclosures to the purposes that make the return or destruction of the PHI infeasible.

5. INDEMNIFICATION

Business Associate shall indemnify, defend and hold harmless Covered Entity and its parent corporation, subsidiaries and related entities, their directors, officers, agents, servants, and employees (collectively "the Indemnitees") from and against all claims, causes of action, liabilities, judgments, fines, assessments, penalties, damages, awards or other expenses of any kind or nature whatsoever, including, without limitation, attorney's fees, expert witness fees, and costs of investigation, litigation or dispute resolution, incurred by the Indemnitees and relating to or arising out of any breach or alleged breach of the terms of this Agreement by Business Associate or any agent or Subcontractor of Business Associate.

Attachment A.5. Name of Management/ Operating Entity

6. NOTICE

All notices, requests, demands and other communications required or permitted to be given or made under this Agreement shall be in writing, shall be effective upon receipt of attempted delivery, and shall be sent by (a) personal delivery; (b) certified or registered United States mail, return receipt requested; (c) overnight delivery service with proof of delivery; or (d) facsimile with return facsimile acknowledging receipt. Except as otherwise herein provided notices shall be sent to the addresses as listed on the Master Agreement. Neither party shall refuse delivery of any notice hereunder.

7. MISCELLANEOUS

7.1 Regulatory References. A reference in this Agreement to a section in the Code of Federal Regulations ("C.F.R.") means the section as in effect as of the effective date of this Agreement, or as thereafter amended.

7.2 Independent Contractor. The parties to this Agreement are independent contractors in carrying out the duties and obligations of this Agreement. This Agreement is not intended, and shall not be construed, to create any relationship between the parties that would allow one party to exercise direction or control over the manner or method by which the other party performs services, duties or obligations under this Agreement.

7.3 Amendment. The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity and Business Associate to comply with legal requirements including, without limitation, the requirements of HIPAA, the HIPAA Regulations and the HITECH Act. Except as provided specifically herein, this Agreement may not be modified or amended except by an instrument in writing declared to be an amendment hereto and executed by both parties.

7.4 Survival. The respective rights and obligations of each party under Sections 1.4, 1.5, 1.6, 1.9, 4, and 5 of this Agreement shall survive the termination of this Agreement.

7.5 Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity and Business Associate to comply with HIPAA, the applicable HIPAA Regulations, the HITECH Act and related statutory provisions and regulations.

7.6 No Third Parties. This Agreement shall inure to the benefit of, and be binding upon, the parties and their respective successors and assigns. There are no third parties to this Agreement and nothing herein is intended for the benefit of a third person.

7.7 Coordination of Documents. In the event of a conflict between a provision of this Agreement and a provision of a Services Agreement, the provision of this Agreement shall control.

7.8 Choice of Law. This Agreement shall be governed and construed by applicable federal law and by the laws of the state where Covered Entity is physically located without regard to laws relating to choice of law or conflicts of law.

7.9 Entire Agreement. This Agreement constitutes the entire agreement between the parties on this subject matter and supersedes all other proposals, understandings or agreements, whether written or oral, regarding the subject matter hereof, including any prior Business Associate Agreement.

7.10 Disputes. If any controversy, dispute, or claim arises between the parties with respect to this agreement, the parties shall make good faith efforts to resolve such matters informally.

7.11 Disclaimer. Covered Entity makes no warranty or representation that compliance by Business Associate with this Agreement or the statutes and regulations cited herein will be adequate or satisfactory for Business Associate's own purposes. Business associate is solely responsible for adequately safeguarding PHI in accordance with applicable law.

8. FURTHER ASSURANCES

The parties agree that from time to time they will amend the Agreement to account for changes in the applicable law or regulations including, without limitation, those arising out of the HITECH Act or other applicable acts and regulations subsequently promulgated and that, on and after the effective date of this Agreement, such then applicable provisions shall be incorporated by reference into the Agreement as written until such time as the parties may amend the Agreement to otherwise specifically provide for the subject matter of such provisions but in no case for a period longer than one year from the effective date of any such statutory or regulatory provision, during which time the parties shall negotiate further assurances in good faith.

Tom Leatherwood, Shelby County Register of Deeds: Instr # EU3333

Attachment A.6. Legal Interest in Site of the Institution

WARRANTY DEED

EU 3333

THIS INSTRUMENT PREPARED BY:	SEND TAX BILLS TO:	MAP PARCEL NO.
CHARLES B. WELCH, JR., ESQ. 5384 POPLAR AVE., SUITE 400 MEMPHIS, TENNESSEE 38119 (901) 768-6000	(NAME) NONCONNAH MANAGEMENT LLC	D02 042 00141
	(STREET ADDRESS) 2129 GORHAM PLACE	
	(CITY) (STATE) (ZIP) GERMANTOWN, TENNESSEE 38139	ST 9411028

THIS INDENTURE, made and entered into this 4th day of November, by and between

JAMES P. HUNTZICKER party of the first part, and

NONCONNAH MANAGEMENT LLC, a Limited Liability Company party of the second part.

WITNESSETH:

That for and in consideration of Ten Dollars ($10.00), cash in hand paid, and other good and valuable considerations, the receipt of all of which is hereby acknowledged, the said party of the first part has bargained and sold and does hereby bargain, sell, convey and confirm unto the said party of the second part the following described real estate, situated and being in County of Shelby, State of Tennessee.

Being a part of the Stephen Stansell property as recorded in Instrument No. JG 5214 in the Shelby County Register's Office and being more particularly described as follows:

Beginning at a point in the north line of Lowrance Road (68.00 feet ROW) said point being located westwardly as measured along said north line a distance of 1,627.42 feet from the tangent intersection of a curve, having a radius of 30.00 feet being located at the northwest corner of Hacks Cross Road (114.00 feet ROW) and said Lowrance Road; thence North 03° 57 minutes 48 seconds West, a distance of 791.46 feet to a point; thence North 86° 02 minutes 12 seconds East, a distance of 662.26 feet to a point; thence South 01° 39 minutes 11 seconds East, a distance of 83.32 feet to a point in a curve on the westerly line of a proposed Roadway (68.00 feet ROW); thence southwardly along said westerly line and along a curve to the left having a radius of 534.00 feet; a chord bearing of South 12° 11 minutes 31 seconds West, a chord length of 297.16 feet, and an arc length of 301.13 feet to a point of tangency; thence South 03° 57 minutes 48 seconds East, along said westerly line a distance of 432.67 feet to a point of curvature; thence southwesterwardly and along a curve to the right, having a radius of 30.00 feet a chord bearing of South 42° 08 minutes 23 seconds West, a chord length of 43.24 feet and an arc length of 48.28 feet to a point of reverse curvature in the north line of said Lowrance Road; thence westwardly along said north line and along curve to the left; having a radius of 6,006.77 feet, a chord bearing of South 86° 52 minutes 37 seconds West, a chord length of 286.53 feet and an arc length of 286.55 feet to a point of tangency; thence South 85° 30 minutes 37 seconds West along said north line a distance of 332.36 feet to the POINT OF BEGINNING and containing 522,905 square feet of 12.00 acres of land.

Being the same property conveyed to the party of the first part by Quit Claim Deed of record under Instrument No. HJ 0038 in said Register's Office.

TO HAVE AND TO HOLD the aforesaid real estate, together with all the appurtenances and hereditaments thereunto belonging or in any wise appertaining unto the said party of the second part, his heirs, successors and assigns in fee simple forever.

And the said party of the first part does hereby covenant with the said party of the second part that he is lawfully seized in fee of the aforedescribed real estate; that he has a good right to sell and convey the same; that the same is unencumbered, but subject to 1995 Shelby County property taxes not yet due and payable; subdivision restrictions, building lines and easements of record in Plat Book 118, Page 48, Plat Book 124, Page 41, Plat Book 123, Page 78 and Plat Book 120, Page 11, all in the Register's Office of Shelby County, Tennessee, and that the title and quiet possession thereto he will warrant and forever defend against the lawful claims of all persons.

The word "party" as used herein shall mean "parties" if more than one person or entity be referred to, and pronouns shall be construed according to their proper gender and number according to the context hereof.

94 NOV 16 PM 3:41

EU3333

WITNESS the signature of the said party of the first part the day and year first above written.

JAMES P. HUNTZICKER

STATE OF TENNESSEE, COUNTY OF SHELBY

Before me, a Notary Public in and for said State and County, duly commissioned and qualified, personally appeared JAMES P. HUNTZICKER to me known to be the person described in and who executed the foregoing instrument, and acknowledged that he executed the same for the purposes therein contained.

WITNESS my hand and Notarial Seal at office this 4TH day of November, 1994.

My Commission Expires: My Commission Expires May 18, 1997

Notary Public

I, or we, hereby swear or affirm that to the best of affiant's knowledge, information, and belief, the actual consideration for this transfer or value of the property transferred, whichever is greater is, $575.00 which amount is equal to or greater than the amount which the property transferred would command at a fair and voluntary sale.

Affiant

Subscribed and sworn to before me this 4th day of November, 1994.

Notary Public

REGISTER'S OFFICE
No. EU 3333
Rec'd
Vol 5750
STATE Tax 2175
Rec Fee 7.00
Mtg Tax 9.00
PROPERTY ADDRESS: 12 acres Lowrance Road
Total 2136.50
STATE OF TENNESSEE
GUY B. BATES
Notary Public
My Commission Expires May 18, 1997

Attachment A.6. Legal Interest in Site of the Institution

Tom Leatherwood
Shelby County Register

As evidenced by the instrument number shown below, this document has been recorded as a permanent record in the archives of the Office of the Shelby County Register.

160 N. Main St., Suite 519 – Memphis, Tennessee 38103 – (901) 545-4366
http://register.shelby.tn.us

Tom Leatherwood, Shelby County Register of Deeds: Instr. # 03156970

Attachment A.6. Legal Interest in Site of the Institution

4

SPECIAL WARRANTY DEED

PREPARED BY:	SEND TAX BILLS TO: KEYSTONE MEMPHIS, LLC	MAP PARCEL NO.
O. Douglas Shipman, Esq. 6750 Poplar Avenue, Suite 208 Memphis, TN 38138 (901) 767-7006	(NAME) 7900 LOWRANCE ROAD	PART OF DO2 42 00262
	(STREET ADDRESS) MEMPHIS, TN	
	(CITY) (STATE) (ZIP)	ST

THIS INDENTURE, made and entered into this 31ST day of JULY, 2003, by and between **COMPASS INTERVENTION CENTER LLC, a Tennessee Limited Liability Company, successor-in-interest to NONCONNAH TREATMENT CENTER, LLC, a Tennessee Limited Liability Company**, party of the first part and

KEYSTONE MEMPHIS, LLC, a Tennessee Limited Liability Company, party of the second part,

WITNESSETH:

That for and in consideration of Ten Dollars ($10.00), cash in hand paid, and other good and valuable considerations, the receipt of all of which is hereby acknowledged, the said party of the first part has bargained and sold and does hereby bargain, sell, convey and confirm unto the said party of the second part the following described real estate, situated and being in Memphis, County of Shelby, State of Tennessee,

"SEE ATTACHED EXHIBIT A FOR LEGAL DESCRIPTION"
"SEE ATTACHED EXHIBIT B FOR PREMITTED EXCEPTONS"

Being a part of the same property conveyed to the Party of the first part by Warranty Deed of record at Instrument No. FB 1309 in said Register's Office.

TO HAVE AND TO HOLD the aforesaid real estate, together with all the appurtenances and hereditaments thereunto belonging or in any wise appertaining unto the said party of the second part, its heirs, successors and assigns in fee simple forever.

And the said party of the first part does hereby covenant with the said party of the second part that it is lawfully seized in fee of the aforedescribed real estate; that it has a good right to sell and convey the same; that the same is unencumbered, and that the title and quiet possession thereto it will warrant and forever defend against the lawful claims of all persons claiming by, through, or under them, but not further or otherwise.

The word "party" as used herein shall mean "parties" if more than one person or entity be referred to, and pronouns shall be construed according to their proper gender and number according to the context hereof.

WITNESS the signature of the said party of the first part the day and year first above written.

COMPASS INTERVENTIONCENTER LLC
Successor-in-interest to
NONCONNAH TREATMENT CENTER, LLC

BY: _____
RICHARD S. COPELAND, CHIEF OPERATING MANAGER

Attachment A.6. Legal Interest in Site of the Institution

STATE OF TENNESSEE
COUNTY OF SHELBY

This day personally appeared before me, the undersigned authority in and for said State and County, the within named **RICHARD S. COPELAND** known to me to be the CHIEF OPERATING MANAGER of COMPASS INTERVENTION CENTER LLC, successor in interest to NONCONNAH TREATMENT CENTER, LLC, who acknowledged that he signed and delivered the foregoing instrument on the day and year therein mentioned, for the purpose therein set forth, and in the capacity therein stated, for in behalf of COMPASS INTERVENTION CENTER LLC, successor in interest to NONCONNAH TREATMENT CENTER, after being duly authorized so to do.

Given under my hand and seal this 31st day of July, 2003.

Alisha Roberts
Notary Public

My Commission Expires:

ALISHA ROBERTS NOTARY PUBLIC AT LARGE SHELBY COUNTY, TENNESSEE My Commission Expires 10-04-2003

I, or we, hereby swear or affirm that to the best of affiant's knowledge, information, and belief, the actual consideration for this transfer or value of the property transferred, whichever is greater is, $50,000.00 which amount is equal to or greater than the amount which the property transferred would command at a fair and voluntary sale.

Affiant

Subscribed and sworn to before me this 31st day of July, 2003.

Alisha Roberts
Notary Public

My Commission Expires:

ALISHA ROBERTS NOTARY PUBLIC AT LARGE SHELBY COUNTY, TENNESSEE My Commission Expires 10-04-2003

PROPERTY OWNER AND ADDRESS:

KEYSTONE MEMPHIS, LLC
7900 Lowrance Road
Memphis, Tennessee

Attachment A.6. Legal Interest in Site of the Institution

EXHIBIT A

Description of part of Stansell Crossing P.D., Parcel 11, as recorded in Plat Book 128, Page 11, in the Shelby County Register's Office, and being more particularly described as follows:

Beginning at the northeast corner of Stansell Crossing P.D, Parcel 11, Phase 12, as recorded in Plat Book152, Page 18 in the Shelby County Register's Office; thence S85°30'37"W, along the north line of said Phase 12, a distance of 420.47 feet to the northwest corner of said Phase 12, said point also being in the west line of Parcel 11 of said Stansell Crossing P.D.; thence N03°57'48W, along the west line of said Parcel 11, a distance of 50.00 feet to a point; thence N85°30'37"E a distance of 420.01 feet to a point; thence S04°29'23"E a distance of 50.00 feet to the POINT OF BEGINNING and containing 21,011 square feet.

Attachment A.6. Legal Interest in Site of the Institution

EXHIBIT B

TO WARRANTY DEED

PERMITTED EXCEPTIONS

Defects, liens, encumbrances, adverse claims or other matters, if any, created, first appearing in the public records or attaching subsequent to the effective date hereof but prior to the date the proposed Purchaser acquires for value of record the estate or interest or mortgage thereon.

Taxes for the year 2003, a lien, which are not yet due and payable on Parcel D02 042 00262.

If improvements are completed after January 1 of any year, the Law requires supplemental assessment for the year in which the improvements are completed as defined by Statute.

Any Lien, or right to Lien for services, labor or material imposed by law and not shown by the public records.

All matters shown on Plat recorded in Book 118, page 48; Book 124, page 41; Book 125, page 78; Book 128, page 11 and Book 152, page 18; and Book 193, page 55.

Easements to City of Memphis, as set forth in Instrument recorded under Instrument No. FP 2838 FP 2837 and AD 9257.

Attachment A.6. Legal Interest in Site of the Institution

Tom Leatherwood

Shelby County Register

As evidenced by the instrument number shown below, this document has been recorded as a permanent record in the archives of the Office of the Shelby County Register.

07044537

03/15/2007 - 02:29 PM

4 PGS : R - WARRANTY DEED	
MAX 477251-7044537	
VALUE	339470.00
MORTGAGE TAX	0.00
TRANSFER TAX	1165.06
RECORDING FEE	20.00
DP FEE	2.00
REGISTER'S FEE	1.00
WALK THRU FEE	0.00
TOTAL AMOUNT	1188.06

TOM LEATHERWOOD

REGISTER OF DEEDS SHELBY COUNTY TENNESSEE

86

Attachment A.6. Legal Interest in Site of the Institution

WARRANTY DEED

THIS INDENTURE, made and entered into this 9th day of March 2007, by and between

HEALTH FACILITIES PARTNERS, L.P. a limited partnership organized and existing pursuant to the laws of the State of Tennessee, Party of the first part

and

KEYSTONE MEMPHIS, LLC, a limited liability company organized and existing pursuant to the laws of the State of Tennessee, Party of the second part,

WITNESSETH:

That for and in consideration of Ten Dollars ($10.00), cash in hand paid, and other good and valuable considerations, the receipt of all of which is hereby acknowledged, the said party of the first part has bargained and sold and does hereby bargain, sell, convey and confirm unto the said party of the second part the following described real estate, situated and being in Shelby County, Tennessee to wit:

SEE ATTACHED EXHIBIT "A" FOR LEGAL DESCRIPTION

PARCEL NO: Part of D02 042 00262

Being part of the same property conveyed to the Party of the First Part herein by Special Warranty Deed in Lieu of Foreclosure recorded on even date herewith in said Register's Office.

TO HAVE AND TO HOLD the aforesaid real estate, together with all the appurtenances and hereditaments thereunto belonging or in any wise appertaining unto the said party of the second part, their heirs, successors and assigns in fee simple forever.

And the said party of the first part does hereby covenant with the said party of the second part that it is lawfully seized in fee of the aforedescribed real estate; that it has a good right to sell and convey the same; that the same is unencumbered, but subject to the 2007 Shelby County property taxes not yet due and payable; subdivision restrictions, building lines and easements of record in Plat Book 118, page 48, and in Plat Book 124, page 41, Plat Book 125, Page 78, Plat Book 128, Page 11, Plat Book 193, Page 55 all in the Register's Office of Shelby County, Tennessee, and that the title and quiet possession thereto it will warrant and forever defend against the lawful claims of all persons.

The word "party" as used herein shall mean "parties" if more than one person or entity be referred to, and pronouns shall be construed according to their proper gender and number according to the context hereof.

Attachment A.6. Legal Interest in Site of the Institution

WITNESS the signature of the said party of the first part the day and year first above written.

HEALTH FACILITIES PARTNERS, L.P.
A Tennessee limited partnership

By: Delta Capital Partners, L.L.C., Managing Partner
A Tennessee limited liability company

By: Donald L. Mundie
DONALD L. MUNDIE

Its: CHIEF MANAGER

STATE OF TENNESSEE
COUNTY OF SHELBY

The foregoing instrument was acknowledged before me this 9th **day of March, 2007 by DONALD L. MUNDIE, the Chief Manager of Delta Capital Partners, L.L.C., a Tennessee limited liability company, the Managing Partner of HEALTH FACILITIES PARTNERS, L.P., a Tennessee limited partnership, on behalf of the limited partnership.**

Alisha Roberts
Print Name

Alisha Roberts
Notary Public
Shelby County, Tennessee

ALISHA ROBERTS STATE OF TENNESSEE NOTARY PUBLIC Commission Expires 8-18-07 SHELBY COUNTY

My Commission Expires _____

Attachment A.6. Legal Interest in Site of the Institution

I, or we, hereby swear or affirm that to the best of affiant's knowledge, information, and belief, the actual consideration for this transfer or value of the property transferred, whichever is greater is, $309,476.00 which amount is equal to or greater than the amount which the property transferred would command at a fair and voluntary sale.

Affiant

Subscribed and sworn to before me this 14 day of March, 2007.

Notary Public

My Commission Expires:

ALISHA ROBERTS STATE OF TENNESSEE NOTARY PUBLIC SHELBY COUNTY

PROPERTY ADDRESS:
Vacant Land 0 Lowrance Road
Memphis, Tennessee

PROPERTY OWNER AND
OWNERS ADDRESS: & MAIL TAX BILLS TO:
Keystone Memphis, LLC
c/o Compass Intervention Center
7900 Lowrance Rd.
Memphis, TN 38125
ATTN: CEO Shelley Nowak

PREPARED BY:
The Law Offices Of
O. Douglas Shipman, P.C.
6750 Poplar Avenue, Suite 208
Memphis, Tennessee 38138

Return To:
Lawyers Title Insurance Corporation
6363 Poplar Avenue, #208
Memphis, TN 38119
MP037130

Attachment A.6. Legal Interest in Site of the Institution

EXHIBIT A

Description of part of Stansell Crossing P. D., Parcel 11, as recorded in Plat Book 128, page 11, in the Shelby County Register's Office, and being more particularly described as follows:

Commencing at the tangent intersection of the north line of Lowrance Road (68-foot R/W) and the west line of Stansell Court (55-foot r/w), thence westward with the north line of Lowrance Road a distance of 718.18 feet to the southwest corner of the Keystone Memphis LLC property;

thence N 03° 57' 48" W, and with the west line of Keystone Memphis, LLC property a distance of 419.62 feet to an iron pin (found), the TRUE POINT OF BEGINNING;

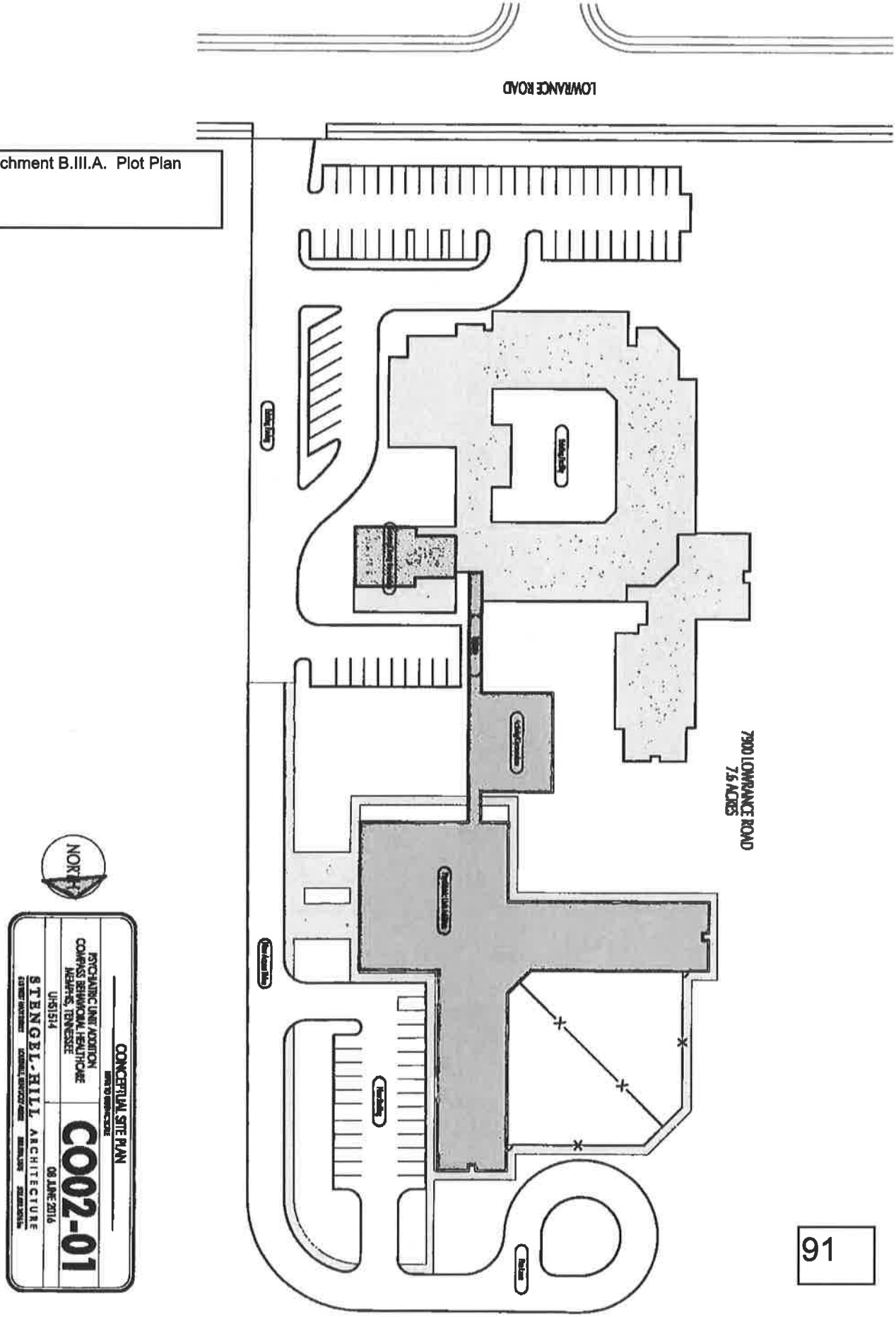
thence continuing N 03° 57' 48" E, and with the east line of Stansell Crossing P.D., Phase 2, Parcel 134 (Plat Book 129, page 89), a distance of 371.84 feet to an iron pin (set);

thence N 86° 02' 12" E, and with the south line of the City of Memphis property (04206144), a distance of 416.61 feet to an iron pin (set);

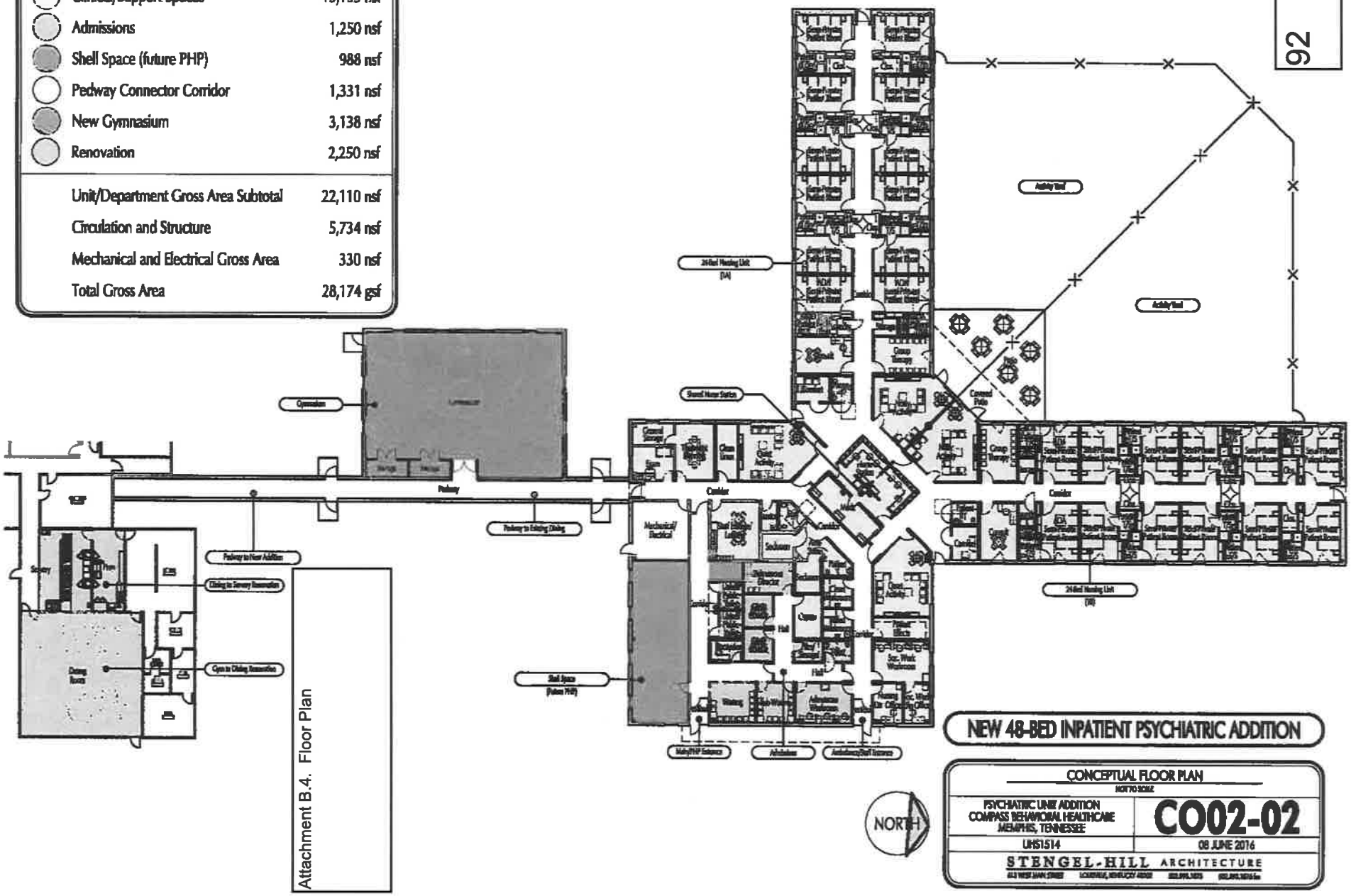
thence S 04° 29' 23" E, and on a new line through the Nonconnah Management LLC property, a distance of 368.00 feet to an iron pin (found) at the northeast corner of the Keystone Memphis, LLC property;

thence S 85° 30' 37" W, and with said north line, a distance of 420.01 feet to the POINT OF BEGINNING and containing 154,738 square feet or 3.552 acres.

Attachment B.III.A. Plot Plan



LEGEND	
Patient Beds	48 Beds
Clinical/Support Spaces	13,153 nsf
Admissions	1,250 nsf
Shell Space (future PHP)	988 nsf
Pedway Connector Corridor	1,331 nsf
New Gymnasium	3,138 nsf
Renovation	2,250 nsf
Unit/Department Gross Area Subtotal	22,110 nsf
Circulation and Structure	5,734 nsf
Mechanical and Electrical Gross Area	330 nsf
Total Gross Area	28,174 gsf



Attachment B.4. Floor Plan

NEW 48-BED INPATIENT PSYCHIATRIC ADDITION

CONCEPTUAL FLOOR PLAN

NOT TO SCALE

PSYCHIATRIC UNIT ADDITION
COMPASS BEHAVIORAL HEALTHCARE
MEMPHIS, TENNESSEE

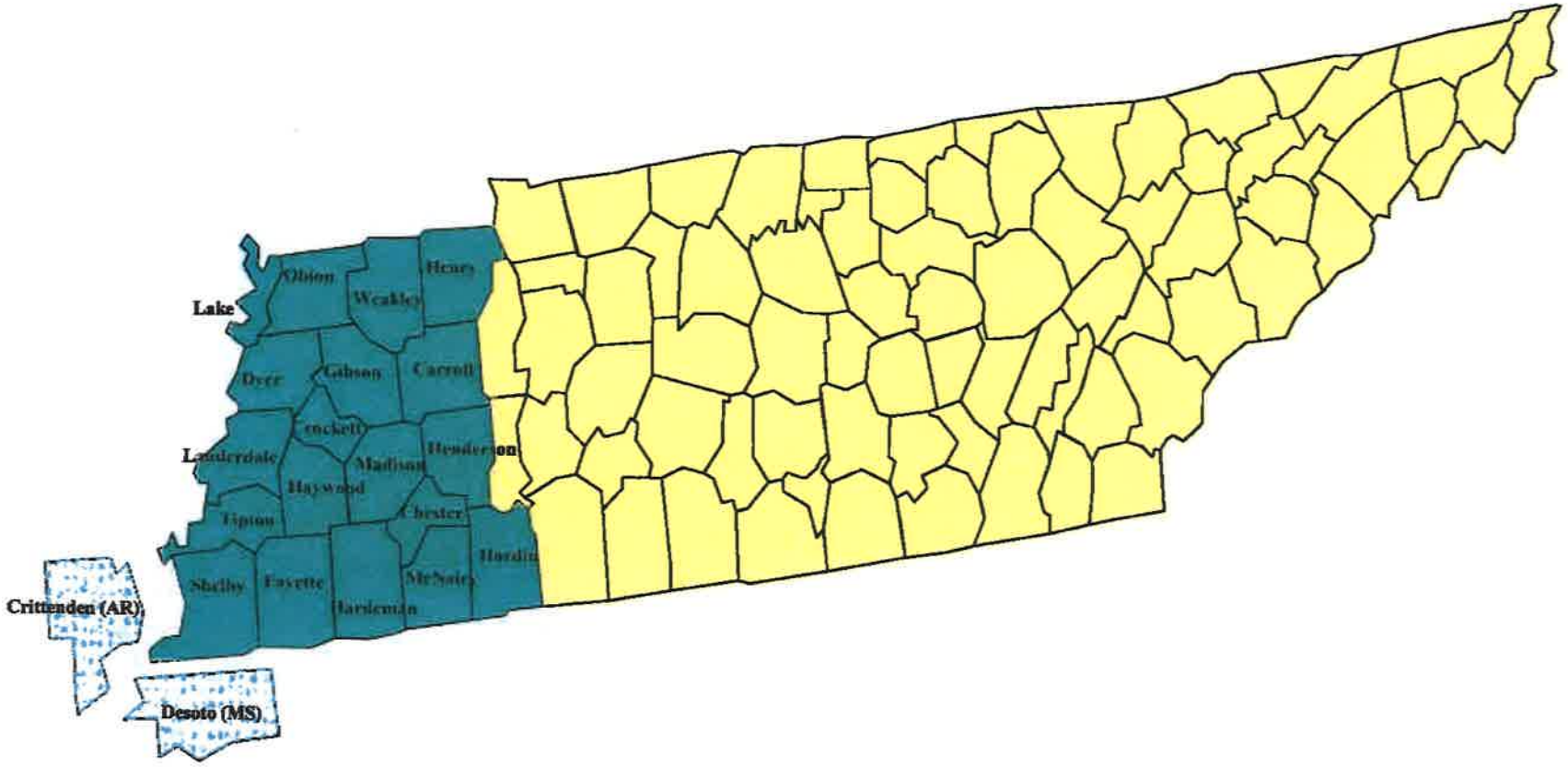
CO02-02

LHS1514

08 JUNE 2016

STENGEL-HILL ARCHITECTURE

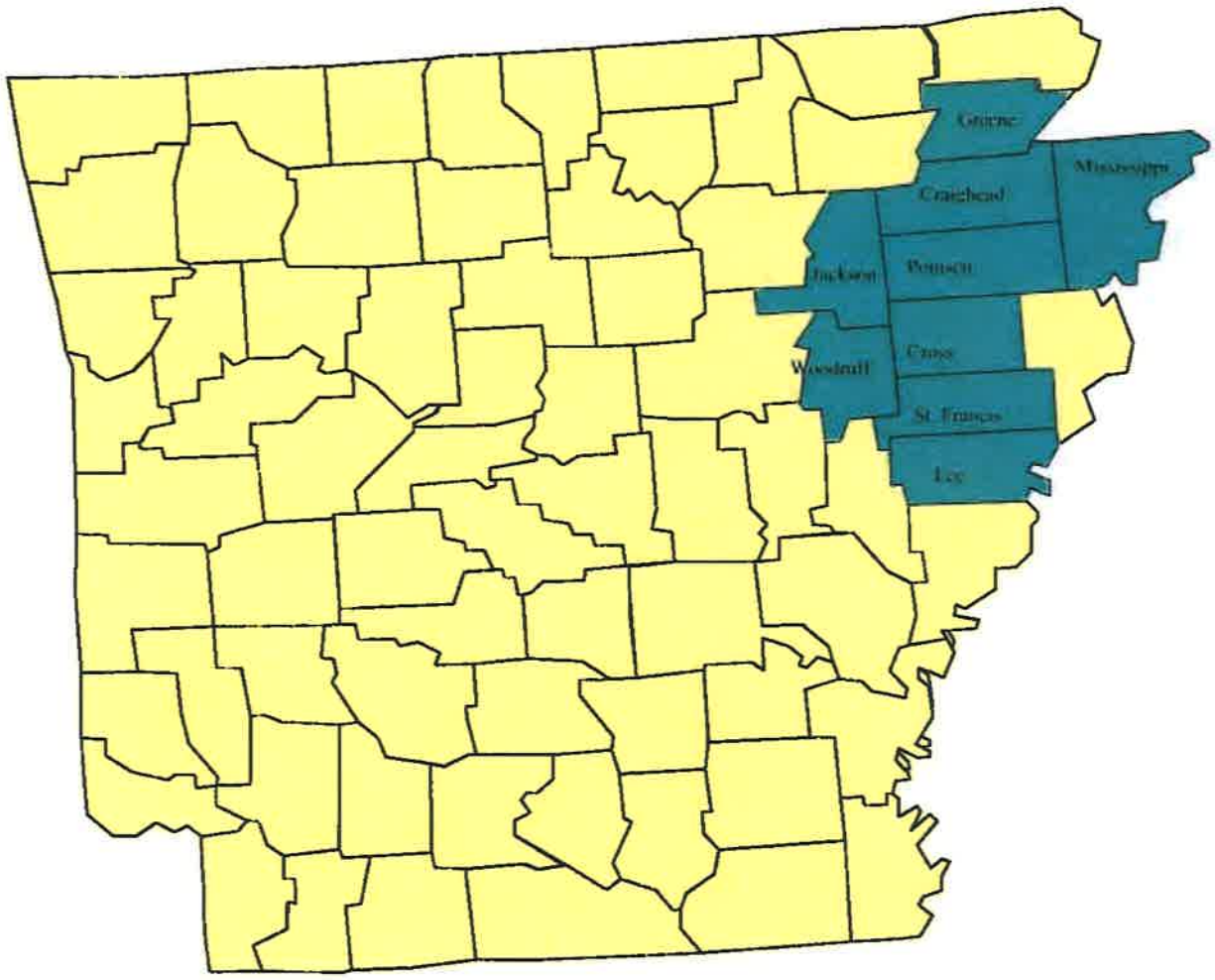
Attachment C.Need.3. Proposed Service Area



Counties in Primary and Secondary Service Areas (Shaded)

Primary: Carroll, Chester, Crockett, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Shelby, Tipton, Weakley, Desoto (MS), Crittenden (AR)

Attachment C.Need.3. Proposed Service Area



Arkansas Counties in Secondary Service Area (Shaded):
Craighead, Cross, Greene, Jackson, Lee, Mississippi, Poinsett, St. Francis, Woodruff

Attachment C. Economic Feasibility 1

Ms. Melanie Hill
Executive Director
State of Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: Psychiatric Unit Addition
Compass Intervention Center – Universal Health Services, Inc.
Memphis, TN

08 June 2016

SHA.UHS1514

Ms. Hill,

The Project Team for the above referenced project has prepared the following supporting documentation for your review.

I have reviewed the project cost estimate provided by Compass Behavioral Healthcare in the CON Submission. Based on my experience and knowledge of the current healthcare market, it is my opinion that the anticipated construction cost of $7,679,726 appears to be reasonable for a project of this type and size.

During early design discussions, the possibility of adding to and renovating Compass' existing facility was discussed. However, this option was deemed infeasible due to code-required area limitations based on the existing facility's construction type. A configuration incorporating separate buildings connected to the existing Facility via pedway, along with limited renovations inside the existing Facility, was determined to be the most effective solution. This configuration also serves to better separate Inpatient and Residential patient populations.

Additionally, please note that the Project will be designed in compliance with all applicable State and Federal Codes and Regulations, including the following:

- Guidelines for the Design and Construction of Health Care Facilities
- Rules of the Tennessee Department of Health Board for Licensing Health Care Facilities
- International Building Code
- National Electric Code
- National Fire Protection Association (NFPA)
- Americans with Disabilities Act

613 WEST MAIN STREET LOUISVILLE, KENTUCKY 40202
tel: 502.893.1875 fax: 502.893.1876 www.stengelhill.com

Attachment C. Economic Feasibility 1

If you have any questions regarding this information, please do not hesitate to contact our office at your convenience.

Thank you.

Bradford P. Stengel, AIA
Architect
Tennessee Professional Architect License #00102523

BPS/mrs

UHS of Delaware, Inc.
a subsidiary of Universal Health Services

367 South Gulph Road
P.O. Box 61558
King of Prussia, PA 19406

P: 610-768-3300

Attachment C. Economic Feasibility 2

June 10, 2016

Melanie Hill
Executive Director
Health Services and Development Agency
502 Deaderick Street
Andrew Jackson Building, 9th Floor
Nashville, TN 37243

RE: Documentation of Availability of Funds for Proposed Addition of 48 new Acute care beds to Compass Intervention Center

Dear Melanie and Members of the Board:

As a requirement of the Certificate of Need process, I have been asked to document the availability of funds for the proposed 48-bed psychiatric inpatient addition to Compass Intervention Center.

Universal Health Services, Inc. ("UHS") is the ultimate parent company of the applicant entity, Keystone Memphis, LLC d/b/a Compass Intervention Center. Please see attached organizational chart. As such, UHS is very familiar with the financial status and performance of the applicant and regularly examines its books. Moreover, UHS has the legal authority to commit funds to its owned entities.

As Vice President and Treasurer, I am familiar with the organization's financial position. If the project is approved, I have the authority to commit funds for this project. The estimated total fixed capital cost of the Compass Intervention Center project is $12,125,378.

UHS intends to fund the project from cash on hand or Revolving Credit Agreement. Based on our current knowledge and belief; the expenditure will not adversely impact any other capital projects currently underway or planned for the immediate future. For verification of our ability to finance projects internally, please refer to the Debt Footnote in the UHS 2015 Audited Financial Statements, which shows available borrowing capacity of $461 million under our Revolver Credit Agreement. These financial statements are included as an Exhibit in this application. The available borrowing capacity under our Credit Agreement today remains sufficient to fund the project.

In addition, UHS reserves the right to fund all or a portion of this project from cash, bond, or other credit instrument proceeds. UHS staff will make this determination based on market conditions at the time capital is actually required. I confirm that UHS now has sufficient capital to fund this project.

If you need any further information relating to financial operations, please do not hesitate to contact me.

Sincerely,

Cheryl K. Ramagano
Vice President and Treasurer

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 March 31, 2016

OR

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

For the transition period from to

Commission file number 1-10765

UNIVERSAL HEALTH SERVICES, INC.

(Exact name of registrant as specified in its charter)

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

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

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

Indicate by check mark whether the registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

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

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

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

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

Indicate the number of shares outstanding of each of the issuer's classes of common stock, as of the latest practicable date. Common shares outstanding, as of April 30, 2016:

Class A	6,595,308
Class B	89,763,934
Class C	663,940
Class D	23,122

Attachment C. Economic Feasibility. 11

UNIVERSAL HEALTH SERVICES, INC.

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This Quarterly Report on Form 10-Q is for the quarter ended March 31, 2016. This Report modifies and supersedes documents filed prior to this Report. Information that we file with the Securities and Exchange Commission (the "SEC") in the future will automatically update and supersede information contained in this Report.

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

PART I. FINANCIAL INFORMATION

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

	Three months ended March 31,	
	2016	2015
Net revenues before provision for doubtful accounts	$ 2,619,593	$ 2,380,101
Less: Provision for doubtful accounts	169,795	154,748
Net revenues	2,449,798	2,225,353
Operating charges:		
Salaries, wages and benefits	1,148,139	1,031,703
Other operating expenses	561,584	505,966
Supplies expense	255,250	238,741
Depreciation and amortization	104,049	98,998
Lease and rental expense	24,452	22,891
	2,093,474	1,898,299
Income from operations	356,324	327,054
Interest expense, net	29,600	30,037
Income before income taxes	326,724	297,017
Provision for income taxes	111,005	102,694
Net income	215,719	194,323
Less: Income attributable to noncontrolling interests	24,960	20,024
Net income attributable to UHS	$ 190,759	$ 174,299
Basic earnings per share attributable to UHS	$ 1.95	$ 1.76
Diluted earnings per share attributable to UHS	$ 1.93	$ 1.73
Weighted average number of common shares - basic	97,607	98,910
Add: Other share equivalents	1,288	1,737
Weighted average number of common shares and equivalents - diluted	98,895	100,647

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

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

	Three months ended March 31,	
	2016	2015
Net income	$ 215,719	$ 194,323
Other comprehensive income (loss):		
Unrealized derivative gains (losses) on cash flow hedges	(14,299)	4,132
Amortization of terminated hedge	(84)	(84)
Foreign currency translation adjustment	5,986	(418)
Other comprehensive income before tax	(8,397)	3,630
Income tax expense related to items of other comprehensive income	(5,360)	1,497
Total other comprehensive income, net of tax	(3,037)	2,133
Comprehensive income	212,682	196,456
Less: Comprehensive income attributable to noncontrolling interests	24,960	20,024
Comprehensive income attributable to UHS	$ 187,722	$ 176,432

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

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

	March 31, 2016	December 31, 2015
Assets		
Current assets:		
Cash and cash equivalents	$ 54,590	$ 61,228
Accounts receivable, net	1,374,737	1,302,429
Supplies	116,725	116,037
Deferred income taxes	0	135,120
Other current assets	89,386	103,490
Total current assets	1,635,438	1,718,304
Property and equipment	6,655,292	6,530,569
Less: accumulated depreciation	(2,774,740)	(2,694,591)
	3,880,552	3,835,978
Other assets:		
Goodwill	3,594,901	3,596,114
Deferred charges	16,235	16,688
Other	437,883	448,360
	$ 9,565,009	$ 9,615,444
Liabilities and Stockholders' Equity		
Current liabilities:		
Current maturities of long-term debt	$ 488,262	$ 62,722
Accounts payable and accrued liabilities	1,147,384	1,033,697
Federal and state taxes	49,794	3,987
Total current liabilities	1,685,440	1,100,406
Other noncurrent liabilities	295,684	278,834
Long-term debt	2,792,144	3,368,634
Deferred income taxes	178,947	315,900
Redeemable noncontrolling interests	261,492	242,509
Equity:		
UHS common stockholders' equity	4,289,218	4,249,647
Noncontrolling interest	62,084	59,514
Total equity	4,351,302	4,309,161
	$ 9,565,009	$ 9,615,444

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

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

	Three months ended March 31,	
	2016	2015
Cash Flows from Operating Activities:		
Net income	$ 215,719	$ 194,323
Adjustments to reconcile net income to net cash provided by operating activities		
Depreciation & amortization	104,049	98,998
Stock-based compensation expense	13,204	10,829
Changes in assets & liabilities, net of effects from acquisitions and dispositions:		
Accounts receivable	(79,962)	(96,972)
Accrued interest	688	1,117
Accrued and deferred income taxes	91,131	79,050
Other working capital accounts	98,972	(29,829)
Other assets and deferred charges	(5,803)	(234)
Other	20,911	17,807
Accrued insurance expense, net of commercial premiums paid	22,616	22,748
Payments made in settlement of self-insurance claims	(17,298)	(26,562)
Net cash provided by operating activities	464,227	271,275
Cash Flows from Investing Activities:		
Property and equipment additions, net of disposals	(127,214)	(89,276)
Acquisition of property and businesses	(19,543)	(34,500)
Net cash used in investing activities	(146,757)	(123,776)
Cash Flows from Financing Activities:		
Reduction of long-term debt	(166,671)	(158,871)
Additional borrowings	14,400	20,800
Financing costs	(44)	0
Repurchase of common shares	(171,042)	(28,767)
Dividends paid	(9,757)	(9,899)
Issuance of common stock	2,331	1,768
Excess income tax benefits related to stock-based compensation	11,002	20,807
Profit distributions to noncontrolling interests	(3,407)	(2,413)
Proceeds received from sale/leaseback of real property	0	12,551
Net cash used in financing activities	(323,188)	(144,024)
Effect of exchange rate changes on cash and cash equivalents	(920)	(466)
(Decrease) increase in cash and cash equivalents	(6,638)	3,009
Cash and cash equivalents, beginning of period	61,228	32,069
Cash and cash equivalents, end of period	$ 54,590	$ 35,078
Supplemental Disclosures of Cash Flow Information:		
Interest paid	$ 27,133	$ 27,158
Income taxes paid, net of refunds	$ 9,093	$ 2,876
Noncash purchases of property and equipment	$ 47,374	$ 33,082

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

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

(1) General

This Quarterly Report on Form 10-Q is for the quarterly period ended March 31, 2016. In this Quarterly Report, "we," "us," "our" "UHS" and the "Company" refer to Universal Health Services, Inc. and its subsidiaries.

The condensed consolidated financial statements include the accounts of our majority-owned subsidiaries and partnerships and limited liability companies controlled by us, or our subsidiaries, as managing general partner or managing member. The condensed consolidated financial statements included herein have been prepared by us, without audit, pursuant to the rules and regulations of the Securities and Exchange Commission ("SEC") and reflect all adjustments (consisting only of normal recurring adjustments) which, in our opinion, are necessary to fairly state results for the interim periods. Certain information and footnote disclosures normally included in financial statements prepared in accordance with accounting principles generally accepted in the United States of America have been condensed or omitted pursuant to such rules and regulations, although we believe that the accompanying disclosures are adequate to make the information presented not misleading. These condensed consolidated financial statements should be read in conjunction with the consolidated financial statements, significant accounting policies and the notes thereto included in our Annual Report on Form 10-K for the year ended December 31, 2015.

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

Relationship with Universal Health Realty Income Trust:

At March 31, 2016, we held approximately 5.9% 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 pursuant to the terms of which we conduct the Trust's day-to-day affairs, provide administrative services and present investment opportunities. In addition, certain of our officers and directors are also officers and/or directors of the Trust. Management believes that it has the ability to exercise significant influence over the Trust, therefore we account for our investment in the Trust using the equity method of accounting. We earned an advisory fee from the Trust, which is included in net revenues in the accompanying consolidated statements of income, of approximately $800,000 and $700,000 during the three-month periods ended March 31, 2016 and 2015, respectively.

Our pre-tax share of income from the Trust was approximately $250,000 and $200,000 during the three-month periods ended March 31, 2016 and 2015, respectively. The carrying value of this investment was approximately $8.4 million and $8.7 million at March 31, 2016 and December 31, 2015, respectively, and is included in other assets in the accompanying consolidated balance sheets. The market value of our investment in the Trust was $44.3 million at March 31, 2016 and $39.4 million at December 31, 2015, based on the closing price of the Trust's stock on the respective dates.

Total rent expense under the operating leases on these three hospital facilities was approximately $4 million during each of the three months ended March 31, 2016 and 2015. In addition, certain of our subsidiaries are tenants in several medical office buildings and two FEDs owned by the Trust or by limited liability companies in which the Trust holds 100% of the ownership interest.

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

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

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

expense paid by us to the Trust, prior to our purchase of The Bridgeway's real property in December, 2014, was approximately $1.1 million annually.

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

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

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

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

Other Related Party Transactions:

In December, 2010, our Board of Directors approved the Company's entering into supplemental life insurance plans and agreements on the lives of our chief executive officer ("CEO") and his wife. As a result of these agreements, based on actuarial tables and other assumptions, during the life expectancies of the insureds, we would pay approximately $25 million in premiums, and certain trusts owned by our chief executive officer, would pay approximately $8 million in premiums. Based on the projected premiums mentioned above, and assuming the policies remain in effect until the death of the insureds, we will be entitled to receive death benefit proceeds of no less than $33 million representing the $25 million of aggregate premiums paid by us as well as the $8 million of aggregate premiums paid by the trusts. In connection with these policies, we paid approximately $1.3 million in premium payments during 2015 and expect to pay similar amounts during 2016.

In August, 2015, Marc D. Miller, our President 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 vest ratably over a seven-year period (2014 through 2020), contingent upon our continued participation and minority ownership interest in the GPO.

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

(3) Other Noncurrent liabilities and Redeemable/Noncontrolling Interests

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

As of March 31, 2016, outside owners held noncontrolling, minority ownership interests of: (i) approximately 28% in our six acute care facilities located in Las Vegas, Nevada (including one facility currently under construction); (ii) 20% in an acute care facility located in Washington, D.C.; (iii) approximately 11% in an acute care facility located in Laredo, Texas, and; (iv) 20% in a behavioral health care facility located in Philadelphia, Pennsylvania. The redeemable noncontrolling interest balances of $261 million as of March 31, 2016 and $243 million as of December 31, 2015, and the noncontrolling interest balances of $62 million as of March 31, 2016 and $60 million as of December 31, 2015, consist primarily of the third-party ownership interests in these hospitals.

In connection with six acute care facilities located in the Las Vegas, Nevada market (including one facility currently under construction), subsequent to March 31, 2016, we agreed to purchase the minority ownership interests held by a third-party for an aggregate cash payment of $445 million which includes both the purchase price and return of capital. The minority ownership interests related to these hospitals are reflected as redeemable noncontrolling interests on our Condensed Consolidated Balance Sheet.

In connection with a behavioral health care facility located in Philadelphia, Pennsylvania, the minority ownership interest of which is also reflected as redeemable noncontrolling interests on our Consolidated Balance Sheet, the outside owner has a "put option" to put its entire ownership interest to us at any time. If exercised, the put option requires us to purchase the minority member's interest at fair market value.

(4) Long-term debt and cash flow hedges

Debt:

On August 7, 2014, we entered into a Fourth Amendment (the "Fourth Amendment") to our credit agreement dated as of November 15, 2010, as amended on March 15, 2011, September 21, 2012 and May 16, 2013, among UHS, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders ("Credit Agreement"). The Credit Agreement, as amended, which is scheduled to mature in August, 2019, consists of: (i) an $800 million revolving credit facility ($195 million of borrowings outstanding as of March 31, 2016), and; (ii) a $1.775 billion term loan A facility ($1.708 billion of borrowings outstanding as of March 31, 2016) which combined our previously outstanding term loan A and term loan A2 facilities which were scheduled to mature in 2016.

Borrowings under the Credit Agreement bear interest at either (1) the ABR rate which is defined as the rate per annum equal to, at our election: the greatest of (a) the lender's prime rate, (b) the weighted average of the federal funds rate, plus 0.5% and (c) one month LIBOR rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.50% to 1.25% for revolving credit and term loan-A borrowings, or (2) the one, two, three or six month LIBOR rate (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.50% to 2.25% for revolving credit and term loan-A borrowings. As of March 31, 2016, the applicable margins were 0.50% for ABR-based loans and 1.50% for LIBOR-based loans under the revolving credit and term loan-A facilities.

As of March 31, 2016, we had $195 million of borrowings outstanding pursuant to the terms of our $800 million revolving credit facility and we had $552 million of available borrowing capacity, net of $19 million of outstanding borrowings pursuant to a short-term, on-demand credit facility and $34 million of outstanding letters of credit. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Credit Agreement is secured by certain assets of the Company (which generally excludes asset classes such as substantially all of the patient-related accounts receivable of our acute care hospitals, certain real estate assets and assets held in joint-ventures with third-parties) and our material subsidiaries and guaranteed by our material subsidiaries.

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

Pursuant to the terms of our $400 million accounts receivable securitization program with a group of conduit lenders and liquidity banks ("Securitization"), which is scheduled to mature in December, 2018, substantially all of the patient-related accounts receivable of our acute care hospitals ("Receivables") serve as collateral for the outstanding borrowings. We have accounted for this Securitization as borrowings. We maintain effective control over the Receivables since, pursuant to the terms of the Securitization, the Receivables are sold from certain of our subsidiaries to special purpose entities that are wholly-owned by us. The Receivables, however, are owned by the special purpose entities, can be used only to satisfy the debts of the wholly-owned special purpose entities, and thus are not available to us except through our ownership interest in the special purpose entities. The wholly-owned special purpose entities use the Receivables to collateralize the loans obtained from the group of third-party conduit lenders and liquidity banks. The group of third-party conduit lenders and liquidity banks do not have recourse to us beyond the assets of the wholly-owned special purpose entities that securitize the loans. At March 31, 2016, we had $350 million of outstanding borrowings and $50 million of additional borrowing capacity pursuant to the terms of the Securitization.

On August 7, 2014, we issued $300 million aggregate principal amount of 3.750% Senior Secured Notes due 2019 (the "2019 Notes") and $300 million aggregate principal amount of 4.750% Senior Secured Notes due 2022 (the "2022 Notes", and together with the 2019 Notes, the "New Senior Secured Notes"). The New Senior Secured Notes were offered only to qualified institutional buyers under Rule 144A and to non-U.S. persons outside the United States in reliance on Regulation S under the Securities Act of 1933, as amended (the "Securities Act"). The New Senior Secured Notes have not been registered under the Securities Act and may not be offered or sold in the United States absent registration or an applicable exemption from registration requirements. Interest is payable

on the New Senior Secured Notes on February 1 and August 1 of each year to the holders of record at the close of business on the January 15 and July 15 immediately preceding the related interest payment dates, commencing on February 1, 2015 until the maturity date of August 1, 2019 for the 2019 Notes and August 1, 2022 for the 2022 Notes.

On June 30, 2006, we issued $250 million of senior secured notes which have a 7.125% coupon rate and mature on June 30, 2016 (the "7.125% Notes"). Interest on the 7.125% Notes is payable semiannually in arrears on June 30th and December 30th of each year. In June, 2008, we issued an additional $150 million of 7.125% Notes which formed a single series with the original 7.125% Notes issued in June, 2006. Other than their date of issuance and initial price to the public, the terms of the 7.125% Notes issued in June, 2008 are identical to and trade interchangeably with, the 7.125% Notes which were originally issued in June, 2006. After giving effect to the $445 million spent in early May, 2016 in connection with the purchase of the minority ownership interests held by a third-party in six acute care hospitals located in Las Vegas, Nevada, as disclosed herein, the 7.125% Notes are classified as current maturities of long-term debt as of March 31, 2016 since we no longer have the capacity to refinance the 7.125% Notes utilizing funds borrowed pursuant to our revolving credit facility. As of December 31, 2015, the 7.125% Notes are classified as long-term on our Consolidated Balance Sheet since we previously had the ability and intent to refinance the 7.125% Notes utilizing funds borrowed pursuant to our revolving credit facility.

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

Our Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens and indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage and minimum interest coverage ratios. We are in compliance with all required covenants as of March 31, 2016.

At March 31, 2016, the carrying value and fair value of our debt were each approximately $3.3 billion. At December 31, 2015, the carrying value and fair value of our debt were each approximately $3.5 billion. The fair value of our debt was computed based upon quotes received from financial institutions. We consider these to be "level 2" in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with debt instruments.

Cash Flow Hedges:

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

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

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

The fair value of interest rate swap agreements approximates the amount at which they could be settled, based on estimates obtained from the counterparties. We assess the effectiveness of our hedge instruments on a quarterly basis. We performed periodic assessments of the cash flow hedge instruments during 2015 and the first three months of 2016 and determined the hedges to be highly effective. We also determined that any portion of the hedges deemed to be ineffective was de minimis and therefore there was no material effect on our consolidated financial position, operations or cash flows. The counterparties to the interest rate swap agreements

expose us to credit risk in the event of nonperformance. We do not anticipate nonperformance by our counterparties. We do not hold or issue derivative financial instruments for trading purposes.

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

During 2015, we entered into nine forward starting interest rate swaps whereby we pay a fixed rate on a total notional amount of $1.0 billion and receive one-month LIBOR. The average fixed rate payable on these swaps, which are scheduled to mature on April 15, 2019, is 1.31%. These interest rates swaps consist of:

- Four forward starting interest rate swaps, entered into during the second quarter of 2015, whereby we pay a fixed rate on a total notional amount of $500 million and receive one-month LIBOR. Each of the four swaps became effective on July 15, 2015 and are scheduled to mature on April 15, 2019. The average fixed rate payable on these swaps is 1.40%;
- Four forward starting interest rate swaps, entered into during the third quarter of 2015, whereby we pay a fixed rate on a total notional amount of $400 million and receive one-month LIBOR. One swap on a notional amount of $100 million became effective on July 15, 2015, two swaps on a total notional amount of $200 million became effective on September 15, 2015 and another swap on a notional amount of $100 million became effective on December 15, 2015. All of these swaps are scheduled to mature on April 15, 2019. The average fixed rate payable on these four swaps is 1.23%, and;
- One interest rate swap, entered into during the fourth quarter of 2015, whereby we pay a fixed rate on a total notional amount of $100 million and receive one-month LIBOR. The swap became effective on December 15, 2015 and is scheduled to mature on April 15, 2019. The fixed rate payable on this swap is 1.21%.

We measure our interest rate swaps at fair value on a recurring basis. The fair value of our interest rate swaps is based on quotes from our counterparties. We consider those inputs to be "level 2" in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with derivative instruments and hedging activities. At March 31, 2016, the fair value of our interest rate swaps was a net liability of $16 million of which $7 million is included in other current liabilities and $9 million is included in other noncurrent liabilities on the accompanying balance sheet. At December 31, 2015, the fair value of our interest rate swaps was a net liability of $1 million comprised of a $5 million asset which is included in other assets offset by a $6 million liability which is included in other current liabilities on the accompanying balance sheet.

(5) Commitments and Contingencies

Professional and General Liability and Workers Compensation Liability:

Effective November, 2010, the vast majority of our subsidiaries are self-insured for professional and general liability exposure up to $10 million and $3 million per occurrence, respectively. These subsidiaries are provided with several excess policies through commercial insurance carriers which provide for coverage in excess of the applicable per occurrence self-insured retention (either $3 million or $10 million) or underlying policy limits up to $250 million per occurrence and in the aggregate for claims incurred after 2013 and up to $200 million per occurrence and in the aggregate for claims incurred from 2011 through 2013. We remain liable for 10% of the claims paid pursuant to the commercially insured coverage in excess of $10 million up to $60 million per occurrence and in the aggregate. 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 £10 million of professional liability coverage and £25 million of general liability coverage.

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 March 31, 2016, the total accrual for our professional and general liability claims was $210 million, of which $48 million is included in current liabilities. As of December 31, 2015, the total accrual for our professional and general liability claims was $204 million, of which $48 million is included in current liabilities.

As of March 31, 2016, the total accrual for our workers' compensation liability claims was $67 million, of which $34 million is included in current liabilities. As of December 31, 2015, the total accrual for our workers' compensation liability claims was $68 million, of which $34 million is included in current liabilities.

Property Insurance:

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

Other

Our accounts receivable as of March 31, 2016 and December 31, 2015 include amounts due from Illinois of approximately $16 million and $28 million, respectively. Collection of the outstanding receivables continues to be delayed due to state budgetary and funding pressures. Approximately $6 million as of March 31, 2016 and $12 million as of December 31, 2015, of the receivables due from Illinois were outstanding in excess of 60 days, as of each respective date. In addition, our accounts receivable as of March 31, 2016 and December 31, 2015 includes approximately $37 million and $80 million, respectively, due from Texas in connection with Medicaid supplemental payment programs. The $37 million due from Texas as of March 31, 2016 consists of $31 million related to uncompensated care program revenues and $6 million related to disproportionate share hospital program revenues. Although the accounts receivable due from Illinois and Texas could remain outstanding for the foreseeable future, since we expect to eventually collect all amounts due to us, no related reserves have been established in our consolidated financial statements. However, we can provide no assurance that we will eventually collect all amounts due to us from Illinois and/or Texas. Failure to ultimately collect all outstanding amounts due from these states would have an adverse impact on our future consolidated results of operations and cash flows.

As of March 31, 2016 we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds which totaled $129 million consisting of: (i) $105 million related to our self-insurance programs, and; (ii) $24 million of other debt and public utility guarantees.

Legal Proceedings

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

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

In February, 2013, the Office of Inspector General for the United States Department of Health and Human Services ("OIG") served a subpoena requesting various documents from January, 2008 to the date of the subpoena directed at Universal Health Services, Inc. ("UHS") concerning it and UHS of Delaware, Inc., and certain UHS owned behavioral health facilities including: Keys of Carolina, Old Vineyard Behavioral Health, The Meadows Psychiatric Center, Streamwood Behavioral Health, Hartgrove Hospital, Rock River Academy and Residential Treatment Center, Roxbury Treatment Center, Harbor Point Behavioral Health Center, f/k/a The Pines Residential Treatment Center, including the Crawford, Brighton and Kempsville campuses, Wekiva Springs Center and River Point Behavioral Health. Prior to receiving this subpoena: (i) the Keys of Carolina and Old Vineyard received notification during the second half of 2012 from the DOJ of its intent to proceed with an investigation following requests for documents for the period of January, 2007 to the date of the subpoenas from the North Carolina state Attorney General's Office; (ii) Harbor Point Behavioral Health Center received a subpoena in December, 2012 from the Attorney General of the Commonwealth of Virginia requesting various documents

from July, 2006 to the date of the subpoena, and; (iii) The Meadows Psychiatric Center received a subpoena from the OIG in February, 2013 requesting certain documents from 2008 to the date of the subpoena. Unrelated to these matters, the Keys of Carolina was closed and the real property was sold in January, 2013. We were advised that a qui tam action had been filed against Roxbury Treatment Center but the government declined to intervene and the case was dismissed.

In April, 2013, the OIG served facility specific subpoenas on Wekiva Springs Center and River Point Behavioral Health requesting various documents from January, 2005 to the date of the subpoenas. In July, 2013, another subpoena was issued to Wekiva Springs Center and River Point Behavioral Health requesting additional records. In October, 2013, we were advised by the DOJ's Criminal Frauds Section that they received a referral from the DOJ Civil Division and opened an investigation of River Point Behavioral Health and Wekiva Springs Center. Subsequent subpoenas have since been issued to River Point Behavioral Health and Wekiva Springs Center requesting additional documentation. In April, 2014, the Centers for Medicare and Medicaid Services ("CMS") instituted a Medicare payment suspension at River Point Behavioral Health in accordance with federal regulations regarding suspension of payments during certain investigations. The Florida Agency for Health Care Administration subsequently issued a Medicaid payment suspension for the facility. River Point Behavioral Health submitted a rebuttal statement disputing the basis of the suspension and requesting revocation of the suspension. Notwithstanding, CMS continued the payment suspension. River Point Behavioral Health provided additional information to CMS in an effort to obtain relief from the payment suspension but the suspension remains in effect. In February, 2016, we received notification from CMS that, effective March, 2016, the payment suspension will be continued for another 180 days. We cannot predict if and/or when the facility's suspended payments will resume. Although the operating results of River Point Behavioral Health did not have a material impact on our consolidated results of operations during the three-month period ended March 31, 2016 or the year ended December 31, 2015, the payment suspension has had a material adverse effect on the facility's results of operations and financial condition.

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

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

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

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

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

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

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

In December, 2015, we were notified by the DOJ Civil Division that the civil investigation also includes Arbour Hospital, Arbour-Fuller Hospital, Pembroke Hospital and Westwood Lodge located in Massachusetts. To date, these facilities have not received any requests for documentation or other information.

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

In December, 2015, we were advised that the DOJ opened an investigation involving the El Paso Behavioral Health System in El Paso, Texas. The DOJ is investigating potential Stark law violations relating to arrangements between the facility and physician(s) at the facility. These agreements were entered into before we acquired the facility as a part of our acquisition of Ascend Health Corporation in October, 2012. To our knowledge, this matter is not a part of the omnibus investigation referenced above. At present, we are uncertain as to potential liability and/or financial exposure, if any, which may be associated with this matter.

In January, 2016, we were notified that the Department of Justice opened an investigation of the South Texas Health System of a potential False Claim Act case regarding compensation paid to cardiologists pursuant to employment agreements entered into in 2005. At present, we are uncertain as to potential liability and/or financial exposure, if any, which may be associated with this matter.

Regulatory Matters:

On July 23, 2015, Timberlawn Mental Health System ("Timberlawn") received notification from CMS of its intent to terminate Timberlawn's Medicare provider agreement effective August 7, 2015. This notification resulted from surveys conducted which alleged that Timberlawn was out of compliance with conditions of participation required for participation in the Medicare/Medicaid program. We filed a request for expedited administrative appeal with the U.S. Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, seeking review and reversal of the termination action. In conjunction with the administrative appeal, we filed litigation in the U.S District Court for the Northern District of Texas seeking a temporary restraining order and preliminary injunction to have the termination stayed pending the conclusion of the administrative appeal. The trial court denied Timberlawn's request for a temporary restraining order and dismissed the case. Timberlawn's provider agreement was terminated effective August 14, 2015. In September, 2015 Timberlawn reached an agreement with CMS relative to its reapplication to the Medicare/Medicaid program. In exchange, Timberlawn agreed to dismiss its administrative appeal as well as not to pursue an appeal of the decision of the trial court. During this time, Timberlawn has remained open. In December, 2015, Timberlawn received notice from the Texas Department of State Health Services of its intent to revoke Timberlawn's license and impose an administrative penalty. We have appealed and are contesting the proposed revocation and fine. In January, 2016, Timberlawn submitted its application for re-enrollment into the Medicare/Medicaid program. Although the operating results of Timberlawn did not have a material impact on our consolidated results of operations or financial condition for the three-month period ended March 31, 2016 or the year ended December 31, 2015, the termination of Timberlawn's provider agreement has had a material adverse effect on the facility's results of operations and financial condition.

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

Other Matters:

In late September, 2015, many hospitals in Pennsylvania, including seven of our behavioral health care hospitals located in the state, received letters from the Pennsylvania Department of Public Welfare ("DPW") demanding repayment of allegedly excess Medicaid Disproportionate Share Hospital payments ("DSH") for the federal fiscal year 2011 ("FFY2011") amounting to approximately $4 million in the aggregate. We have filed administrative appeals for all of our facilities contesting the recoupment efforts since we believe DPW's calculation methodology is inaccurate and conflicts with applicable federal and state laws and regulations. DPW has agreed to postpone the recoupment of the state's share of the DSH payments until all hospital appeals are resolved. DPW also extended the deadline to recoup the federal share (2011 federal share is 55%) until April 30, 2016. However, if DPW is ultimately successful in its demand related to FFY2011, it could take similar action with regards to FFY2012 through FFY2014. Due to a change in the Pennsylvania Medicaid State Plan and implementation of a CMS-approved Medicaid Section 1115 Waiver, we do not believe the methodology applied by DPW to FFY2011 is applicable to reimbursements received for Medicaid services provided after January 1, 2015 by our behavioral health care facilities located in Pennsylvania. We can provide no assurance that we will ultimately be successful in our legal and administrative appeals related to DPW'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.

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

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

Department of Justice Investigation of Friends Hospital:

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

Department of Justice Investigation of Riveredge Hospital:

In 2008, Riveredge Hospital in Chicago, Illinois received a subpoena from the DOJ requesting certain information from the facility. Additional requests for documents were also received from the DOJ in 2009 and 2010. The requested documents have been provided to the DOJ. All documents requested and produced pertained to the operations of the facility while under PSI's ownership prior to our

acquisition. At present, we are uncertain as to the focus, scope or extent of the investigation, liability of the facility and/or potential financial exposure, if any, in connection with this matter.

General:

We operate in a highly regulated and litigious industry which subjects us to various claims and lawsuits in the ordinary course of business as well as regulatory proceedings and government investigations. These claims or suits include claims for damages for personal injuries, medical malpractice, commercial/contractual disputes, wrongful restriction of, or interference with, physicians' staff privileges, and employment related claims, In addition, health care companies are subject to investigations and/or actions by various state and federal governmental agencies or those bringing claims on their behalf. Government action has increased with respect to investigations and/or allegations against healthcare providers concerning possible violations of fraud and abuse and false claims statutes as well as compliance with clinical and operational regulations. Currently, and from time to time, we and some of our facilities are subjected to inquiries in the form of subpoenas, Civil Investigative Demands, audits and other document requests from various federal and state agencies. These inquiries can lead to notices and/or actions including repayment obligations from state and federal government agencies associated with potential non-compliance with laws and regulations. Further, the federal False Claim Act allows private individuals to bring lawsuits (qui tam actions) against healthcare providers that submit claims for payments to the government. Various states have also adopted similar statutes. When such a claim is filed, the government will investigate the matter and decide if they are going to intervene in the pending case. These qui tam lawsuits are placed under seal by the court to comply with the False Claims Act's requirements. If the government chooses not to intervene, the private individual(s) can proceed independently on behalf of the government. Health care providers that are found to violate the False Claims Act may be subject to substantial monetary fines/penalties as well as face potential exclusion from participating in government health care programs or be required to comply with Corporate Integrity Agreements as a condition of a settlement of a False Claim Act matter. In September 2014, the Criminal Division of the DOJ, announced that all qui tam cases will be shared with their Division to determine if a parallel criminal investigation should be opened. The 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 Affordable Care Act has added additional obligations on healthcare providers to report and refund overpayments by government healthcare programs and authorizes the suspension of Medicare and Medicaid payments "pending an investigation of a credible allegation of fraud." We monitor our business and have developed an ethics and compliance program with respect to these complex laws, rules and regulations. Although we believe our policies, procedures and practices comply with government regulations, there is no assurance that we will not be faced with the sanctions referenced above which include fines, penalties and/or substantial damages, repayment obligations, payment suspensions, licensure revocation, and expulsion from government healthcare programs. Even if we were to ultimately prevail in any action brought against us or our facilities or in responding to any inquiry, such action or inquiry could have a material adverse effect on us.

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

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

(6) Segment Reporting

Our reportable operating segments consist of acute care hospital services and behavioral health care services. The "Other" segment column below includes centralized services including information services, purchasing, reimbursement, accounting, taxation, legal, advertising, design and construction and patient accounting as well as the operating results for our other operating entities including outpatient surgery and radiation centers. The chief operating decision making group for our acute care hospital services and behavioral health care services is comprised of the Chief Executive Officer, the President and the Presidents of each operating segment. The Presidents of each operating segment also manage the profitability of each respective segment's various facilities. The operating segments are managed separately because each operating segment represents a business unit that offers different types of healthcare services or operates in different healthcare environments. The accounting policies of the operating segments are the same as those described in the summary of significant accounting policies included in our Annual Report on Form 10-K for the year ended December 31, 2015.

	Three months ended March 31, 2016			
	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 4,965,537	$ 1,959,570	$ -	$ 6,925,107
Gross outpatient revenues	$ 2,767,329	$ 221,643	$ -	$ 2,988,972
Total net revenues	$ 1,287,147	$ 1,161,046	$ 1,605	$ 2,449,798
Income/(loss) before allocation of corporate overhead and income taxes	$ 185,918	$ 265,577	$ (124,771)	$ 326,724
Allocation of corporate overhead	$ (42,649)	$ (38,716)	$ 81,365	$ 0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 143,269	$ 226,861	$ (43,406)	$ 326,724
Total assets as of March 31, 2016	$ 3,498,240	$ 5,929,802	$ 136,967	$ 9,565,009

	Three months ended March 31, 2015			
	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 4,328,767	$ 1,823,425	$ -	$ 6,152,192
Gross outpatient revenues	$ 2,284,712	$ 204,569	$ 7,827	$ 2,497,108
Total net revenues	$ 1,145,940	$ 1,076,345	$ 3,068	$ 2,225,353
Income/(loss) before allocation of corporate overhead and income taxes	$ 155,200	$ 253,442	$ (111,625)	$ 297,017
Allocation of corporate overhead	$ (49,426)	$ (29,666)	$ 79,092	$ 0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 105,774	$ 223,776	$ (32,533)	$ 297,017
Total assets as of March 31, 2015	$ 3,431,688	$ 5,315,270	$ 315,445	$ 9,062,403

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

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

The following table sets forth the computation of basic and diluted earnings per share for classes A, B, C and D common stockholders for the periods indicated (in thousands, except per share data):

	Three months ended March 31, (amounts in thousands) 2016	2015
Basic and Diluted:		
Net income attributable to UHS	$ 190,759	$ 174,299
Less: Net income attributable to unvested restricted share grants	(89)	(68)
Net income attributable to UHS – basic and diluted	$ 190,670	$ 174,231
Weighted average number of common shares - basic	97,607	98,910
Net effect of dilutive stock options and grants based on the treasury stock method	1,288	1,737
Weighted average number of common shares and equivalents - diluted	98,895	100,647
Earnings per basic share attributable to UHS:	$ 1.95	$ 1.76
Earnings per diluted share attributable to UHS:	$ 1.93	$ 1.73

The "Net effect of dilutive stock options and grants based on the treasury stock method", for all periods presented above, excludes certain outstanding stock options applicable to each period since the effect would have been anti-dilutive. The excluded weighted-average stock options totaled 6.0 million for the three months ended March 31, 2016 and 3.0 million for the three months ended March 31, 2015. All classes of our common stock have the same dividend rights.

Stock-Based Compensation: During the three-month periods ended March 31, 2016 and 2015, compensation cost of $12.7 million and $10.5 million, respectively, was recognized related to outstanding stock options. In addition, during the three-month periods ended March 31, 2016 and 2015, compensation cost of approximately $318,000 and $219,000, respectively, was recognized related to restricted stock. As of March 31, 2016 there was $115.2 million of unrecognized compensation cost related to unvested options and restricted stock which is expected to be recognized over the remaining weighted average vesting period of 3.2 years. There were 2,912,050 stock options granted (net of cancellations) during the first three months of 2016 with a weighted-average grant date fair value of $23.77 per share.

The expense associated with share-based compensation arrangements is a non-cash charge. In the Consolidated Statements of Cash Flows, share-based compensation expense is an adjustment to reconcile net income to cash provided by operating activities and aggregated to $13.2 million and $10.8 million during the three-month periods ended March 31, 2016 and 2015, respectively. In accordance with ASC 718, excess income tax benefits related to stock based compensation are classified as cash inflows from financing activities on the Consolidated Statement of Cash Flows. During the first three months of 2016 and 2015, we generated $11.0 million and $20.1 million, respectively, of excess income tax benefits related to stock based compensation which are reflected as cash inflows from financing activities in our Consolidated Statements of Cash Flows.

(8) Dispositions and acquisitions

Transaction subsequent to March 31, 2016:

Purchase of third-party ownership interests in six acute care hospitals in Las Vegas, Nevada market:

Subsequent to March 31, 2016, we agreed to purchase the minority ownership interests held by a third-party in our six acute care hospitals located in the Las Vegas, Nevada market for an aggregate cash payment of $445 million which includes both the purchase price and return of capital. The ownership interests purchased, which range from 26.1% to 27.5%, relate to Centennial Hills Hospital Medical Center, Desert Springs Hospital, Henderson Hospital (currently under construction), Spring Valley Hospital Medical Center, Summerlin Hospital Medical Center and Valley Hospital Medical Center.

Three-month period ended March 31, 2016:

Acquisitions:

During the first quarter of 2016, we paid approximately $20 million to acquire various businesses and property.

Three-month period ended March 31, 2015:

Acquisitions:

During the first quarter of 2015, we paid approximately $35 million to acquire: (i) a 46-bed behavioral health care facility located in the U.K. and; (ii) various other businesses, a management contract and real property assets.

(9) Dividends

We declared and paid dividends of $9.8 million, or $.10 per share, during the first quarter of 2016 and $9.9 million or $.10 per share during the first quarter of 2015.

(10) Income Taxes

As of January 1, 2016, our unrecognized tax benefits were approximately $2 million. The amount, if recognized, that would affect the effective tax rate is approximately $1 million. During the quarter ended March 31, 2016, 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 March 31, 2016, we have less than $1 million of accrued interest and penalties. The U.S. federal statute of limitations remains open for the 2012 and subsequent years. Foreign and U.S. state and local jurisdictions have statutes of limitations generally ranging from 3 to 4 years. The statute of limitations on certain jurisdictions could expire within the next twelve months. It is reasonably possible that the amount of uncertain tax benefits will change during the next 12 months, however, it is anticipated that any such change, if it were to occur, would not have a material impact on our results of operations.

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

(11) Supplemental Condensed Consolidating Financial Information

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

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

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF INCOME
FOR THE THREE MONTHS ENDED MARCH 31, 2016
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net revenues before provision for doubtful accounts	$ 0	$ 1,812,098	$ 815,838	$ (8,343)	$ 2,619,593
Less: Provision for doubtful accounts	0	107,680	62,115	0	169,795
Net revenues	0	1,704,418	753,723	(8,343)	2,449,798
Operating charges:					
Salaries, wages and benefits	0	824,295	323,844	0	1,148,139
Other operating expenses	0	387,677	181,980	(8,073)	561,584
Supplies expense	0	153,387	101,863	0	255,250
Depreciation and amortization	0	72,253	31,796	0	104,049
Lease and rental expense	0	15,294	9,428	(270)	24,452
	0	1,452,906	648,911	(8,343)	2,093,474
Income from operations	0	251,512	104,812	0	356,324
Interest expense	28,300	1,136	164	0	29,600
Interest (income) expense, affiliate	0	23,054	(23,054)	0	0
Equity in net income of consolidated affiliates	(208,227)	(70,175)	0	278,402	0
Income before income taxes	179,927	297,497	127,702	(278,402)	326,724
Provision for income taxes	(10,832)	97,979	23,858	0	111,005
Net income	190,759	199,518	103,844	(278,402)	215,719
Less: Income attributable to noncontrolling interests	0	0	24,960	0	24,960
Net income attributable to UHS	$ 190,759	$ 199,518	$ 78,884	$ (278,402)	$ 190,759

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF INCOME
FOR THE THREE MONTHS ENDED MARCH 31, 2015
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net revenues before provision for doubtful accounts	$ 0	$ 1,661,612	$ 726,080	$ (7,591)	$ 2,380,101
Less: Provision for doubtful accounts	0	106,304	48,444	0	154,748
Net revenues	0	1,555,308	677,636	(7,591)	2,225,353
Operating charges:					
Salaries, wages and benefits	0	740,554	291,149	0	1,031,703
Other operating expenses	0	351,580	161,686	(7,300)	505,966
Supplies expense	0	141,361	97,380	0	238,741
Depreciation and amortization	0	69,645	29,353	0	98,998
Lease and rental expense	0	13,755	9,427	(291)	22,891
	0	1,316,895	588,995	(7,591)	1,898,299
Income from operations	0	238,413	88,641	0	327,054
Interest expense	28,512	1,227	298	0	30,037
Interest (income) expense, affiliate	0	23,054	(23,054)	0	0
Equity in net income of consolidated affiliates	(191,898)	(59,515)	0	251,413	0
Income before income taxes	163,386	273,647	111,397	(251,413)	297,017
Provision for income taxes	(10,913)	92,130	21,477	0	102,694
Net income	174,299	181,517	89,920	(251,413)	194,323
Less: Income attributable to noncontrolling interests	0	0	20,024	0	20,024
Net income attributable to UHS	$ 174,299	$ 181,517	$ 69,896	$ (251,413)	$ 174,299

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME
FOR THE THREE MONTHS ENDED MARCH 31, 2016
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net income	$ 190,759	$ 199,518	$ 103,844	$ (278,402)	$ 215,719
Other comprehensive income (loss):					
Unrealized derivative gains on cash flow hedges	(14,299)	0	0	0	(14,299)
Amortization of terminated hedge	(84)	0	0	0	(84)
Foreign currency translation adjustment	5,986	5,986	0	(5,986)	5,986
Other comprehensive income before tax	(8,397)	5,986	0	(5,986)	(8,397)
Income tax expense related to items of other comprehensive income	(5,360)	0	0	0	(5,360)
Total other comprehensive income, net of tax	(3,037)	5,986	0	(5,986)	(3,037)
Comprehensive income	187,722	205,504	103,844	(284,388)	212,682
Less: Comprehensive income attributable to noncontrolling interests	0	0	24,960	0	24,960
Comprehensive income attributable to UHS	$ 187,722	$ 205,504	$ 78,884	$ (284,388)	$ 187,722

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME
FOR THE THREE MONTHS ENDED MARCH 31, 2015
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net income	$ 174,299	$ 181,517	$ 89,920	$ (251,413)	$ 194,323
Other comprehensive income (loss):					
Unrealized derivative gains on cash flow hedges	4,132	0	0	0	4,132
Amortization of terminated hedge	(84)	0	0	0	(84)
Currency translation adjustment	(418)	(418)	0	418	(418)
Other comprehensive income before tax	3,630	(418)	0	418	3,630
Income tax expense related to items of other comprehensive income	1,497	0	0	0	1,497
Total other comprehensive income, net of tax	2,133	(418)	0	418	2,133
Comprehensive income	176,432	181,099	89,920	(250,995)	196,456
Less: Comprehensive income attributable to noncontrolling interests	0	0	20,024	0	20,024
Comprehensive income attributable to UHS	$ 176,432	$ 181,099	$ 69,896	$ (250,995)	$ 176,432

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING BALANCE SHEET
AS OF MARCH 31, 2016
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Assets					
Current assets:					
Cash and cash equivalents	$ 0	$ 40,381	$ 14,209	$ 0	$ 54,590
Accounts receivable, net	0	957,504	417,233	0	1,374,737
Supplies	0	72,559	44,166	0	116,725
Other current assets	0	67,954	21,432	0	89,386
Total current assets	0	1,138,398	497,040	0	1,635,438
Investments in subsidiaries	7,974,369	1,946,590	0	(9,920,959)	0
Intercompany receivable	0	0	801,649	(801,649)	0
Intercompany note receivable	0	0	1,242,937	(1,242,937)	0
Property and equipment	0	4,782,483	1,872,809	0	6,655,292
Less accumulated depreciation	0	(1,897,760)	(876,980)	0	(2,774,740)
	0	2,884,723	995,829	0	3,880,552
Other assets:					
Goodwill	0	3,065,409	529,492	0	3,594,901
Deferred charges	6,708	5,586	3,941	0	16,235
Other	8,180	390,548	39,155	0	437,883
	$ 7,989,257	$ 9,431,254	$ 4,110,043	$(11,965,545)	$ 9,565,009
Liabilities and Stockholders' Equity					
Current liabilities:					
Current maturities of long-term debt	$ 485,862	$ 1,241	$ 1,159	$ 0	$ 488,262
Accounts payable and accrued liabilities	20,343	821,832	305,209	0	1,147,384
Federal and state taxes	49,794	0	0	0	49,794
Total current liabilities	555,999	823,073	306,368	0	1,685,440
Intercompany payable	186,164	615,485	0	(801,649)	0
Intercompany note payable	0	1,242,937	0	(1,242,937)	0
Other noncurrent liabilities	11,324	213,818	70,542	0	295,684
Long-term debt	2,767,605	16,468	8,071	0	2,792,144
Deferred income taxes	178,947	0	0	0	178,947
Redeemable noncontrolling interests	0	0	261,492	0	261,492
Equity:					
UHS common stockholders' equity	4,289,218	6,519,473	3,401,486	(9,920,959)	4,289,218
Noncontrolling interest	0	0	62,084	0	62,084
Total equity	4,289,218	6,519,473	3,463,570	(9,920,959)	4,351,302
	$ 7,989,257	$ 9,431,254	$ 4,110,043	$(11,965,545)	$ 9,565,009

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING BALANCE SHEET
AS OF DECEMBER 31, 2015
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Assets					
Current assets:					
Cash and cash equivalents	$ 0	$ 47,192	$ 14,036	$ 0	$ 61,228
Accounts receivable, net	0	918,699	383,730	0	1,302,429
Supplies	0	72,499	43,538	0	116,037
Deferred income taxes	132,975	2,145	0		135,120
Other current assets	0	89,973	13,517	0	103,490
Total current assets	132,975	1,130,508	454,821	0	1,718,304
Investments in subsidiaries	7,760,156	1,876,415	0	(9,636,571)	0
Intercompany receivable	80,764	0	747,709	(828,473)	0
Intercompany note receivable	0	0	1,242,937	(1,242,937)	0
Property and equipment	0	4,722,050	1,808,519	0	6,530,569
Less: accumulated depreciation	0	(1,845,746)	(848,845)	0	(2,694,591)
	0	2,876,304	959,674	0	3,835,978
Other assets:					
Goodwill	0	3,070,061	526,053	0	3,596,114
Deferred charges	7,208	5,530	3,950	0	16,688
Other	14,251	394,998	39,111	0	448,360
	$ 7,995,354	$ 9,353,816	$ 3,974,255	$(11,707,981)	$ 9,615,444
Liabilities and Stockholders' Equity					
Current liabilities:					
Current maturities of long-term debt	$ 60,368	$ 1,223	$ 1,131	$ 0	$ 62,722
Accounts payable and accrued liabilities	19,996	744,137	269,564	0	1,033,697
Federal and state taxes	3,987	0	0	0	3,987
Total current liabilities	84,351	745,360	270,695	0	1,100,406
Intercompany payable	0	828,473	0	(828,473)	0
Intercompany note payable	0	1,242,937	0	(1,242,937)	0
Other noncurrent liabilities	1,982	206,287	70,565	0	278,834
Long-term debt	3,343,474	16,790	8,370	0	3,368,634
Deferred income taxes	315,900	0	0	0	315,900
Redeemable noncontrolling interests	0	0	242,509	0	242,509
Equity:					
UHS common stockholders' equity	4,249,647	6,313,969	3,322,602	(9,636,571)	4,249,647
Noncontrolling interest	0	0	59,514	0	59,514
Total equity	4,249,647	6,313,969	3,382,116	(9,636,571)	4,309,161
	$ 7,995,354	$ 9,353,816	$ 3,974,255	$(11,707,981)	$ 9,615,444

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
FOR THE THREE MONTHS ENDED MARCH 31, 2016
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net cash (used in) provided by operating activities	$ 52,278	$ 279,625	$ 132,324	$ 0	$ 464,227
Cash Flows from Investing Activities:					
Property and equipment additions, net of disposals	0	(61,718)	(65,496)	0	(127,214)
Acquisition of property and businesses	0	(10,506)	(9,037)	0	(19,543)
Net cash used in investing activities	0	(72,224)	(74,533)	0	(146,757)
Cash Flows from Financing Activities:					
Reduction of long-term debt	(166,096)	(304)	(271)	0	(166,671)
Additional borrowings	14,400	0	0	0	14,400
Financing costs	(44)	0	0	0	(44)
Repurchase of common shares	(171,042)	0	0	0	(171,042)
Dividends paid	(9,757)	0	0	0	(9,757)
Issuance of common stock	2,331	0	0	0	2,331
Excess income tax benefits related to stock-based compensation	11,002	0	0	0	11,002
Profit distributions to noncontrolling interests	0	0	(3,407)	0	(3,407)
Changes in intercompany balances with affiliates, net	266,928	(212,988)	(53,940)	0	0
Net cash provided by (used in) financing activities	(52,278)	(213,292)	(57,618)	0	(323,188)
Effect of exchange rate changes on cash and cash equivalents	0	(920)	0	0	(920)
(Decrease) increase in cash and cash equivalents	0	(6,811)	173	0	(6,638)
Cash and cash equivalents, beginning of period	0	47,192	14,036	0	61,228
Cash and cash equivalents, end of period	$ 0	$ 40,381	$ 14,209	$ 0	$ 54,590

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
FOR THE THREE MONTHS ENDED MARCH 31, 2015
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net cash provided by operating activities	$ 62,343	$ 124,046	$ 84,886	$ 0	$ 271,275
Cash Flows from Investing Activities:					
Property and equipment additions, net of disposals	0	(59,217)	(30,059)	0	(89,276)
Acquisition of property and businesses	0	(22,513)	(11,987)	0	(34,500)
Net cash used in investing activities	0	(81,730)	(42,046)	0	(123,776)
Cash Flows from Financing Activities:					
Reduction of long-term debt	(156,097)	(2,561)	(213)	0	(158,871)
Additional borrowings	20,800	0	0	0	20,800
Repurchase of common shares	(28,767)	0	0	0	(28,767)
Dividends paid	(9,899)	0	0	0	(9,899)
Issuance of common stock	1,768	0	0	0	1,768
Excess income tax benefits related to stock-based compensation	20,807	0	0	0	20,807
Profit distributions to noncontrolling interests	0	0	(2,413)	0	(2,413)
Proceeds received from sale/leaseback of real property	0	0	12,551		12,551
Changes in intercompany balances with affiliates, net	89,045	(45,555)	(43,490)	0	0
Net cash (used in) provided by financing activities	(62,343)	(48,116)	(33,565)	0	(144,024)
Effect of exchange rate changes on cash and cash equivalents	0	(466)	0	0	(466)
Increase in cash and cash equivalents	0	(6,266)	9,275	0	3,009
Cash and cash equivalents, beginning of period	0	21,784	10,285	0	32,069
Cash and cash equivalents, end of period	$ 0	$ 15,518	$ 19,560	$ 0	$ 35,078

(12) Recent Accounting Standards

In November, 2015, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2015-17, "Income Taxes (Topic 740): Balance Sheet Classification of Deferred Taxes", which eliminates the guidance in Topic 740, Income Taxes, that required an entity to separate deferred tax liabilities and assets between current and noncurrent amounts in a classified balance sheet. The amendments require that all deferred tax liabilities and assets of the same tax jurisdiction or a tax filing group, as well as any related valuation allowance, be offset and presented as a single noncurrent amount in a classified balance sheet. The amendments are effective for public business entities for annual fiscal years beginning after December 15, 2016. We early adopted this standard effective January 1, 2016, on a prospective basis and did not adjust prior periods presented. The adoption of this standard had no impact on our Condensed Consolidated Statements of Income or Condensed Consolidated Statement of Cash Flows.

In April and August 2015, the FASB issued ASU No. 2015-03 and ASU No. 2015-15, "Interest- Imputation of Interest," respectively, to simplify the presentation of debt issuance costs. The standard requires debt issuance costs be presented in the balance sheet as a direct deduction from the carrying value of the debt liability. The FASB clarified that debt issuance costs related to line-of-credit arrangements can be presented as an asset and amortized over the term of the arrangement. The guidance is effective for annual fiscal periods beginning after December 15, 2015. We adopted this standard on January 1, 2016, on a retrospective basis and adjusted prior periods presented. In connection with the adoption of this ASU, debt issuance costs of $17 million as of March 31, 2016 and $19 million as of December 31, 2015 were reclassified from deferred charges to long-term debt. The adoption of this standard had no impact on our financial position or overall results of operations.

In March, 2016, the FASB issued ASU 2016-09, "Compensation – Stock Compensation (Topic 718): Improvements to Employee Share-Based Payment Accounting", which amends the accounting for employee share-based payment transactions to require recognition of the tax effects resulting from the settlement of stock-based awards as income tax expense or benefit in the income statement in the reporting period in which they occur. In addition, the ASU requires that all tax-related cash flows resulting from share-based payments, including the excess tax benefits related to the settlement of stock-based awards, be classified as cash flows from operating activities in the statement of cash flows. The ASU also requires that cash paid by directly withholding shares for tax withholding purposes be classified as a financing activity in the statement of cash flows. In addition, the ASU also allows companies to make an accounting policy election to either estimate the number of awards that are expected to vest, consistent with current U.S. GAAP, or account for forfeitures when they occur. The new standard is effective for annual reporting periods beginning after December 15, 2016 with early adoption permitted. We are currently evaluating the effect that ASU 2016-09 will have on our condensed consolidated financial statements and related disclosures.

In May 2014 and March 2016, the FASB issued ASU 2014-09 and ASU 2016-08, "Revenue from Contracts with Customers (Topic 606)" and "Revenue from Contracts with Customers: Principal versus Agent Considerations (Reporting Revenue Gross versus Net)", respectively, which provides guidance for revenue recognition. The standard's core principle is that a company will recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods or services. This ASU also requires additional disclosures. The FASB updated the new revenue standard by clarifying the principal versus agent implementation guidance, but does not change the core principle of the new standard. ASU 2014-09 is effective for annual reporting periods beginning after December 15, 2016; however, in July 2015, the FASB approved a one-year deferral of this standard, with a new effective date for fiscal years beginning after December 15, 2017. We are currently in the process of evaluating the impact of adoption of this ASU on our consolidated financial statements and related disclosures.

In February, 2016, the FASB issued ASU 2016-02, "Leases (Topic 842): Amendments to the FASB Accounting Standards Codification " ("Update 2016-02"), which requires an entity to recognize lease assets and lease liabilities on the balance sheet and to disclose key qualitative and quantitative information about the entity's leasing arrangements. This update is effective for annual reporting periods beginning after December 15, 2018 with early adoption permitted. A modified retrospective approach is required. We are currently evaluating the effect that ASU 2016-02 will have on our consolidated financial statements and related disclosures.

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, behavioral health centers, surgical hospitals, ambulatory surgery centers and radiation oncology centers. As of March 31, 2016, we owned and/or operated 24 inpatient acute care hospitals, 3 free-standing emergency departments and 214 inpatient and 16 outpatient behavioral health care facilities located in 37 states, Washington, D.C., the United Kingdom, Puerto Rico and the U.S. Virgin Islands. In addition, we are building a newly-constructed acute care hospital located in Henderson, Nevada, that is scheduled to be completed and opened during the fourth quarter of 2016. We also manage and/or own outright or in partnerships with physicians, 4 surgical hospitals and surgery and radiation oncology centers located in 4 states.

As a percentage of our consolidated net revenues, net revenues from our acute care hospitals, surgical hospitals, commercial health insurer, surgery centers and radiation oncology centers accounted for 53% and 52% during the three-month periods ended March 31, 2016 and 2015, respectively. Net revenues from our behavioral health care operations accounted for 47% and 48% of our consolidated net revenues during the three-month periods ended March 31, 2016 and 2015, respectively.

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

Forward-Looking Statements and Risk Factors

You should carefully review the information contained in this Quarterly Report, and should particularly consider any risk factors that we set forth in this Quarterly Report and in other reports or documents that we file from time to time with the Securities and Exchange Commission (the "SEC"). In this Quarterly Report, we state our beliefs of future events and of our future financial performance. This Quarterly Report contains "forward-looking statements" that reflect our current estimates, expectations and projections about our future results, performance, prospects and opportunities. Forward-looking statements include, among other things, the information concerning our possible future results of operations, business and growth strategies, financing plans, expectations that regulatory developments or other matters will not have a material adverse effect on our business or financial condition, our competitive position and the effects of competition, the projected growth of the industry in which we operate, and the benefits and synergies to be obtained from our completed and any future acquisitions, and statements of our goals and objectives, and other similar expressions concerning matters that are not historical facts. Words such as "may," "will," "should," "could," "would," "predicts," "potential," "continue," "expects," "anticipates," "future," "intends," "plans," "believes," "estimates," "appears," "projects" and similar expressions, as well as statements in future tense, identify forward-looking statements. In evaluating those statements, you should specifically consider various factors, including the risks related to healthcare industry trends and those detailed in our filings with the SEC including those set forth herein and in our Annual Report on Form 10-K for the year ended December 31, 2015 in *Item 1A Risk Factors* and in *Item 7 Management's Discussion and Analysis of Financial Condition and Results of Operations – Forward Looking Statements and Risk Factors*. Those factors may cause our actual results to differ materially from any of our forward-looking statements.

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

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

- the outcome of known and unknown litigation, government investigations, false claim act allegations, and liabilities and other claims asserted against us and other matters as disclosed in *Item 1. Legal Proceedings;*
- the potential unfavorable impact on our business of deterioration in national, regional and local economic and business conditions, including a worsening of unfavorable credit market conditions;
- competition from other healthcare providers (including physician owned facilities) in certain markets;
- technological and pharmaceutical improvements that increase the cost of providing, or reduce the demand for healthcare;
- our ability to attract and retain qualified personnel, nurses, physicians and other healthcare professionals and the impact on our labor expenses resulting from a shortage of nurses and other healthcare professionals;
- demographic changes;
- our ability to successfully integrate and improve our recent acquisitions and the availability of suitable acquisitions and divestiture opportunities;
- as discussed below in *Sources of Revenue,* we receive revenues from various state and county based programs, including Medicaid in all the states in which we operate, (we receive Medicaid revenues in excess of $90 million annually from each of Texas, Washington, D.C., California, Nevada, Illinois, Pennsylvania, Massachusetts and Virginia); CMS-approved Medicaid supplemental programs in certain states including Texas, Illinois, Oklahoma, Mississippi, California, Ohio and Arkansas, and; state Medicaid disproportionate share hospital payments in certain states including Texas and South Carolina. We are therefore particularly sensitive to potential reductions in Medicaid and other state based revenue programs as well as regulatory, economic, environmental and competitive changes in those states. We can provide no assurance that reductions to revenues earned pursuant to these programs, particularly in the above-mentioned states, will not have a material adverse effect on our future results of operations;
- our ability to continue to obtain capital on acceptable terms, including borrowed funds, to fund the future growth of our business;
- some of our acute care facilities experience decreasing inpatient admission trends;
- our financial statements reflect large amounts due from various commercial and private payors and there can be no assurance that failure of the payors to remit amounts due to us will not have a material adverse effect on our future results of operations;
- in March, 2010, the Health Care and Education Reconciliation Act of 2010 and the Patient Protection and Affordable Care Act were enacted into law and created significant changes to health insurance coverage for U.S. citizens as well as material revisions to the federal Medicare and state Medicaid programs. The two combined primary goals of these acts are to provide for increased access to coverage for healthcare and to reduce healthcare-related expenses. Medicare, Medicaid and other health care industry changes are scheduled to be implemented at various times during this decade. We cannot predict the effect, if any, these enactments will have on our future results of operations;
- the Department of Health and Human Services ("HHS") published final regulations in July, 2010 implementing the health information technology ("HIT") provisions of the American Recovery and Reinvestment Act (referred to as the "HITECH Act"). The final regulation defines the "meaningful use" of Electronic Health Records ("EHR") and establishes the requirements for the Medicare and Medicaid EHR payment incentive programs. The implementation period for these new Medicare and Medicaid incentive payments started in federal fiscal year 2011 and can end as late as 2016 for Medicare and 2021 for the state Medicaid programs. Hospitals that do not qualify as a meaningful user of EHR by 2015 are subject to a reduced market basket update to the inpatient prospective payment system ("IPPS") standardized amount in 2015 and each subsequent fiscal year. We believe that all of our acute care hospitals have met the applicable meaningful use criteria and therefore were not subject to a reduced market basked update to the IPPS standardized amount in federal fiscal year 2015. However, under the HITECH Act, hospitals must continue to meet the applicable meaningful use criteria in each fiscal year or they will be subject to a market basket update reduction in a subsequent fiscal year. Failure of our acute care hospitals to continue to meet the applicable meaningful use criteria would have an adverse effect on our future net revenues and results of operations. There will likely be timing differences in the recognition of the incentive income and expenses recorded in connection with the implementation of the EHR applications which may cause material period-to-period changes in our future results of operations;

- in August, 2011, the Budget Control Act of 2011 (the "2011 Act") was enacted into law. The 2011 Act imposed annual spending limits for most federal agencies and programs aimed at reducing budget deficits by $917 billion between 2012 and 2021, according to a report released by the Congressional Budget Office. Among its other provisions, the law established a bipartisan Congressional committee, known as the Joint Select Committee on Deficit Reduction (the "Joint Committee"), which was tasked with making recommendations aimed at reducing future federal budget deficits by an additional $1.5 trillion over 10 years. The Joint Committee was unable to reach an agreement by the November 23, 2011 deadline and, as a result, across-the-board cuts to discretionary, national defense and Medicare spending were implemented on March 1, 2013 resulting in Medicare payment reductions of up to 2% per fiscal year (annual reduction of approximately $36 million to our Medicare net revenues) 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. 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;
- our accounts receivable as of March 31, 2016 and December 31, 2015 include amounts due from Illinois of approximately $16 million and $28 million, respectively. Collection of the outstanding receivables continues to be delayed due to state budgetary and funding pressures. Approximately $6 million as of March 31, 2016 and $12 million as of December 31, 2015, of the receivables due from Illinois were outstanding in excess of 60 days, as of each respective date. In addition, our accounts receivable as of March 31, 2016 and December 31, 2015 includes approximately $37 million and $80 million, respectively, due from Texas in connection with Medicaid supplemental payment programs. The $37 million due from Texas as of March 31, 2016 consists of $31 million related to uncompensated care program revenues and $6 million related to disproportionate share hospital program revenues. Although the accounts receivable due from Illinois and Texas could remain outstanding for the foreseeable future, since we expect to eventually collect all amounts due to us, no related reserves have been established in our consolidated financial statements. However, we can provide no assurance that we will eventually collect all amounts due to us from Illinois and/or Texas. Failure to ultimately collect all outstanding amounts due from these states would have an adverse impact on our future consolidated results of operations and cash flows;
- there have been several attempts in Congress to repeal or modify various provisions of the Patient Protection and Affordable Care Act (the "PPACA"). We cannot predict whether or not any of these proposed changes to the PPACA will become law and therefore can provide no assurance that changes to the PPACA, as currently implemented, will not have a material adverse effect on our future results of operations;
- uninsured and self-pay patients treated at our acute care facilities unfavorably impact our ability to satisfactorily and timely collect our self-pay patient accounts;
- the ability to obtain adequate levels of general and professional liability insurance on current terms;
- changes in our business strategies or development plans;
- fluctuations in the value of our common stock, and;
- other factors referenced herein or in our other filings with the Securities and Exchange Commission.

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

Critical Accounting Policies and Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires us to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes. We consider our critical accounting policies to be those that require us to make significant judgments and estimates when we prepare our consolidated financial statements. For a summary of our significant accounting policies, please see *Note 1 to the Consolidated Financial Statements* as included in our Annual Report on Form 10-K for the year ended December 31, 2015.

Revenue recognition: We record revenues and related receivables for health care services at the time the services are provided. Medicare and Medicaid revenues represented 33% and 36% of our net patient revenues during the three-month periods ended March 31, 2016 and 2015, respectively. Revenues from managed care entities, including health maintenance organizations and managed Medicare and Medicaid programs, accounted for 52% and 50% of our net patient revenues during the three-month periods ended March 31, 2016 and 2015, respectively.

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

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

The total accrual for our professional and general liability claims and workers' compensation claims was $277 million as of March 31, 2016, of which $82 million is included in current liabilities. The total accrual for our professional and general liability claims and workers' compensation claims was $271 million as of December 31, 2015, of which $82 million is included in current liabilities.

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

Results of Operations

Three-month periods ended March 31, 2016 and 2015:

The following table summarizes our results of operations and is used in the discussion below for the three-month periods ended March 31, 2016 and 2015 (dollar amounts in thousands):

	Three months ended March 31, 2016		Three months ended March 31, 2015	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$2,619,593		$2,380,101	
Less: Provision for doubtful accounts	169,795		154,748	
Net revenues	2,449,798	100.0%	2,225,353	100.0%
Operating charges:				
Salaries, wages and benefits	1,148,139	46.9%	1,031,703	46.4%
Other operating expenses	561,584	22.9%	505,966	22.7%
Supplies expense	255,250	10.4%	238,741	10.7%
Depreciation and amortization	104,049	4.2%	98,998	4.4%
Lease and rental expense	24,452	1.0%	22,891	1.0%
Subtotal-operating expenses	2,093,474	85.5%	1,898,299	85.3%
Income from operations	356,324	14.5%	327,054	14.7%
Interest expense, net	29,600	1.2%	30,037	1.3%
Income before income taxes	326,724	13.3%	297,017	13.3%
Provision for income taxes	111,005	4.5%	102,694	4.6%
Net income	215,719	8.8%	194,323	8.7%
Less: Income attributable to noncontrolling interests	24,960	1.0%	20,024	0.9%
Net income attributable to UHS	$ 190,759	7.8%	$ 174,299	7.8%

Net revenues increased 10%, or $224 million, to $2.45 billion during the three-month period ended March 31, 2016 as compared to $2.23 billion during the first quarter of 2015. The net increase was primarily attributable to: (i) a $173 million or 8% 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) $51 million of other combined revenue increases consisting primarily of the revenues generated at 4 behavioral health care hospitals acquired in the U.K. during the third quarter of 2015 and 4 inpatient facilities and 8 outpatient centers acquired during the third quarter of 2015 as a result of our acquisition of Foundations Recovery Network, LLC.

Income before income taxes (before deduction for income attributable to noncontrolling interests) increased $30 million to $327 million during the three-month period ended March 31, 2016 as compared to $297 million during the comparable quarter of the prior year. The net increase in our income before income taxes during the first quarter of 2016, as compared to the comparable quarter of 2015, was due to:

a. an increase of $31 million at our acute care facilities as discussed below in Acute Care Hospital Services;

b. an increase of $12 million at our behavioral health care facilities, as discussed below in Behavioral Health Services, and;

c. $13 million of other combined net decreases.

Net income attributable to UHS increased $16 million to $191 million during the three-month period ended March 31, 2016 as compared to $174 million during the comparable prior year quarter. The increase during the first quarter of 2016, as compared to the comparable prior year quarter, consisted of:

- an increase of $30 million in income before income taxes, as discussed above;
- a decrease of $5 million resulting from an increase in the income attributable to noncontrolling interests, and;
- a decrease of $8 million resulting from an increase in the provision for income taxes recorded on the $25 million increase in pre-tax income ($30 million increase in income before income taxes less $5 million increase in income attributable to noncontrolling interests).

Acute Care Hospital Services

Same Facility Basis Acute Care Hospital Services

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

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-month periods ended March 31, 2016 and 2015 (dollar amounts in thousands):

	Three months ended March 31, 2016		Three months ended March 31, 2015	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$ 1,408,961		$ 1,257,470	
Less: Provision for doubtful accounts	139,755		124,350	
Net revenues	1,269,206	100.0%	1,133,120	100.0%
Operating charges:				
Salaries, wages and benefits	509,396	40.1%	455,944	40.2%
Other operating expenses	285,046	22.5%	253,097	22.3%
Supplies expense	206,768	16.3%	191,282	16.9%
Depreciation and amortization	59,046	4.7%	57,080	5.0%
Lease and rental expense	13,042	1.0%	12,553	1.1%
Subtotal-operating expenses	1,073,298	84.6%	969,956	85.6%
Income from operations	195,908	15.4%	163,164	14.4%
Interest expense, net	821	0.1%	1,017	0.1%
Income before income taxes	$ 195,087	15.4%	$ 162,147	14.3%

Three-month periods ended March 31, 2016 and 2015:

During the three-month period ended March 31, 2016, as compared to the comparable prior year quarter, net revenues from our acute care hospital services, on a same facility basis, increased $136 million or 12.0%. Income before income taxes (and before income attributable to noncontrolling interests) increased $33 million or 20% to $195 million or 15.4% of net revenues during the first quarter of 2016 as compared to $162 million or 14.3% of net revenues during the comparable prior year quarter.

During the three-month period ended March 31, 2016, net revenue per adjusted admission increased 3.0% and net revenue per adjusted patient day increased 7.3%, as compared to the comparable quarter of the prior year. During the three-month period ended March 31, 2016, as compared to the comparable prior year quarter, inpatient admissions to our acute care hospitals increased 6.5% and adjusted admissions (adjusted for outpatient activity) increased 7.8%. Patient days at these facilities increased 2.3% and adjusted patient days increased 3.5% during the three-month period ended March 31, 2016 as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities was 4.7 days and 4.9 days during the three-month periods ended March 31, 2016 and 2015, respectively. The occupancy rate, based on the average available beds at these facilities, was 63% during each of the three-month periods ended March 31, 2016 and 2015.

All Acute Care Hospitals

The following table summarizes the results of operations for all our acute care operations during the three-month periods ended March 31, 2016 and 2015. These amounts include: (i) our acute care results on a same facility basis, as indicated above; (ii) the impact of the implementation of EHR applications at our acute care hospitals; (iii) the impact of provider tax assessments which increased net revenues and other operating expenses but had no impact on income before income taxes, and; (iv) certain other amounts. Dollar amounts below are reflected in thousands.

	Three months ended March 31, 2016		Three months ended March 31, 2015	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$ 1,426,902		$ 1,270,290	
Less: Provision for doubtful accounts	139,755		124,350	
Net revenues	1,287,147	100.0%	1,145,940	100.0%
Operating charges:				
Salaries, wages and benefits	512,022	39.8%	456,772	39.9%
Other operating expenses	299,961	23.3%	262,655	22.9%
Supplies expense	206,768	16.1%	191,282	16.7%
Depreciation and amortization	68,615	5.3%	66,461	5.8%
Lease and rental expense	13,042	1.0%	12,553	1.1%
Subtotal-operating expenses	1,100,408	85.5%	989,723	86.4%
Income from operations	186,739	14.5%	156,217	13.6%
Interest expense, net	821	0.1%	1,017	0.1%
Income before income taxes	$ 185,918	14.4%	$ 155,200	13.5%

Three-month periods ended March 31, 2016 and 2015:

Income before income taxes increased $31 million or 20% to $186 million during the first quarter of 2016 as compared to $155 million during the first quarter of 2015. The increase in income before income taxes at our acute care facilities resulted from:

- a $33 million increase at our acute care facilities on a same facility basis, as discussed above, and;
- a decrease of $2 million from other combined net changes.

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

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

A portion of the accounts receivable at our acute care facilities are comprised of Medicaid accounts that are pending approval from third-party payers but we also have smaller amounts due from other miscellaneous payers such as county indigent programs in certain states. Our patient registration process includes an interview of the patient or the patient's responsible party at the time of registration. At that time, an insurance eligibility determination is made and an insurance plan code is assigned. There are various pre-established insurance profiles in our patient accounting system which determine the expected insurance reimbursement for each patient based on the insurance plan code assigned and the services rendered. Certain patients may be classified as Medicaid pending at registration based upon a screening evaluation if we are unable to definitively determine if they are currently Medicaid eligible. When a patient is registered as Medicaid eligible or Medicaid pending, our patient accounting system records net revenues for services provided to that

patient based upon the established Medicaid reimbursement rates, subject to the ultimate disposition of the patient's Medicaid eligibility. When the patient's ultimate eligibility is determined, reclassifications may occur which impacts the reported amounts in future periods for the provision for doubtful accounts and other accounts such as Medicaid pending. Although the patient's ultimate eligibility determination may result in amounts being reclassified among these accounts from period to period, these reclassifications did not have a material impact on our results of operations during the three-month periods ended March 31, 2016 and 2015 since our facilities make estimates at each financial reporting period to reserve for amounts that are deemed to be uncollectible.

We also provide discounts to uninsured patients (included in "uninsured discounts" amounts below) who do not qualify for Medicaid or charity care. Because we do not pursue collection of amounts classified as uninsured discounts, they are not reported in our net revenues or in our net accounts receivable. In implementing the discount policy, we first attempt to qualify uninsured patients for governmental programs, charity care or any other discount program. If an uninsured patient does not qualify for these programs, the uninsured discount is applied. Our accounts receivable are recorded net of allowance for doubtful accounts of $366 million and $399 million at March 31, 2016 and December 31, 2015, respectively.

The following tables show the amounts recorded at our acute care hospitals for charity care and uninsured discounts, based on charges at established rates, for the three-month periods ended March 31, 2016 and 2015:

Uncompensated care:

Amounts in millions	Three Months Ended			
	March 31, 2016	%	March 31, 2015	%
Charity care	$ 186	54%	$ 132	46%
Uninsured discounts	159	46%	155	54%
Total uncompensated care	$ 345	100%	$ 287	100%

As reflected on the table above in All Acute Care Hospitals, the provision for doubtful accounts at our acute care hospitals amounted to approximately $140 million and $124 million during the three-month periods ended March 31, 2016 and 2015, respectively. During the three-month period ended March 31, 2016, as compared to the comparable quarter of 2015, our acute care hospitals experienced an increase in the aggregate of charity care, uninsured discounts and provision for doubtful accounts as a percentage of gross charges.

Estimated cost of providing uncompensated care:

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

Estimated cost of providing uncompensated care

Amounts in millions	Three Months Ended	
	March 31, 2016	March 31, 2015
Estimated cost of providing charity care	$ 26	$ 18
Estimated cost of providing uninsured discounts related care	22	22
Estimated cost of providing uncompensated care	$ 48	$ 40

Behavioral Health Services

Our same facility basis results which include the operating results for facilities and businesses operated in both the current year and prior year period, neutralize the effect of items that are non-operational in nature including items such as, but not limited to, gains on sales of assets and businesses, impacts of settlements, legal judgments and lawsuits and other amounts that may be reflected in the current or prior year financial statements that relate to prior periods. Our same facility basis results reflected on the tables 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 Behavioral Health Care Facilities*. 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.

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-month periods ended March 31, 2016 and 2015 (dollar amounts in thousands):

Same Facility—Behavioral Health

	Three months ended March 31, 2016		Three months ended March 31, 2015	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$1,119,045		$1,083,119	
Less: Provision for doubtful accounts	29,335		30,266	
Net revenues	1,089,710	100.0%	1,052,853	100.0%
Operating charges:				
Salaries, wages and benefits	535,762	49.2%	507,967	48.2%
Other operating expenses	203,973	18.7%	199,459	18.9%
Supplies expense	46,498	4.3%	46,107	4.4%
Depreciation and amortization	31,448	2.9%	29,447	2.8%
Lease and rental expense	9,822	0.9%	9,439	0.9%
Subtotal-operating expenses	827,503	75.9%	792,419	75.3%
Income from operations	262,207	24.1%	260,434	24.7%
Interest expense, net	452	0.0%	475	0.0%
Income before income taxes	$ 261,755	24.0%	$ 259,959	24.7%

Three-month periods ended March 31, 2016 and 2015:

On a same facility basis during the first quarter of 2016, as compared to the first quarter of 2015, net revenues at our behavioral health care facilities increased 4% or $37 million to $1.09 billion from $1.05 billion. Income before income taxes increased $2 million or 1% to $262 million or 24.0% of net revenues during the three-month period ended March 31, 2016, as compared to $260 million or 24.7% of net revenues during the comparable prior year quarter.

During the three-month period ended March 31, 2016, net revenue per adjusted admission increased 1.8% and net revenue per adjusted patient day increased 2.2%, as compared to the comparable quarter of 2015. On a same facility basis, inpatient admissions and adjusted admissions to our behavioral health facilities increased 1.6% and 1.4%, respectively, during the three-month period ended March 31, 2016 as compared to the comparable quarter of 2015. Patient days and adjusted patient days increased 1.2% and 1.0%, respectively, during the three-month period ended March 31, 2016 as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities remained unchanged at 12.7 days during each of the three-month periods ended March 31, 2016 and 2015. The occupancy rate, based on the average available beds at these facilities, was 76% and 77% during the three-month periods ended March 31, 2016 and 2015, respectively.

All Behavioral Health Care Facilities

The following table summarizes the results of operations for all our behavioral health care facilities during the three-month periods ended March 31, 2016 and 2015 which includes our behavioral health results on a same facility basis, the impact of the facilities acquired or opened within the previous twelve months, and the impact of provider tax assessments which increased net revenues and other operating expenses but had no impact on income before income taxes (dollar amounts in thousands):

	Three months ended March 31, 2016		Three months ended March 31, 2015	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$1,191,090		$1,106,701	
Less: Provision for doubtful accounts	30,044		30,356	
Net revenues	1,161,046	100.0%	1,076,345	100.0%
Operating charges:				
Salaries, wages and benefits	564,872	48.7%	513,875	47.7%
Other operating expenses	237,023	20.4%	221,179	20.5%
Supplies expense	48,336	4.2%	46,545	4.3%
Depreciation and amortization	33,532	2.9%	30,706	2.9%
Lease and rental expense	11,262	1.0%	10,123	0.9%
Subtotal-operating expenses	895,025	77.1%	822,428	76.4%
Income from operations	266,021	22.9%	253,917	23.6%
Interest expense, net	444	0.0%	475	0.0%
Income before income taxes	$ 265,577	22.9%	$ 253,442	23.5%

Three-month periods ended March 31, 2016 and 2015:

Income before income taxes increased $12 million or 5% to $266 million during the first quarter of 2016 as compared to $253 million during the first quarter of 2015. The increase in income before income taxes at our behavioral health care facilities resulted from:

- a $2 million increase at our behavioral health care facilities on a same facility basis, as discussed above, and;
- an increase of $10 million from other combined net changes, including the income generated at 4 behavioral health care facilities acquired in the U.K. during the third quarter of 2015 and 4 inpatient facilities and 8 outpatient centers acquired during the third quarter of 2015 as a result of our acquisition of Foundations Recovery Network, LLC.

Sources of Revenue

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

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

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

The following table shows the approximate percentages of net patient revenue for the three-month periods ended March 31, 2016 and 2015 presented on: (i) a combined basis for both our acute care and behavioral health facilities; (ii) for our acute care facilities only, and; (iii) for our behavioral health facilities only. Net patient revenue is defined as revenue from all sources after deducting contractual allowances and discounts from established billing rates, which we derived from various sources of payment for the periods indicated.

Acute Care and Behavioral Health Facilities Combined	Percentage of Net Patient Revenues Three Months Ended March 31,	
	2016	2015
Third Party Payors:		
Medicare	20%	22%
Medicaid	13%	14%
Managed Care (HMO and PPOs)	52%	50%
Other Sources	15%	14%
Total	100%	100%

Acute Care Facilities	Percentage of Net Patient Revenues Three Months Ended March 31,	
	2016	2015
Third Party Payors:		
Medicare	26%	27%
Medicaid	6%	7%
Managed Care (HMO and PPOs)	62%	60%
Other Sources	6%	6%
Total	100%	100%

Behavioral Health Facilities	Percentage of Net Patient Revenues Three Months Ended March 31,	
	2016	2015
Third Party Payors:		
Medicare	14%	17%
Medicaid	19%	21%
Managed Care (HMO and PPOs)	41%	40%
Other Sources	26%	22%
Total	100%	100%

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

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

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

In April, 2016, CMS published its IPPS 2017 proposed payment rule which provides for a 2.8% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments and Health Care Reform mandated adjustments are considered, without consideration for the decreases related to the required Medicare Disproportionate Share Hospital ("DSH") payment changes and increase to the Medicare Outlier threshold, the overall increase in IPPS payments would approximate 0.9%. Including the estimated decreases to our DSH payments (approximating 0.5%), we estimate our overall decrease from the proposed IPPS 2017 rule (covering the period of October 1, 2016 through September 30, 2017) will approximate -0.1%. This projected impact from the IPPS 2017 proposed rule includes both the impact of the American Taxpayer Relief Act of 2012 documentation and coding adjustment and the required changes to the DSH payments related to the traditional Medicare fee for service, however, it excludes the impact of the sequestration reductions related to the Budget Control Act of 2011, and Bipartisan Budget Act of 2015, as discussed below.

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

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

In August, 2013, CMS published its final IPPS 2014 payment rule which expanded CMS's policy under which it defines inpatient admissions to include the use of an objective time of care standard. Specifically, it would require Medicare's external review contractors to presume that hospital inpatient admissions are reasonable and necessary when beneficiaries receive a physician order for admission and receive medically necessary services for at least two midnights (the "Two Midnight" rule). Correspondingly, under the final rule, CMS presumes that hospital services spanning less than two midnights should have been provided on an outpatient basis and paid under Medicare Part B unless the medical record contains clear documentation supporting the physician's order and an expectation that the Medicare beneficiary would need medically necessary care for more than two midnights, or is receiving services which CMS designates as inpatient only. In April, 2015, Congress voted to extend an enforcement moratorium on the Two Midnight rule through the end of fiscal year 2015. Although the prohibition of recovery auditor patient status reviews expired on October 1, 2015, CMS did not approve recovery auditors to conduct patient status reviews for admission dates through December 31, 2015.

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

In its IPPS 2017 proposed payment rule, CMS has proposed to: (i) reverse the Two-Midnight rule's 0.2% reduction in hospital payments, and; (ii) implement a temporary one-time increase of 0.6% in FFY2017 payments to offset cuts in the three preceding fiscal years.

In August, 2011, the Budget Control Act of 2011 (the "2011 Act") was enacted into law. Included in this law are the imposition of annual spending limits for most federal agencies and programs aimed at reducing budget deficits by $917 billion between 2012 and 2021, according to a report released by the Congressional Budget Office. Among its other provisions, the law established a bipartisan Congressional committee, known as the Joint Committee, which was responsible for developing recommendations aimed at reducing future federal budget deficits by an additional $1.5 trillion over 10 years. The Joint Committee was unable to reach an agreement by the November 23, 2011 deadline and, as a result, across-the-board cuts to discretionary, national defense and Medicare spending were implemented on March 1, 2013 resulting in Medicare payment reductions of up to 2% per fiscal year. The Bipartisan Budget Act of 2015, enacted on November 2, 2015, continued the 2% reductions to Medicare reimbursement imposed under the 2011 Act. For federal fiscal year 2015, the aggregate annual sequestration reduction to our Medicare net revenues was approximately $36 million with a uniform percentage reduction across all Medicare programs.

On January 2, 2013 ATRA was enacted which, among other things, includes a requirement for CMS to recoup $11 billion from hospitals from Medicare IPPS rates during federal fiscal years 2014 to 2017. The recoupment relates to IPPS documentation and coding adjustments for the period 2008 to 2013 for which adjustments were not previously applied by CMS. Both the 2014 and 2015 IPPS final rules include a -0.8% recoupment adjustment. CMS has included the same 0.8% recoupment adjustment in fiscal year 2016 and has proposed to include a 1.5% recoupment adjustment in federal fiscal year 2017 in order to recover the entire $11 billion. This adjustment is reflected in the IPPS estimated impact amounts noted above. On April 16, 2015, the Medicare Access and CHIP Reauthorization Act of 2015 was enacted and an anticipated 3.2% payment increase in 2018 is scheduled to be phased in at 0.5% per year over 6 years beginning in fiscal year 2018.

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

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

In October, 2015, CMS published its OPPS final rule for 2016. The hospital market basket increase is 2.4%. The Medicare statute requires a productivity adjustment reduction of 0.5% and 0.2% reduction to the 2016 OPPS market basket. Additionally, CMS also proposes a reduction of 2.0%, which the CMS claims is necessary to eliminate $1 billion in excess laboratory payments that CMS packaged into OPPS payment rates in 2014 resulting in a 2016 OPPS market basket update at -0.3%. When other statutorily required adjustments and hospital patient service mix are considered, we estimate that our overall Medicare OPPS update for 2016 will aggregate to a net decrease of -0.2% which includes a 7.0% increase to behavioral health division partial hospitalization rates. When the behavioral health division's partial hospitalization rate impact is excluded, we estimate that our Medicare 2016 OPPS payments will result in -1.6% decrease in payment levels for our acute care division, as compared to 2015.

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

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

managing Medicaid. All of our acute care hospitals and most of our behavioral health centers are certified as providers of Medicaid services by the appropriate governmental authorities.

We receive Medicaid revenues in excess of $90 million annually from each of Texas, Washington, D.C., California, Nevada, Illinois, Pennsylvania, Massachusetts and Virginia, making us particularly sensitive to reductions in Medicaid and other state based revenue programs as well as regulatory, economic, environmental and competitive changes in those states.

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

Texas and South Carolina Medicaid Disproportionate Share Hospital Payments:

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

Upon meeting certain conditions and serving a disproportionately high share of Texas' and South Carolina's low income patients, five of our facilities located in Texas and one facility located in South Carolina received additional reimbursement from each state's DSH fund. The South Carolina and Texas DSH programs were renewed for each state's 2016 DSH fiscal year (covering the period of October 1, 2015 through September 30, 2016). During the second quarter of 2015, the Texas Health and Human Services Commission ("THHSC") finalized DSH payments for federal fiscal year 2014 which resulted in a $6 million annualized reduction in our Texas Medicaid DSH payments retroactive to October, 2013. In connection with these DSH programs, included in our financial results was an aggregate of $7 million and $13 million during the three-month periods ended March 31, 2016 and 2015, respectively. We expect reimbursements to our hospitals, pursuant to the 2016 fiscal year programs for Texas and South Carolina, to be at amounts similar to each state's 2015 fiscal year amounts.

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

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.

Under the various state Medicaid supplemental payment programs including the impact of the below-mentioned Uncompensated Care and Upper Payment Limit programs, the Texas Delivery System Reform Incentive program and the Nevada state plan amendment, we earned revenues (before Provider Taxes) of approximately $78 million and $68 million during the three-month periods ended March 31, 2016 and 2015, respectively. These revenues were offset by Provider Taxes of $36 million and $28 million during the three-month periods ended March 31, 2016 and 2015, respectively, which are recorded in other operating expenses on the Condensed Consolidated Statements of Income as included herein. We estimate that our aggregate net revenues/benefit from the various state Medicaid supplemental payment programs (including Provider Tax programs) will approximate $170 million (net of Provider Taxes of $152 million) during 2016. The aggregate net benefit is earned from multiple states and therefore no particular state's portion is individually material to our consolidated financial statements. However, Provider Taxes are governed by both federal and state laws and are subject to future legislative changes that, if reduced from current rates in several states, could have a material adverse impact on our consolidated future results of operations.

Texas Uncompensated Care/Upper Payment Limit Payments:

Certain of our acute care hospitals located in various counties of Texas (Hidalgo, Maverick, Potter and Webb) participate in Medicaid supplemental payment Section 1115 Waiver indigent care programs. Section 1115 Waiver Uncompensated Care ("UC") payments replace the former Upper Payment Limit ("UPL") payments. These hospitals also have affiliation agreements with third-party hospitals to provide free hospital and physician care to qualifying indigent residents of these counties. Our hospitals receive both supplemental payments from the Medicaid program and indigent care payments from third-party, affiliated hospitals. The supplemental payments are contingent on the county or hospital district making an Inter-Governmental Transfer ("IGT") to the state Medicaid program while the indigent care payment is contingent on a transfer of funds from the applicable affiliated hospitals. However, the county or hospital district is prohibited from entering into an agreement to condition any IGT on the amount of any private hospital's indigent care obligation.

We recorded net revenues/benefit from UC and affiliated hospital indigent care revenues of $15 million during each of the three-month periods ended March 31, 2016 and 2015, respectively, net of Provider Taxes of $1 million and $3 million during the first quarters of 2016 and 2015, respectively. If the applicable hospital district or county makes IGTs consistent with 2015 levels, we believe we would be entitled to aggregate net revenues/benefit earned pursuant to these programs of approximately $55 million (net of Provider Taxes of $10 million) during 2016.

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

For state fiscal year 2016, Texas Medicaid will continue to operate under a CMS-approved Section 1115 five-year Medicaid waiver demonstration program. During the first five years of this program that started in state fiscal year 2012, the THHSC transitioned away from UPL payments to new waiver incentive payment programs, UC payments and Delivery System Reform Incentive Payments ("DSRIP"). During the first year of transition, which commenced on October 1, 2011, THHSC made payments to Medicaid UPL recipient providers that received payments during the state's prior fiscal year. During demonstration years two through five (October 1, 2012 through September 30, 2016), THHSC has, and will continue to, make incentive payments under the program after certain qualifying criteria are met by hospitals. Supplemental payments are also subject to aggregate statewide caps based on CMS approved Medicaid waiver amounts. In May, 2016, CMS approved a 15-month extension of the 1115 Waiver until December 31, 2017 at terms relatively consistent with current Waiver terms and conditions. The UC and DSRIP pools will continue to be funded at their current levels of $3.1 billion annually on a pro rata basis.

Texas Delivery System Reform Incentive Payments:

In addition, the Texas Medicaid Section 1115 Waiver includes a DSRIP pool to incentivize hospitals and other providers to transform their service delivery practices to improve quality, health status, patient experience, coordination, and cost-effectiveness. DSRIP pool payments are incentive payments to hospitals and other providers that develop programs or strategies to enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. In May, 2014, CMS formally approved specific DSRIP projects for certain of our hospitals for demonstration years 3 to 5 (our facilities did not materially participate in the DSRIP pool during demonstration years 1 or 2). DSRIP payments are contingent on the hospital meeting certain pre-determined milestones, metrics and clinical outcomes. Additionally, DSRIP payments are contingent on a governmental entity providing an IGT for the non-federal share component of the DSRIP payment. THHSC generally approves DSRIP reported metrics, milestones and clinical outcomes on a semi-annual basis in June and December.

There were essentially no DSRIP revenues/benefit recorded during the three-month periods ended March 31, 2016 and 2015. Although we can provide no assurance that we will ultimately qualify for additional DSRIP revenues, subject to CMS's approval and other conditions as outlined above, we estimate that we may be entitled to additional DSRIP revenues/benefit of approximately $25 million (net of Provider Taxes of $16 million) during 2016.

Nevada SPA:

In Nevada, CMS approved a state plan amendment ("SPA") in August, 2014 that implemented a hospital supplemental payment program retroactive to January 1, 2014 and effective to June 30, 2015. In September, 2015, CMS also approved the successor supplemental payment program retroactive to July 1, 2015 to June 30, 2016. Included in our financial results for the three-month

periods ended March 31, 2016 and 2015, was approximately $4 million and $2 million, respectively, recorded in connection with this program. We estimate that our reimbursements pursuant to this program will approximate $10 million during 2016.

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's) 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. The Company is unable to determine the financial impact of this aspect of the final rule. However, we can provide no assurance that the final rule will not have a material adverse effect on our future results of operations.

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

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

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

Our consolidated results of operations during each of the three-month periods ended March 31, 2016 and 2015 include an unfavorable pre-tax impact of approximately $5 million related primarily to the depreciation and amortization expense incurred in connection with the implementation of electronic health records applications ("EHR") at our acute care hospitals.

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

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

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

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

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

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

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

Implemented Medicare Reductions and Reforms:

- The Reconciliation Act reduced the market basket update for inpatient and outpatient hospitals and inpatient behavioral health facilities by 0.25% in each of 2010 and 2011, by 0.10% in each of 2012 and 2013, 0.30% in 2014 and 0.20% in 2015.
- The Affordable Care Act implemented certain reforms to Medicare Advantage payments, effective in 2011.
- A Medicare shared savings program, effective in 2012.
- A hospital readmissions reduction program, effective in 2012.
- A value-based purchasing program for hospitals, effective in 2012.
- A national pilot program on payment bundling, effective in 2013.
- Reduction to Medicare disproportionate share hospital ("DSH") payments, effective in 2014, as discussed above.

Medicaid Revisions:

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

  $2.0 billion for FFY 2018

  $3.0 billion for FFY 2019

  $4.0 billion for FFY 2020

  $5.0 billion for FFY 2021

  $6.0 billion for FFY 2022

  $7.0 billion for FFY 2023

  $8.0 billion for FFY 2024

  $8.0 billion for FFY 2025

Health Insurance Revisions:

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

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

Value-Based Purchasing:

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

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

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

Readmission Reduction Program:

In the Affordable Care Act, Congress also mandated implementation of the hospital readmission reduction program ("HRRP"). 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 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. The impact of HRRP for federal fiscal year 2016 will not have a material adverse effect on our results of operations.

Accountable Care Organizations:

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

In addition to statutory and regulatory changes to the Medicare and each of the state Medicaid programs, our operations and reimbursement may be affected by administrative rulings, new or novel interpretations and determinations of existing laws and regulations, post-payment audits, requirements for utilization review and new governmental funding restrictions, all of which may materially increase or decrease program payments as well as affect the cost of providing services and the timing of payments to our facilities. The final determination of amounts we receive under the Medicare and Medicaid programs often takes many years, because

of audits by the program representatives, providers' rights of appeal and the application of numerous technical reimbursement provisions. We believe that we have made adequate provisions for such potential adjustments. Nevertheless, until final adjustments are made, certain issues remain unresolved and previously determined allowances could become either inadequate or more than ultimately required.

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

Other Operating Results

Interest Expense:

As reflected on the schedule below, interest expense was $30 million during each of the three-month periods ended March 31, 2016 and 2015 (amounts in thousands):

	Three Months Ended March 31, 2016	Three Months Ended March 31, 2015
Revolving credit & demand notes	$ 1,595	$ 798
$400 million, 7.125% Senior Notes due 2016	7,124	7,124
$300 million, 3.75% Senior Notes due 2019	2,812	2,812
$300 million, 4.75% Senior Notes due 2022	3,563	3,563
Term loan facility A	8,347	7,528
Accounts receivable securitization program (a.)	1,203	781
Subtotal-revolving credit, demand notes, Senior Notes, term loan facilities and accounts receivable securitization program	24,644	22,606
Interest rate swap expense, net	2,269	4,148
Amortization of financing fees	1,780	1,763
Other combined interest expense	1,298	1,525
Capitalized interest on major projects	(361)	0
Interest income	(30)	(5)
Interest expense, net	$ 29,600	$ 30,037

(a.) In December, 2015, we amended our accounts receivable securitization program, which was scheduled to expire in October, 2016, to extend the term through December 21, 2018 and increase the borrowing limit to $400 million from $360 million.

Interest expense was relatively unchanged during the three-month period ended March 31, 2016, as compared to the comparable quarter of 2015. The aggregate interest expense on our revolving credit, demand notes, senior notes, term loan facility and accounts receivable securitization program increased by $2 million during the three-month period ended March 31, 2016, as compared to the comparable quarter of 2015 primarily due to an increase in our average outstanding borrowings, partially offset by a decrease in our aggregate average cost of borrowings pursuant to these facilities. Additionally, our interest rate swap expense decreased by $2 million during the three months ended March 31, 2016, as compared to the three months ended March 31, 2015, resulting primarily from the May, 2015, maturity of our previously outstanding interest rate swaps.

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-month periods ended March 31, 2016 and 2015 (dollar amounts in thousands):

	Three months ended	
	March 31, 2016	March 31, 2015
Provision for income taxes	$ 111,005	$ 102,694
Income before income taxes	326,724	297,017
Effective tax rate	34.0%	34.6%

Outside owners hold various noncontrolling, minority ownership interests in seven of our acute care facilities (excluding a new acute care hospital located in Henderson, Nevada which is currently under construction) and one behavioral health care facility. Each of

these facilities are owned and operated by limited liability companies ("LLC") or limited partnerships ("LP"). As a result, since there is no income tax liability incurred at the LLC/LP level (since it passes through to the members/partners), the net income attributable to noncontrolling interests does not include any income tax provision/benefit. When computing the provision for income taxes, as reflected on our consolidated statements of income, the net income attributable to noncontrolling interests is deducted from income before income taxes since it represents the third-party members'/partners' share of the income generated by the joint-venture entities. In addition to providing the effective tax rates, as indicated above (as calculated from dividing the provision for income taxes by the income before income taxes as reflected on the consolidated statements of income), we believe it is helpful to our investors that we also provide our effective tax rate as calculated after giving effect to the portion of our pre-tax income that is attributable to the third-party members/partners.

The effective tax rates, as calculated by dividing the provision for income taxes by the difference in income before income taxes, minus net income attributable to noncontrolling interests, were as follows for the three-month periods ended March 31, 2016 and 2015 (dollar amounts in thousands):

	Three months ended	
	March 31, 2016	March 31, 2015
Provision for income taxes	$ 111,005	$ 102,694
Income before income taxes	326,724	297,017
Less: Net income attributable to noncontrolling interests	(24,960)	(20,024)
Income before income taxes and after net income attributable to noncontrolling interests	301,764	276,993
Effective tax rate	36.8%	37.1%

Liquidity

Net cash provided by operating activities

Net cash provided by operating activities was $464 million during the three-month period ended March 31, 2016 and $271 million during the comparable period of 2015. The net increase of $193 million was primarily attributable to the following:

- a favorable change of $29 million due to an increase in net income plus/minus depreciation and amortization expense and stock-based compensation expense;
- a $129 million favorable change in other working capital accounts due primarily to favorable changes in accrued compensation and accounts payable resulting from the timing of disbursements;
- a $17 million favorable change in accounts receivable;
- a $9 million favorable change in accrued insurance expense net of payment made in settlement of self-insured claims, and;
- $9 million of other combined net favorable changes.

Days sales outstanding ("DSO"): Our DSO are calculated by dividing our net revenue by the number of days in the three-month periods. The result is divided into the accounts receivable balance at March 31st of each year to obtain the DSO. Our DSO were 51 days at March 31, 2016 and 56 days at March 31, 2015.

Our accounts receivable as of March 31, 2016 and December 31, 2015 include amounts due from Illinois of approximately $16 million and $28 million, respectively. Collection of the outstanding receivables continues to be delayed due to state budgetary and funding pressures. Approximately $6 million as of March 31, 2016 and $12 million as of December 31, 2015, of the receivables due from Illinois were outstanding in excess of 60 days, as of each respective date. In addition, our accounts receivable as of March 31, 2016 and December 31, 2015 includes approximately $37 million and $80 million, respectively, due from Texas in connection with Medicaid supplemental payment programs. The $37 million due from Texas as of March 31, 2016 consists of $31 million related to uncompensated care program revenues and $6 million related to disproportionate share hospital program revenues. Although the accounts receivable due from Illinois and Texas could remain outstanding for the foreseeable future, since we expect to eventually collect all amounts due to us, no related reserves have been established in our consolidated financial statements. However, we can provide no assurance that we will eventually collect all amounts due to us from Illinois and/or Texas. Failure to ultimately collect all outstanding amounts due from these states would have an adverse impact on our future consolidated results of operations and cash flows;

Net cash used in investing activities

The $147 million of net cash used in investing activities during the first three months of 2016 consisted of:

- $127 million spent on capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities and the construction costs related to Henderson Hospital, a newly constructed 142-bed acute care facility scheduled to be completed and opened during the fourth quarter of 2016, and;
- $20 million spent related to the acquisition of businesses and property;

The $124 million of net cash used in investing activities during the first three months of 2015 consisted of:

- $89 million spent on capital expenditures, and;
- $35 million spent related to the acquisition of businesses and property including the acquisition of a 46-bed behavioral health care facility located in the U.K.

Net cash used in financing activities

During the first three months of 2016, we used $323 million of net cash in financing activities as follows:

- spent $167 million on net repayments of debt due primarily to repayments pursuant to our revolving credit facility ($105 million), term loan A facility ($11 million), accounts receivable securitization program ($50 million) and various other debt facilities ($1 million);
- generated $14 million of proceeds from new borrowings pursuant to our on-demand credit facility;
- generated $11 million of excess income tax benefits related to stock-based compensation;
- spent $171 million to repurchase shares of our Class B Common Stock in connection with: (i) income tax withholding obligations related to stock-based compensation programs ($12 million), and; (ii) open market purchases pursuant to our $400 million stock repurchase program ($159 million);
- spent $10 million to pay quarterly cash dividends of $.10 per share;
- spent $3 million to pay profit distributions related to noncontrolling interests in majority owned businesses, and;
- generated $2 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

During the first three months of 2015, we used $144 million of net cash in financing activities as follows:

- spent $159 million on net repayments of debt due primarily to repayments pursuant to our revolving credit facility ($140 million), term loan A facility ($11 million), accounts receivable securitization program ($5 million) and various other debt facilities ($3 million);
- generated $21 million of proceeds from new borrowings pursuant to our on-demand credit facility;
- generated $21 million of excess income tax benefits related to stock-based compensation;
- spent $29 million to repurchase shares of our Class B Common Stock in connection with: (i) income tax withholding obligations related to stock-based compensation programs ($23 million), and; (ii) open market purchases pursuant to our $400 million stock repurchase program ($6 million);
- generated $13 million from the sale/leaseback of two free-standing emergency departments;
- spent $10 million to pay quarterly cash dividends of $.10 per share;
- spent $2 million to pay profit distributions related to noncontrolling interests in majority owned businesses, and;
- generated $2 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

Expected Capital Expenditures During the Remainder of 2016:

During the remaining nine months of 2016, we expect to spend approximately $275 million to $300 million on capital expenditures which includes expenditures for capital equipment, renovations, new projects at existing hospitals and construction of new facilities (Henderson Hospital). 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

On August 7, 2014, we entered into a Fourth Amendment (the "Fourth Amendment") to our credit agreement dated as of November 15, 2010, as amended on March 15, 2011, September 21, 2012 and May 16, 2013, among UHS, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders ("Credit Agreement"). The Credit Agreement, as amended, which is scheduled to mature in August, 2019, consists of: (i) an $800 million revolving credit facility ($195 million of borrowings outstanding as of March 31, 2016), and; (ii) a $1.775 billion term loan A facility ($1.708 billion of borrowings outstanding as of March 31, 2016) which combined our previously outstanding term loan A and term loan A2 facilities which were scheduled to mature in 2016.

Borrowings under the Credit Agreement bear interest at either (1) the ABR rate which is defined as the rate per annum equal to, at our election: the greatest of (a) the lender's prime rate, (b) the weighted average of the federal funds rate, plus 0.5% and (c) one month LIBOR rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.50% to 1.25% for revolving credit and term loan-A borrowings, or (2) the one, two, three or six month LIBOR rate (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.50% to 2.25% for revolving credit and term loan-A borrowings. As of March 31, 2016, the applicable margins were 0.50% for ABR-based loans and 1.50% for LIBOR-based loans under the revolving credit and term loan-A facilities.

As of March 31, 2016, we had $195 million of borrowings outstanding pursuant to the terms of our $800 million revolving credit facility and we had $552 million of available borrowing capacity, net of $19 million of outstanding borrowings pursuant to a short-term, on-demand credit facility and $34 million of outstanding letters of credit. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Credit Agreement is secured by certain assets of the Company (which generally excludes asset classes such as substantially all of the patient-related accounts receivable of our acute care hospitals, certain real estate assets and assets held in joint-ventures with third-parties) and our material subsidiaries and guaranteed by our material subsidiaries.

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

Pursuant to the terms of our $400 million accounts receivable securitization program with a group of conduit lenders and liquidity banks ("Securitization"), which is scheduled to mature in December, 2018, substantially all of the patient-related accounts receivable of our acute care hospitals ("Receivables") serve as collateral for the outstanding borrowings. We have accounted for this Securitization as borrowings. We maintain effective control over the Receivables since, pursuant to the terms of the Securitization, the Receivables are sold from certain of our subsidiaries to special purpose entities that are wholly-owned by us. The Receivables, however, are owned by the special purpose entities, can be used only to satisfy the debts of the wholly-owned special purpose entities, and thus are not available to us except through our ownership interest in the special purpose entities. The wholly-owned special purpose entities use the Receivables to collateralize the loans obtained from the group of third-party conduit lenders and liquidity banks. The group of third-party conduit lenders and liquidity banks do not have recourse to us beyond the assets of the wholly-owned special purpose entities that securitize the loans. At March 31, 2016, we had $350 million of outstanding borrowings and $50 million of additional borrowing capacity pursuant to the terms of the Securitization.

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

On June 30, 2006, we issued $250 million of senior secured notes which have a 7.125% coupon rate and mature on June 30, 2016 (the "7.125% Notes"). Interest on the 7.125% Notes is payable semiannually in arrears on June 30th and December 30th of each year. In June, 2008, we issued an additional $150 million of 7.125% Notes which formed a single series with the original 7.125% Notes issued in June, 2006. Other than their date of issuance and initial price to the public, the terms of the 7.125% Notes issued in June, 2008 are identical to and trade interchangeably with, the 7.125% Notes which were originally issued in June, 2006. After giving effect to the $445 million spent in early May, 2016 in connection with the purchase of the minority ownership interests held by a third-party in six acute care hospitals located in Las Vegas, Nevada, as disclosed herein, the 7.125% Notes are classified as current maturities of long-term debt as of March 31, 2016 since we no longer have the capacity to refinance the 7.125% Notes utilizing funds borrowed pursuant

to our revolving credit facility. As of December 31, 2015, the 7.125% Notes are classified as long-term on our Consolidated Balance Sheet since we previously had the ability and intent to refinance the 7.125% Notes utilizing funds borrowed pursuant to our revolving credit facility.

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

Our Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens and indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage and minimum interest coverage ratios. We are in compliance with all required covenants as of March 31, 2016.

At March 31, 2016, the carrying value and fair value of our debt were each approximately $3.3 billion. At December 31, 2015, the carrying value and fair value of our debt were each approximately $3.5 billion. The fair value of our debt was computed based upon quotes received from financial institutions. We consider these to be "level 2" in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with debt instruments.

Our total debt as a percentage of total capitalization was 43% at March 31, 2016 and 45% at December 31, 2015.

We expect to finance all capital expenditures and acquisitions, pay dividends and potentially repurchase shares of our common stock utilizing internally generated and additional funds. Additional funds may be obtained through: (i) the issuance of equity; (ii) borrowings under our existing revolving credit facility or through refinancing the existing revolving credit agreement, and/or; (iii) the issuance of other long-term debt. We believe that our operating cash flows, cash and cash equivalents, available borrowing capacity under our $800 million revolving credit facility and $400 million accounts receivable securitization program, as well as access to the capital markets, provide us with sufficient capital resources to fund our operating, investing and financing requirements for the next twelve months. However, in the event we need to access the capital markets or other sources of financing, there can be no assurance that we will be able to obtain financing on acceptable terms or within an acceptable time. Our inability to obtain financing on terms acceptable to us could have a material unfavorable impact on our results of operations, financial condition and liquidity.

Off-Balance Sheet Arrangements

During the three months ended March 31, 2016, there have been no material changes in the off-balance sheet arrangements consisting of operating leases and standby letters of credit and surety bonds. Reference is made to *Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations – Contractual Obligations and Off-Balance Sheet Arrangements,* in our Annual Report on Form 10-K for the year ended December 31, 2015.

As of March 31, 2016 we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds which totaled $129 million consisting of: (i) $105 million related to our self-insurance programs, and; (ii) $24 million of other debt and public utility guarantees.

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

Item 3. Quantitative and Qualitative Disclosures About Market Risk

There have been no material changes in the quantitative and qualitative disclosures during the three months ended March 31, 2016. 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, 2015.

Item 4. Controls and Procedures

As of March 31, 2016, 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 first quarter of 2016 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II. OTHER INFORMATION

Item 1. Legal Proceedings

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

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

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

In April, 2013, the OIG served facility specific subpoenas on Wekiva Springs Center and River Point Behavioral Health requesting various documents from January, 2005 to the date of the subpoenas. In July, 2013, another subpoena was issued to Wekiva Springs Center and River Point Behavioral Health requesting additional records. In October, 2013, we were advised by the DOJ's Criminal Frauds Section that they received a referral from the DOJ Civil Division and opened an investigation of River Point Behavioral Health and Wekiva Springs Center. Subsequent subpoenas have since been issued to River Point Behavioral Health and Wekiva Springs Center requesting additional documentation. In April, 2014, the Centers for Medicare and Medicaid Services ("CMS") instituted a Medicare payment suspension at River Point Behavioral Health in accordance with federal regulations regarding suspension of payments during certain investigations. The Florida Agency for Health Care Administration subsequently issued a Medicaid payment suspension for the facility. River Point Behavioral Health submitted a rebuttal statement disputing the basis of the suspension and requesting revocation of the suspension. Notwithstanding, CMS continued the payment suspension. River Point Behavioral Health provided additional information to CMS in an effort to obtain relief from the payment suspension but the suspension remains in effect. In February, 2016, we received notification from CMS that, effective March, 2016, the payment suspension will be continued for another 180 days. We cannot predict if and/or when the facility's suspended payments will resume. Although the operating results of River Point Behavioral Health did not have a material impact on our consolidated results of operations during the three-month period ended March 31, 2016 or the year ended December 31, 2015, the payment suspension has had a material adverse effect on the facility's results of operations and financial condition.

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

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

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

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

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

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

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

In December, 2015, we were notified by the DOJ Civil Division that the civil investigation also includes Arbour Hospital, Arbour-Fuller Hospital, Pembroke Hospital and Westwood Lodge located in Massachusetts. To date, these facilities have not received any requests for documentation or other information.

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

In December, 2015, we were advised that the DOJ opened an investigation involving the El Paso Behavioral Health System in El Paso, Texas. The DOJ is investigating potential Stark law violations relating to arrangements between the facility and physician(s) at the facility. These agreements were entered into before we acquired the facility as a part of our acquisition of Ascend Health Corporation in October, 2012. To our knowledge, this matter is not a part of the omnibus investigation referenced above. At present, we are uncertain as to potential liability and/or financial exposure, if any, which may be associated with this matter.

In January, 2016, we were notified that the Department of Justice opened an investigation of the South Texas Health System of a potential False Claim Act case regarding compensation paid to cardiologists pursuant to employment agreements entered into in 2005. At present, we are uncertain as to potential liability and/or financial exposure, if any, which may be associated with this matter.

Regulatory Matters:

On July 23, 2015, Timberlawn Mental Health System ("Timberlawn") received notification from CMS of its intent to terminate Timberlawn's Medicare provider agreement effective August 7, 2015. This notification resulted from surveys conducted which alleged that Timberlawn was out of compliance with conditions of participation required for participation in the Medicare/Medicaid program. We filed a request for expedited administrative appeal with the U.S. Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, seeking review and reversal of the termination action. In conjunction with the administrative appeal, we filed litigation in the U.S District Court for the Northern District of Texas seeking a temporary restraining order and preliminary injunction to have the termination stayed pending the conclusion of the administrative appeal. The trial court denied Timberlawn's request for a temporary restraining order and dismissed the case. Timberlawn's provider agreement was terminated effective August 14, 2015. In September, 2015 Timberlawn reached an agreement with CMS relative to its reapplication to the Medicare/Medicaid program. In exchange, Timberlawn agreed to dismiss its administrative appeal as well as not to pursue an appeal of the decision of the trial court. During this time, Timberlawn has remained open. In December, 2015, Timberlawn received notice from the Texas Department of State Health Services of its intent to revoke Timberlawn's license and impose an administrative penalty. We have appealed and are contesting the proposed revocation and fine. In January, 2016, Timberlawn submitted its application for re-enrollment into the Medicare/Medicaid program. Although the operating results of Timberlawn did not have a material impact on our consolidated results of operations or financial condition for the three-month period ended March 31, 2016 or the year ended December 31, 2015, the termination of Timberlawn's provider agreement has had a material adverse effect on the facility's results of operations and financial condition.

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

Other Matters:

In late September, 2015, many hospitals in Pennsylvania, including seven of our behavioral health care hospitals located in the state, received letters from the Pennsylvania Department of Public Welfare ("DPW") demanding repayment of allegedly excess Medicaid Disproportionate Share Hospital payments ("DSH") for the federal fiscal year 2011 ("FFY2011") amounting to approximately $4 million in the aggregate. We have filed administrative appeals for all of our facilities contesting the recoupment efforts since we believe DPW's calculation methodology is inaccurate and conflicts with applicable federal and state laws and regulations. DPW has

agreed to postpone the recoupment of the state's share of the DSH payments until all hospital appeals are resolved. DPW also extended the deadline to recoup the federal share (2011 federal share is 55%) until April 30, 2016. However, if DPW is ultimately successful in its demand related to FFY2011, it could take similar action with regards to FFY2012 through FFY2014. Due to a change in the Pennsylvania Medicaid State Plan and implementation of a CMS-approved Medicaid Section 1115 Waiver, we do not believe the methodology applied by DPW to FFY2011 is applicable to reimbursements received for Medicaid services provided after January 1, 2015 by our behavioral health care facilities located in Pennsylvania. We can provide no assurance that we will ultimately be successful in our legal and administrative appeals related to DPW'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.

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

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

Department of Justice Investigation of Friends Hospital:

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

Department of Justice Investigation of Riveredge Hospital:

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

General:

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

regulations. Although we believe our policies, procedures and practices comply with government regulations, there is no assurance that we will not be faced with the sanctions referenced above which include fines, penalties and/or substantial damages, repayment obligations, payment suspensions, licensure revocation, and expulsion from government healthcare programs. Even if we were to ultimately prevail in any action brought against us or our facilities or in responding to any inquiry, such action or inquiry could have a material adverse effect on us.

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

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

Item 1A. Risk Factors

Our Annual Report on Form 10-K for the year ended December 31, 2015 includes a listing of risk factors to be considered by investors in our securities. There have been no material changes in our risk factors from those set forth in our Annual Report on Form 10-K for the year ended December 31, 2015.

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

In February, 2016, our Board of Directors authorized a $400 million increase to our stock repurchase program, which increased the aggregate authorization to $800 million from the previous $400 million authorization approved during the third quarter of 2014. Pursuant to this program, we may purchase shares of our Class B Common Stock, 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 March 31, 2016, 1,343,830 shares ($152.4 million in the aggregate) were repurchased pursuant to the terms of our stock repurchase program and 109,674 shares were repurchased in connection with income tax withholding obligations resulting from the exercise of stock options and restricted stock grant vestings.

During the period of January 1, 2016 through March 31, 2016, 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)
January 2016	—	818,579	—	N/A	760,000	$ 111.55	$ 84,774	—	$ 91,054
February, 2016	$ 400,000	141,139	—	N/A	126,782	112.34	14,243	—	$ 476,811
March, 2016	—	493,786	—	N/A	457,048	116.89	53,423	—	$ 423,388
Total January through March	—	1,453,504	—	N/A	1,343,830	$ 113.44	$ 152,440		

Dividends

During the quarter ended March 31, 2016, we declared and paid dividends of $.10 per share.

Attachment C. Economic Feasibility. 11

Item 6. Exhibits

(a) Exhibits:

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

* Management contract or compensatory plan or arrangement.

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

Signatures

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

Universal Health Services, Inc.
(Registrant)

Date: May 6, 2016

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

/s/ STEVE FILTON
Steve Filton, Senior Vice President and Chief Financial Officer (Principal Financial Officer)

EXHIBIT INDEX

Exhibit No.	Description
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101.LAB	XBRL Taxonomy Extension Label Linkbase Document
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document

Exhibit 31.1

CERTIFICATION—Chief Executive Officer

I, Alan B. Miller, certify that:

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

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

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

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

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

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

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

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

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

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

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

Date: May 6, 2016

/s/ Alan B. Miller
Chief Executive Officer

Exhibit 31.2

CERTIFICATION—Chief Financial Officer

I, Steve Filton, certify that:

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

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

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

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

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

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

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

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

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

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

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

Date: May 6, 2016

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

Exhibit 32.1

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

In connection with the Quarterly Report of Universal Health Services, Inc. (the "Company") on Form 10-Q for the quarter ended March 31, 2016, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Alan B. Miller, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, and to the best of my knowledge, that:

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

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

/s/ Alan B. Miller
Chief Executive Officer
May 6, 2016

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 March 31, 2016, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Steve Filton, Senior Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, and to the best of my knowledge, that:

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

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

/s/ Steve Filton
Senior Vice President and Chief Financial Officer
May 6, 2016

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.

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

LICENSE

THE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES GRANTS THIS FULL LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

KEYSTONE MEMPHIS, LLC
(Name of Licensee)

TO OPERATE A FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE PROVISION OF MENTAL HEALTH, PERSONAL SUPPORT, OR ALCOHOL AND DRUG ABUSE SERVICES:

Compass Intervention Center
(Name of Facility or Service as Known to the Public)

7900 Lowrance Road, Memphis, TN 38125
(Street Address or Location, City or Town)

THE LICENSEE HAS DEMONSTRATED COMPLIANCE WITH T.C.A. TITLE 33, CHAPTER 2, PART 4 AND WITH RULES OF THE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING DISTINCT CATEGORY OF FACILITY OR SERVICES TO BE PROVIDED.

License Category	Accessible to mobile, non-ambulatory individuals	Approved for persons w hearing loss	vision loss	Capacity
Alcohol & Drug Residential Treatment for Children & Youth	Y	Y	Y	30
Mental Health Outpatient Facility	Y	Y	Y	n/a
Mental Health Partial Hospitalization Facility	Y	Y	Y	n/a
Mental Health Residential Treatment for Children & Youth	Y	Y	Y	76
MH Intensive Day Treatment for Children & Adolescents	Y	Y	Y	n/a

December 01, 2015	November 30, 2016	L0000000017343
Effective Date	Date License Expires	License Number

Commissioner of Mental Health and Substance Abuse Services

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

Attachment C. Contribution to the Orderly Development of Health Care. 7-c

Keystone Memphis L.L.C.

Memphis, TN

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Behavioral Health Care Accreditation Program

March 28, 2015

Accreditation is customarily valid for up to 36 months.

Rebecca J. Patchin, MD
Chair, Board of Commissioners

ID #103149
Print/Reprint Date: 05/11/2015

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

Attachment C. Contribution to the Orderly Development of Health Care. 7-d

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
West Tennessee Regional Office of Licensure
951 Court Avenue
MEMPHIS, TENNESSEE 38103

BILL HASLAM
GOVERNOR

E. DOUGLAS VARNEY
COMMISSIONER

November 30, 2015

Mr. Jeremy Pitzer
CEO
Keystone Memphis, LLC
7900 Lowrance Road
Memphis, TN 38125

Dear Mr. Pitzer:

Attached is a Full License issued to Keystone Memphis, LLC to operate a facility/service at the address listed herein. This license is effective December 01, 2015 and will expire on November 30, 2016.

This license is being issued in accordance with regulation 0940-5-2-.11 which provides that facilities/services accredited by Joint Commission on Accreditation of Health Care Organizations (JCAHO) may be deemed to be in compliance with the Department of Mental Health licensure program standards. Compliance with applicable life safety standards has been demonstrated. The facility/service remains subject to at least one unannounced inspection annually.

Should a facility/service for some reason fail to maintain its accredited or certified status, you are required to notify this office. At that point, we will proceed to make a licensure determination under other licensure regulations.

Compass Intervention Center at: 7900 Lowrance Road, Memphis, TN 38125 **Site ID: 312**

Attached: L000000017343 - Alcohol & Drug Residential Treatment for Children & Youth, Capacity: 30; Mental Health Outpatient Facility; Mental Health Partial Hospitalization Facility; Mental Health Residential Treatment for Children & Youth, Capacity: 78; MH Intensive Day Treatment for Children & Adolescents

Also enclosed is a status report for your agency's most recent inspection.

Sincerely,

Cynthia Tyler, Esq.
Director of Office of Licensure

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Phone: (901)543-7442 Fax: (844)844-5538

Attachment C. Contribution to the Orderly Development of Health Care. 7-d

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
West Tennessee Regional Office of Licensure
951 Court Avenue
MEMPHIS, TENNESSEE 38103

BILL HASLAM
GOVERNOR

E. DOUGLAS VARNEY
COMMISSIONER

COMPLIANCE EVENT STATUS REPORT

LICENSEE:	Licensee ID: 282	FACILITY:	Site ID: 312
Keystone Memphis, LLC 7900 Lowrance Road Memphis, TN 38125		Compass Intervention Center 7900 Lowrance Road Memphis, TN 38125	

NOTICE TO LICENSEE: A review has been completed of your recently submitted plan of compliance. The approval status given your plan is indicated below. Read the approval status given below carefully. This approval status form and your plan of compliance should become part of your records.

DATE OF NOTICE / REPORT: 11/30/15 **DATE OF ASSOCIATED NOTICE OF NON-COMPLIANCE:** 10/9/15
COMPLIANCE EVENT & DATE: Annual Inspection 10/5/15 Site ID:312 Event ID:6,602

I. REVIEW OF PLAN OF NON-COMPLIANCE COMPLETED BY:

Adrienne Brent, West Tennessee Licensure

II. APPROVAL STATUS OF PLAN OF NON-COMPLIANCE:

POC Approved

Your plan of compliance has been accepted. You are expected to meet the terms of your plan. Re-inspection may be conducted to verify compliance. With re-inspection, you will incur a $50 re-inspection fee.

EVENT SUMMARY

09450-5-02 Licensure Administration and Procedures	1 deficiency
09450-5-04-.02 Life Safety: HealthCare Occupancies	3 deficiencies
09450-5-04-.09 Life Safety: Mobile Non-ambulatory	0 deficiencies
09450-5-05-.02 Adequacy of Facility Environment and Ancillary Services (ALL FACILITIES)	12 deficiencies
09450-5-05-.03 Adequacy of Facility Environment & Ancillary Services (RESIDENTIAL)	4 deficiencies
09450-5-05-.04 Adequacy of Facility Environment & Ancillary Services (NON-RESIDENTIAL)	0 deficiencies
09450-5-05-.05 Adequacy of Facility Environment & Ancillary Services (FOOD SERVICE)	0 deficiencies
09450-5-05-.06 Adequacy of Facility Environment & Ancillary Services (TRANSPORTATION)	0 deficiencies
09450-5-05-.07 Adequacy of Facility Environment & Ancillary Services (CHILDREN)	0 deficiencies
09450-5-05-.09 Adequacy of Facility Environment & Ancillary Services (VISION LOSS)	0 deficiencies
09450-5-05-.10 Residential Facilities Serving Hearing Impaired (HEARING LOSS)	0 deficiencies
09450-5-05-.11 Non-Residential Facilities Serving Hearing Impaired (HEARING LOSS)	0 deficiencies
09450-5-06 Program Requirements for All Services and Facilities (DEEMED)	0 deficiencies
09450-5-14 Mental Health Outpatient Facilities (DEEMED)	0 deficiencies
09450-5-30 Mental Health Intensive Day Treatment Program Children & Adolescents Facilitie	0 deficiencies

09450-5-33 Mental Health Partial Hospitalization Programs (DEEMED)	0 deficiencies
09450-5-37 Mental Health Residential Treatment Facility For Children and Youth (DEEMED)	0 deficiencies
09450-5-46 Alcohol and Drug Residential Treatment Facilities for Children and Youth (DEEM	0 deficiencies

Attachment C. Contribution to the Orderly Development of Health Care. 7-d

Attachment C. Contribution to the Orderly Development of Health Care. 7-d

Compass Intervention Center
Plan of Compliance
Annual Inspection October 5, 2015

0940-5-4-.02 LICENSURE ADMINISTRATION AND PROCEDURES
0940-5-4.-02 16 POSTING OF THE LICENSE. The license certificate shall be posted for public viewing in a conspicuous place at the facility or service.
1. At the time of inspection the license certificate was located behind the front desk and not easily visible for public viewing at the facility.. Licensee's Planned Date of Compliance: 10/19/2015 Licensee's Plan of Compliance: The license was removed from behind the front desk and placed in the lobby for public viewing. (See picture attached)
0940-5-4 Life Safety Licensure Rules
0940-5-4-.02 HEALTH CARE OCCUPANCIES
0940-5-4-.02(2) Criteria. For the purpose of life safety facilities required to meet Health Care Occupancies must comply with the applicable standards of the Life Safety Code of the National Fire Protection Association, 1985 Edition, Health Care Occupancies, Chapter 12 (n32) or Chapter 13 (existing) or equivalent standards hereafter adopted by the Office of the State Fire Marshal.
2. At the time of inspection boxes located in the kitchen bathroom were not adequately stored 18 inches from the sprinklers creating a potential hazard if a fire were to start. Licensee's Planned Date of Completion: 10-9-15 Licensee's Plan of Compliance: Items in the kitchen were removed immediately and placed in a different location. The Kitchen Supervisor was instructed on the importance of maintaining items below the red line. Kitchen bathroom will continue to be checked during our monthly Environmental Inspections. (See picture attached)
3. At the time of inspection boxes located in the administrative hallway storage closet were not adequately stored 18 inches from the sprinklers creating a potential hazard if a fire were to start. Licensee's Planned Date of Completion: 10-23-15 Licensee's Plan of Compliance: At the time of the survey, numerous staff had keys to this area. This closet has been cleaned out and reorganized. The locks have been changed and given to three individuals for continued monitoring. We will continue to monitor this area on a monthly basis during Environmental Inspections. (See picture attached)
0940-5-4-.02(2) Criteria. For the purpose of life safety facilities require to meet Health Care Occupancies must comply with the applicable standards of the Life Safety Code of the National Fire Protection Association, 1985 Edition, Health Care Occupancies. Chapter 12 (new) or Chapter 13 (existing) or equivalent standards hereafter adopted by the Office of the State Fire Marshal.
4. At the time of inspection 1 of the dryers were missing a lint filter which causes a potential fire hazard. Licensee's Planned Date of Completion: 10-23-15 Licensee's Plan of Compliance A new dryer lint filter was ordered. The dryer was removed from operation until the lint filter was received. Will monitor during Monthly Environmental Inspections. (See picture attached)
0940-5-5 Adequacy of Facility Environment and Ancillary Services
0940-5-5-.02 GENERAL ENVIRONMENTAL REQUIREMENTS FOR ALL FACILITIES
0940-5-5-02(1) The facility must be maintained in a safe manner and a continuing effort made to eliminate potential hazards.
5. At the time of inspection there was a cable wire and wall covering plate hanging from the ceiling in Dayroom 100 potential causing a hazard. Licensee's Planned Date of Completion: 10-19-15 Licensee's Plan of Compliance: 100 Dayroom ceiling repaired (See picture attached)

0940-5-5-02(1) The facility must be maintained in a safe manner and a continuing effort made to eliminate potential hazards.
6. In Dayroom 300, the window sill was broken presenting shape edges sticking out causing a potential hazard for the service recipients. Licensee's Planned Date of Completion: 10-23-15 Licensee's Plan of Compliance: Window sill was repaired (See attached picture)
0940-5-5-02(1) The facility must be maintained in a safe manner and a continuing effort made to eliminate potential hazards.
7. In bedroom 201, the shower curtain was located on the floor in front of the shower presenting a potential trip hazard for the service recipients. Licensee's Planned Date of Completion: 10-19-15 Licensee's Plan of Compliance: Shower curtain was placed back on the track by Maintenance. (See picture attached) Housekeeping will complete a daily report showing that this has been checked and will contact maintenance if they need to be replaced. (See attached Housekeeping report)
0940-5-5-02(1) The facility must be maintained in a safe manner and a continuing effort made to eliminate potential hazards.
8. At the time of inspection the in-ground drain pipe located in the outside area, was in disrepair with protruding shape pieces. Licensee's Planned Date of Completion: 10-13-15 Licensee's Plan of Compliance: We have received bids on new gutters and are awaiting corporate approval before the gutters will be replaced. In the meantime, we have corrected the deficiencies noted. (See picture attached)
0940-5-5-02(1) The facility must be maintained in a safe manner and a continuing effort made to eliminate potential hazards.
9. At the time of inspection the gutter located outside the fire exit on the classroom hallway, was dangling from the roof potentially causing a hazard Licensee's Planned Date of Completion: 10-13-15 Licensee's Plan of Compliance: We have received bids on new gutters and are awaiting corporate approval before the gutters will be replaced. In the meantime, we have corrected the deficiencies noted. (See picture attached)
0940-5-5-02(1) The facility must be maintained in a safe manner and a continuing effort made to eliminate potential hazards.
10. There was a hole on the wall located close to the top of the door outside of classroom 4 that needs repair. Licensee's Planned Date of Completion: 10-13-15 Licensee's Plan of Compliance: Hole fixed 10-20-15 (See picture attached)
0940-5-5-.02(2) The facility must be maintained in a sanitary and clean condition, free from all accumulation of dirt and rubbish, well-ventilated, and free from foul, stale or musty odors.
11. At the time of inspections there was paper and trash in the outside area where the service recipients participate in leisure activities. Licensee's Planned Date of Completion: 10-13-15 Licensee's Plan of Compliance: This area was cleaned immediately following Licensure visit. Housekeeping to continue to clean them daily. Community Counselors will make sure these rooms are clean prior to transitioning their groups. (See picture attached) Housekeeping will complete a daily report showing that this has been checked and will contact maintenance if they need to be replaced. (See attached Housekeeping report)
0940-5-5-.02(2) The facility must be maintained in a sanitary and clean condition, free from all accumulation of dirt and rubbish, well-ventilated, and free from foul, stale or musty odors. (See picture attached)
12. At the time of inspections was an accumulation of dirt, spider webs and bugs located in the 300 dayroom window. Licensee's Planned Date of Completion: 10-13-15 Licensee's Plan of Compliance: Housekeeping cleaned this area immediately and will put in on their rotation to be done every other week. Housekeeping will complete a daily report showing that this has been checked and will contact maintenance if they need to be replaced. (See attached Housekeeping report) Monthly Environmental inspections will be done to monitor. (See picture attached)
0940-5-5 Adequacy of Facility Environment and Ancillary Services
0940-5-5-.02(4) Housekeeping practices and standards must be maintained which will ensure the eradication of flies, roaches and other vermin.
13. At the time of inspections was an accumulation of spider webs, bugs and dirt daubers' nest located outside the classroom hallway fire exit.

Licensee's Planned Date of Completion: 10-13-15
Licensee's Plan of Compliance:
Housekeeping cleaned this area immediately. Housekeeping is putting these outside areas on their rotation to be done every other week. Monthly environmental inspections will be done to monitor (See picture attached)
Housekeeping will complete a daily report showing that this has been checked and will contact maintenance if they need to be replaced. (See attached Housekeeping report)

0940-5-5-.02(4) Housekeeping practices and standards must be maintained which will ensure the eradication of flies, roaches and other vermin.

14. At the time of inspections was an accumulation of spider webs, bugs and dirt daubers' next located outside the therapist hallway fire exit.

Licensee's Planned Date of Completion: 10-13-15
Licensee's Plan of Compliance:
Housekeeping cleaned this area immediately. Housekeeping is putting these outside areas on their rotation to be done every other week. Monthly environmental inspections will be done to monitor (See picture attached)
Housekeeping will complete a daily report showing that this has been checked and will contact maintenance if they need to be replaced. (See attached Housekeeping report)

0940-5-5.02(4) Housekeeping practices and standards must be maintained which will ensure the eradication of flies, roaches, and other vermin.

15. There was food, cups and trash located on the floor between the window and chair in the 400 Dayroom.

Licensee's Planned Date of Completion: 10-5-15
Licensee's Plan of Completion:
This area was cleaned immediately following the licensure visit. The Community Counselors will make sure these areas are cleaned prior to transitioning their groups from these areas. Monthly environmental inspections will be done. (See picture attached)
Housekeeping will complete a daily report showing that this has been checked and will contact maintenance if they need to be replaced. (See attached Housekeeping report)

0940-5-5-02(6) All interior and exterior stairways, halls porches, walkways and all other means of egress and areas of exit discharge must be maintained free of any obstacles, including furniture or other stored items.

16. At the time of inspection there were broken pieces of hard brown plastic located outside the classroom in the hallway causing a potential trip hazard and potential obstacles during means of egress.

Licensee's Planned Date of Completion: 10-5-15
Licensee's Plan of Completion: Plastic removed (See picture attached)
Housekeeping will complete a daily report showing that this has been checked and will contact maintenance if they need to be replaced. (See attached Housekeeping report)

0940-5-5 Adequacy of Facility Environment and Ancillary Services

0940-5-5-.03 ENVIRONMENTAL REQUIREMENTS FOR RESIDENTIAL FACILITIES

The governing body must ensure that each client is provided with the following:
0940-5-5-.03(1)(b) A mattress and springs, or a mattress foundation, both of which are clean comfortable and in good repair;

17. Mattress located in bedroom 102 was torn and in disrepair
Licensee's Planned Date of Completion: 10-5-15
Licensee's Plan of Completion: Mattress was immediately removed and thrown away. CCs are being trained to ensure that torn mattresses are called into the Maintenance Hotline for removal. Environmental walk inspections
Housekeeping will complete a daily report showing that this has been checked and will contact maintenance if they need to be replaced. (See attached Housekeeping report)

The governing body must ensure that each client is provided with the following:
0940-5-5-.03(1)(C)
Clean linens consisting of both a top and bottom sheet, which are clean, in good repair and are changed as often as needed, but at least weekly.
Housekeeping will complete a daily report showing that this has been checked and will contact maintenance if they need to be replaced. (See attached Housekeeping report)

The governing body must ensure that each client is provided with the following:
0940-5-5-.03(1)(d) Bedding such as blankets, which are clean, in good repair and appropriate to the weather:

19. 1 bed in bedroom 301 was missing a blanket. There was only a flat sheet present.
Licensee's Planned Date of Completion:
Licensee's Plan of Completion: CCs have been receiving training on the required linens in their room. (See attached training agenda) This is monitored on Monthly environmental inspections. (See picture attached)
Housekeeping will complete a daily report showing that this has been checked and will contact maintenance if they need to be replaced. (See

attached Housekeeping report)

Bathrooms must be provided within the facility which are equipped as follows:
0940-5-5-03(4)(f) Adequate and sanitary toilet paper provided at each toilet.

20. The toilet paper in the bathroom located in bedroom 207 was not in the storage dispenser and located on the back of the toilet which prevents it from remaining sanitary.
The toilet paper in the bathroom located in bedroom 203 was not in the storage dispenser and located on the top of the sink which prevents it from remaining sanitary.
Licensee's Planned Date of Completion: 10 -5-15
Licensee's Plan of Completion:
Community Counselors should make sure that toilet paper is placed in the dispenser after hygiene time in the morning. Housekeeping will also ensure that toilet paper is placed in the dispenser to ensure that it remains sanitary. (See picture attached) Housekeeping will complete a daily report showing that this has been checked and will contact maintenance if they need to be replaced. (See attached Housekeeping report)

By submitting this Plan of Correction, Compass Intervention Center does not agree that the facts alleged are true or admit that it violated the rules. Compass Intervention Center submits this Plan of Correction to document the actions it has taken to address the citations."

Signature of Licensee or Authorized Agent _____Date_____

AFFIDAVIT

STATE OF TN

COUNTY OF SHELBY

JEREMY PITZER, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

CEO
SIGNATURE/TITLE

Sworn to and subscribed before me this 13th day of JUNE (Month), 2016 (Year) a Notary

Public in and for the County/State of SHELBY, TN.

Terri Sweet
NOTARY PUBLIC

My commission expires 10/5 (Month/Day), 2019 (Year).

TERRI SWEET
STATE OF TENNESSEE
NOTARY PUBLIC
SHELBY COUNTY
MY COMMISSION EXPIRES 10-5-2019

Letters of Support

Steve McManus
State Representative
96th Legislative District

Home Office
9406 Riveredge Drive
Cordova, TN 38018
(901) 237-7488

rep.steve.mcmanus@capitol.tn.gov

House of Representatives
State of Tennessee

NASHVILLE

COMMITTEES
Insurance and Banking, Chairman
Insurance and Banking Sub, Member
Consumer and Human Resources, Member
Calendar and Rules, Member

Suite 20 Legislative Plaza
Nashville, TN 37243
Phone: (615) 741-1920
Fax (615) 253-0232

October 1, 2015

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street
Andrew Jackson Bldg., 9th Floor
Nashville, TN 37243

RE: Compass Intervention Center

Dear Director Hill:

As the State Representative for the 96th District, I want to take this opportunity to express my strong support for Compass Intervention Center's CON application.

Compass Intervention Center is a premier facility providing residential treatment for psychiatric and dual diagnosis disorders for children. They treat children with severe and chronic mental health, behavioral problems, and substance use disorders who are predominantly underserved, low-income, and have the greatest need across domains. Through their work with all children in need, Compass Intervention Center specializes in children's trauma recovery and the treatment of co-occurring mental health and substance abuse disorders. Their entire clinical team is trained in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), with multiple therapists pursuing or eligible for national certification.

There is a great need in our community and region for additional capacity for child and adolescent mental health services. The vast majority of psychiatric beds in the region are dedicated to treating adult patients, and as a result accessing child and adolescent services is increasingly difficult. The children that Compass serves face an overwhelming amount of barriers to health including higher amounts of violence and trauma exposure, higher numbers of contact with the justice system, economic and educational deficits and a lack of appropriate treatment resources. Their facility and leadership teams are actively

involved in a variety of community service that ranges from non-profit board membership, volunteerism, committee leadership and sponsorship. They are invested in our communities and most especially, the people and agencies that they have the privilege of working with. They strive to help eliminate the stigma of mental health by promoting awareness and offering education to the community.

Again, I offer my full support for Compass in this endeavor. Please do not hesitate to contact me should you have any questions or need more information.

Sincerely,

Steve McManus
State Representative

SM/db

REGINALD TATE
STATE SENATOR
33rd SENATORIAL DISTRICT

VICE CHAIR
SHELBY COUNTY DELEGATON

MEMBER OF COMMITTEES:
VICE CHAIR
EDUCATION
COMMERCE

Senate Chamber
State of Tennessee
NASHVILLE

FINANCE WAYS & MEANS
FISCAL REVIEW
SELECT COMMITTEE ON ETHICS
SELECT OVERSIGHT COMMITTEE ON BUSINESS TAXES
SELECT COMMITTEE ON TENNESSEE EDUCATION LOTTERY CORPORATION
COVER TENNESSEE ADVISORY COMMITTEE

October 16, 2015

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street
Andrew Jackson Bldg., 9th Floor
Nashville, TN 37243

Re: Compass Intervention Center CON

Dear Ms. Hill:

I am writing to express my support for Compass Intervention Center's Certificate of Need application.

Compass Intervention Center is a residential treatment center for psychiatric and dual diagnosis disorders for children and adolescents. The facility is located in southeast Memphis. They treat children with severe and chronic mental health, behavioral problems, and substance use disorders who are predominantly underserved, low-income, and have the greatest need across domains. Like the children and families they serve, their employees represent a diverse mix of backgrounds and educations and are dedicated to providing care that is outcome driven, culturally competent, and focused on treating the patients and families as a whole.

Compass Intervention Center has partnered with several universities, including the University of Tennessee, the University of Memphis, the University of Mississippi, Harding University and Union University to provide high quality clinical internship experiences to Bachelors and Masters level students pursuing a variety of degrees. Compass not only serves Memphis but the greater Tennessee area through their initiatives and programs.

There is a great need in our community and region for additional capacity for child and adolescent mental health services. The vast majority of psychiatric beds in the region are dedicated to treating adult patients, and as a result accessing child and adolescent services is increasingly difficult. The level of need in our community is high. The children that Compass serves face an overwhelming amount of barriers to health including higher

301 6th Avenue North, 320 War Memorial Building, Nashville, TN 37243
Phone (615) 741-2509 Fax (615) 253-0167 Toll Free 1-800-449-8366 Ext. 12509
sen.reginald.tate@capitol.tn.gov

amounts of violence and trauma exposure, higher numbers of contact with the justice system, economic and educational deficits and a lack of appropriate treatment resources.

Again I offer my full support for Compass in this endeavor. Please do not hesitate to contact me should you have any questions or need more information.

Sincerely,

Senator Reginald Tate

Tennessee Suicide Prevention Network Advisory Council

Tim Bevern, MA
Chair, Chattanooga

Karyl Chastain Beal, M. Ed. CT
Co-Chair, Columbia

Anne Staggs
Secretary, Livingston

[illegible]

Jennifer Harris, MS
Past Chair, Centerville

Sabrina Anderson
Jackson

John Averitt, Ph.D.
Coalmont

Nancy L. Badger, Ph.D.
Chattanooga

Ursula Bailey, JD, MBA
Knoxville

Kathy Bensadoun, LPC, SAP, LMFT
Johnson City

[illegible]

Patty Crocken, BSW
Paris

[illegible]

Brenda S. Harper
Lafayette

Kelly S. Haught, MA, LPC-MHSP
Johnson City

[illegible]

Debra K. Moore
Chattanooga

Eve Nisi
Chattanooga

Whiting Porter
Memphis

Stephanie Robb
Jackson

Kim Rush, M.Ed., LPC-MHSP
Murfreesboro

Kandi Shearer
Johnson City

Jack Stewart, MA
Greeneville

[illegible]

Tobi R. Upson
Chattanooga

[illegible]

Anne Young, MS, CAS
Knoxville

Scott Ridgway, MS
Executive Director

Vladimir Erlow, MTS
Executive Assistant

Mary Leibach, BBA, BSW
Zero Suicide Coordinator

Amy Doherty, BS
East Tennessee Regional Coordinator

Samantha Naeter, BS
Middle Tennessee Regional Coordinator

[illegible]

Pam Arnold, Ed.D.
Member Emeritus, Pulaski

Sam Bernard, PhD, FAAETS, DABCEM
Chair Emeritus, Chattanooga

Carol Burroughs, MSCPS
Member Emeritus, Lexington

Barbara Dooley, Ph.D.
Member Emeritus, Memphis

Clark Flatt
Member Emeritus, Hendersonville

[illegible]

Judith Johnston, AAS, CC
Member Emeritus, Smyrna

Claudia M. Mapp, LCSW, BCD
Member Emeritus, Nashville

Anna Shugart
Member Emeritus, Maryville

Ken Tuttle, MD
Member Emeritus, Memphis

Madge Tuttle
Chair Emeritus, Memphis

Mary Yarbrough, BBA, BSW
Member Emeritus, Nashville

[illegible]

Tennessee Suicide Prevention Network

"Saving Lives in Tennessee"

October 1, 2015

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street
Andrew Jackson Building, Ninth Floor
Nashville, TN 37243

Re: Compass Intervention Center

Dear Ms. Hill:

The Tennessee Suicide Prevention Network (TSPN) wishes to convey its support for Compass Intervention Center's recent Certificate of Need application.

Established in 2001, TSPN works across the state to eliminate the stigma of suicide and educate communities about the warning signs of suicide, with the ultimate intention of reducing suicide rates in the state of Tennessee. We seek to achieve these objectives through organizing and promoting regular regional activities, providing suicide prevention and crisis intervention training to community organizations, and conducting postvention sessions for schools and organizations after suicides occur.

About 950 people in Tennessee die by suicide each year (including about 100 children and teens), and many more attempt suicide or engage in self-harm. Yet we know most suicides can be prevented through treatment of what is often an underlying mental illness. Most psychiatric beds in the area are dedicated to treating adult patients, which makes finding consistent services for children and adolescents in crisis difficult. Our state needs additional capacity for child and adolescent mental health services, and with your support, Compass can provide exactly that.

TSPN has previously partnered with Compass to raise awareness of the issue of suicide in the Memphis/Shelby County area. Staff members are frequent guests and speakers at our regional meetings, and the agency usually sponsors any TSPN events we stage in the area. We find their staff and leadership to be both competent and compassionate in their efforts to serve youth in crisis. It has a sterling reputation in this regard, having provided internships to several local colleges and universities, maintained the highly regarded and award-winning Compass Academy, and demonstrated considerable progress working with juvenile offenders through its HERO program.

With the completion of its expansion project, Compass will be the only BHO in the area that focuses on childhood and adolescent mental health treatment. These services are desperately needed, and I believe that Compass Intervention Center is up to the task.

You are welcome to contact me if you need additional information. Compass Intervention Center is an invaluable participants in our state's suicide prevention agenda, and we believe your agency's support of Compass will literally save lives.

Sincerely,

Scott Ridgway

Scott Ridgway, MS
Executive Director

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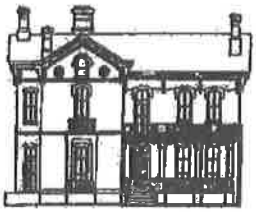
446 Metroplex Drive, Suite A-224 • Nashville, TN 37211 • Office (615) 297-1077 • Fax (615) 269-5413
National Suicide Prevention Lifeline: 1-800-273-TALK



Memphis
Child Advocacy
Center

December 11, 2015

Melanie Hill, Executive Director
Tennessee Health Services And Development Agency
Andrew Jackson Building 9th Floor
502 Deaderick Street
Nashville, TN 37243

Dear Ms. Hill,

I am writing in support of Compass Intervention Center's plan to upgrade and expand their physical facility and services with the goal of building a comprehensive children's behavioral health system. The vision of this expansion includes adding 24 new inpatient beds and additional outpatient capacity to serve children and adolescents struggling with addiction and mental health issues.

Compass Intervention Center and the Memphis Child Advocacy Center share a common goal: the health and wellness of our community's most vulnerable youth. At the Memphis Child Advocacy Center (CAC), a collaboration of compassionate, specialized professionals work together under a shared protocol to help children following reported child sexual or other severe abuse. The Shelby County Child Protection Investigation Team, headquartered at the Memphis CAC, includes 15 agencies involved in the investigation, prosecution, and intervention of child abuse. Memphis CAC employees include forensic interviewers, therapists, and advocates.

Compass and the Memphis Child Advocacy Center also share a common therapeutic approach. We both have clinicians trained in Trauma-focused Cognitive Behavioral Therapy (TF-CBT). This therapy modality is a best practice approach to treatment for youth who have experienced trauma. We are pleased that Compass also has chosen this best practice approach.

We recognize that our community needs more quality mental health resources for children and adolescents. Upon completion of their expansion project, Compass Intervention Center will be the only behavioral health system dedicated exclusively to treating children in Memphis/Shelby County. Increased capacity to provide this level of treatment for children and adolescents will meet a critical need in our community.

Compass Intervention Center has committed to providing quality services for kids facing the toughest of challenges. Their clients are predominantly underserved from low-income families. Successful intervention with these children not only greatly enhances our lives, but is an investment in our community.

Sincerely,

Virginia Stallworth
Executive Director

George E. Mabon
Chair

Robert S. Shaw, Jr.
Chair-Elect

Chris Williams
Vice Chair

Dotty Summerfield Giusti
Treasurer

Mary M.D. Selvidge
Secretary

Amy W. Martin
Board Counsel

Virginia Stallworth
Executive Director

Annette Askew
Scott Barton
Susan Lawless Glassman
Travis Green
Sheryl H. Lipman
R. Anthony Murphy
Deborah Northcross
Lori M. Patton
Carol W. Prentiss
Cathy Ross
Mike Ryall
Betsy Shaw
Amy P. Weirich
Eldra White

Ex-Officio
James H. Prentiss, Jr.
Jill Shanker

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United Way
United Way of the Mid-South

Mental Health America
of Middle Tennessee

October 1, 2015

Melanie Hill, Executive director
Tennessee Health Services and Development Agency
502 Deaderick Street
Andrew Jackson Bldg., 9th Floor
Nashville, TN 37243

Re: Compass Intervention Center

Dear Ms. Hill:

As the CEO of Mental Health America of Middle Tennessee, I am writing to urge you to strongly consider Compass Intervention Center's certificate of need application. Two of our staff work in West Tennessee.

Our 70-year-old nonprofit agency focuses on advocacy, education, and referrals for families and individuals impacted by behavioral health. Our programs focus on suicide prevention, Alzheimer's support, domestic violence support groups, school retention and academic success, a helpline, and more. We also provide professional education and CEUs for a variety of professionals. In West Tennessee we specifically focus on suicide prevention, school retention and academic success, and professional education.

There is a great need in our community and region for additional capacity for child and adolescent mental health services. The vast majority of psychiatric beds in the region are dedicated to treating adult patients, resulting to difficult referrals when we need to help identify services for children and adolescents. Even the National Institute of Health and NIMH (mental health) now recognize the importance of early treatment. According to NAMI, half of all lifetime mental illness is diagnosable by age 14, but most people do not get help until age 24, on average.

Aside from the dire need for these beds, I must also compliment Compass for being willing to expand to meet this need. They are excellent in their treatment of children and youth.

We offer our full support for Compass in this endeavor.

Respectfully submitted,

Tom Starling, EdD
President/CEO

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295 Plus Park Blvd, Suite 201 ~ Nashville, TN 37217 ~ (615) 269-5355 ~ Fax: (615) 269-5413

The Richard G. Farmer & Allen O. Battle
CRISIS CENTER

Suicide and Crisis Intervention Service

October 1, 2015

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street
Andrew Jackson Bldg., 9th Floor
Nashville, TN 37243

Re: Compass Intervention Center Certificate of Need Application

Dear Ms. Hill:

The Memphis Crisis Center (MCC) strongly supports Compass Intervention Center's Certificate of Need application. The MCC provides help, builds hope, and save lives through our volunteer-powered hotlines. Our trained volunteers—using a combination of empathic listening, collaborative problem-solving and crisis intervention—help callers with immediate problems and link them to the long-term professional resources they need to cope and overcome.

Along with the main crisis line, we administer the Call4Kids Hotline, the Elder Lifeline, the HIV Care Line, and serve as the local affiliate of the National Suicide Prevention Lifeline and the National Veterans Line. We also provide after-hours answering services for the Rape Crisis Center and the Family Safety Center.

Through our Call4Kids Line, we are aware of the great need for additional community capacity for child and adolescent mental health services—especially residential treatment options. Knowing the quality of the work of Compass and our own need to have adequate community resources to meet our own client needs, we offer our full support for Compass in this endeavor.

Please do not hesitate to contact me should you have any questions or need more information.

Sincerely,

Mike LaBonte
Executive Director
Office: (901) 448-2802
Fax: (901) 448-4030
Email: mike.labonte@crisis7.org
Website: www.MemphisCrisisCenter.org

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AMERICAN FOUNDATION FOR
Suicide Prevention

October 21, 2015

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street
Andrew Jackson Bldg., 9th Floor
Nashville, TN 37243

Re: Compass Intervention Center

Dear Ms. Hill:

On behalf of the Memphis Mid-South Chapter of the American Foundation for Suicide Prevention, I express our support for Compass Intervention Center's Certificate of Need application.

The Memphis-MidSouth Chapter of AFSP does not provide crisis services; we depend on partnering agencies with which we have made strategic alliances to refer folks in need in our community. Services are needed to support individuals and families in all socio-economic categories, all neighborhoods, and all age groups. It is imperative that we have a referring resource for children and adolescent services - suicide and mental health issues affect everyone in the family, and the youngest members sometimes can be overlooked for care. Compass Intervention Center provides that much needed resource for families to heal and thrive.

There is a great need in our community and region for additional capacity for child and adolescent mental health services. The vast majority of psychiatric beds in the region are dedicated to treating adult patients, and as a result accessing child and adolescent services is increasingly difficult.

We strongly recommend Compass Intervention Center for their Certificate of Need application. Thank you for your interest and support of mental health issues in our community. Please do not hesitate to contact me should you have any questions or need more information.

Sincerely,

Mary Jean Coleman

Mary Jean Coleman, MSW
American Foundation for Suicide Prevention
Senior Director, Southern Division

November 4, 2015

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street
Andrew Jackson Bldg., 9th Floor
Nashville, TN 37243

Re: Compass Intervention Center

Dear Ms. Hill:

On behalf of The Oaks at La Paloma and Foundations Memphis, I want to express our strong support for Compass Intervention Center's Certificate of Need application.

The Oaks at La Paloma and Foundations Memphis are partners in a comprehensive system that treats alcohol, drug and co-occurring disorders. Together we make up a full continuum of care for adult patients with a focus on individualized treatment and a philosophy of recovery. We are a primary provider for these critical services in our community.

There is a great need in our community and region for additional capacity for child and adolescent mental health services. Most of the inpatient psychiatric beds in Memphis are for adult patients, and as a result accessing child and adolescent services is increasingly difficult. Compass works with complex adolescent patients, treating mental health needs and dual diagnosis. They are dedicated to providing quality care to the children and families they work with.

Again we offer our full support for Compass in their Certificate of Need Application. Please do not hesitate to contact me should you need more information.

Sincerely,

Paige Bottoms, Group CEO
Foundations Recovery Network
615-372-8928
Paige.Bottoms@FRNmail.com

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MEMPHIS UNION MISSION
"Rebuilding lives since 1945"

Men's Emergency Shelter | Opportunity Center | Calvary Colony | Wright Transitional House | Moriah House | Intact Family Ministry | Grace Church

November 18, 2015

Ms. Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building 9th Floor
502 Deaderick Street
Nashville, TN 37143

Re: Compass Intervention Center

Dear Ms. Hill:

Memphis Union Mission is honored to serve among the network of agencies who provide a myriad of services to our community's most vulnerable citizens. Providing these critical services often become the safety net an individual or family may need to overcome their dire situation.

When a strong and vibrant community of service providers are doing what they do best - serving people - the community benefits. Substance abuse issues are dealt with, behavioral and mental health disorders are addressed, and families are restored. The entire community benefits.

One agency that is key to the success of addressing psychiatric and dual diagnosis disorders for children and adolescents here in Shelby County is *Compass Intervention Center*. Children and adolescents become adults, and adults who lack a high school education are at high risk of homelessness. Adolescent substance abuse which continues into adulthood often becomes the precipitate for an individual's homelessness. Childhood abuse, left unaddressed, may set the stage for a lifetime of behavioral issues. The entire community is affected.

We would ask that you support *Compass Intervention Center's* Certificate of Need Application to add 24 new beds and additional outpatient and support space.

Respectfully,

D. Scott Bjork
President & CEO

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GREATER COMMUNITY TEMPLE COGIC • BISHOP BRANDON B. PORTER

June 24, 2015

It is my pleasure to write a letter in support of the Compass Intervention Center's expansion project. I am particularly drawn to the organization's focus on treating disadvantaged children with severe and chronic mental health and behavioral issues.

Greater Community Temple Church of God in Christ, the church where I pastor, has always been a church that catered to the community. Our motto is, "A church in the heart of the community with the community in its heart." We are committed to building up the community through our outreach efforts, and we support any entity with the same goal and purpose. We endorse any opportunity for positive reinforcement, such as the treatment program that Compass Intervention Center endeavors to employ.

Not only am I the pastor of Greater Community Temple, but I am also a General Board member of the Churches Of God in Christ, Inc., whose headquarters happens to be in Memphis, Tennessee. As a representative for the National Church and this headquarters region, one of my objectives is to be an advocate for programs that offer proactive solutions to the problems that plague our city.

Because of the great need for a program in our area willing to treat youth with extreme behavioral challenges, I believe that the completion of the expansion project is vital. Currently, not enough inpatient programs exist, and the result is some youth's becoming delinquent and part of the already overcrowded penal system, rather than their getting the treatment that they really need and/or deserve. The addition of the inpatient children's services to the current curriculum of care may help remedy the problem and subsequently lower our city's crime statistics.

Overall, the Compass Intervention Center's expansion program is a notable endeavor. I am convinced that its fruition will prove to be a welcomed asset to Memphis and its surrounding communities.

Sincerely,

Bishop Brandon B. Porter
Senior Pastor
Greater Community Temple COGIC

TCSW
Tennessee Conference on Social Welfare

November 16, 2015

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street
Andrew Jackson Bldg., 9th Floor
Nashville, TN 37243

Re: Compass Intervention Center

Dear Ms. Hill:

I am writing in support of Compass Intervention Center's Certificate of Need application. My organization, the Tennessee Conference on Social Welfare (TCSW), has a very positive relationship with Compass Intervention Center. They have an excellent reputation for providing innovative, evidence-based care of children and youth, specializing in trauma recovery and treatment of co-occurring mental health and substance abuse disorders. Notably, they provide treatment for predominantly underserved, low-income youth. An expansion of their program will add important services in Tennessee and the Mid-South for children with severe and chronic mental illnesses.

Compass Intervention Center is uniquely qualified to provide high-quality services to an increased number of children and youth. Their entire clinical team is trained in Trauma-Focused Cognitive Behavioral Therapy. The organization provides clinical internships for Bachelor and Master's degree students attending the University of Tennessee, the University of Memphis, the University of Mississippi, and Harding and Union Universities. Compass Intervention Center also recently piloted the HERO program to screen and divert teens with minor offenses out of the juvenile justice system and into treatment.

On behalf of TCSW, I fully endorse Compass Intervention Center's certificate of need application. Approving their application will enable Compass Intervention Center to expand the scope and impact of an already successful program.

Sincerely,

Terri Lawson

Terri Lawson, LAPSW, ACSW
Executive Director

CAMELOT
SERVING OUR COMMUNITY SINCE 1972

June 29, 2015

I am writing a letter of support for Compass Intervention Center's expansion. The level of need in our community is high. The children that they serve face an overwhelming amount of barriers to health including higher amounts of violence and trauma exposure, higher numbers of contact with the justice system, economic and educational deficits and a lack of appropriate treatment resources. Existing inpatient programs for children and adolescents are consistently full, and/or not accepting patients.

They have the ability to work with even the toughest kids. They believe all children should be offered superior care no matter their circumstances. At Compass Intervention Center, they often accept challenging children that have difficulty gaining access to services. They recognize that every child and family is unique and that we have to offer individualized, culturally competent care. Their satisfaction comes from helping children and families make meaningful and lifelong changes in their lives.

West Tennessee has a great deal of need for more resources and could benefit greatly from the expansion of Compass. Please do not hesitate to contact me with any further questions.

Sincerely,

Jennifer Predmore, LAPSW

Vice President West TN Region

901-230-1116

JPredmore@camelotcare.com

www.thecamelotdifference.com

183

CAMELOT of WEST TENNESSEE
1910 Nonconnah Blvd
SUITE 100
MEMPHIS, TN 38132
TEL 901.346.1270
FAX 901.346.1271
www.thecamelotdifference.com

UNION UNIVERSITY
GERMANTOWN

October 20, 2015

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building 9th Floor
502 Deaderick St.
Nashville, TN 97243

Ms. Hill:

It is our pleasure to write a letter in support of Compass Intervention Center's proposal to upgrade and expand its services.

Compass Intervention Center is a 108-bed Residential Treatment Center for children and adolescents who possess psychiatric and dual diagnosis disorders. In addition, it provides intensive outpatient services and a partial hospital program. They predominantly serve individuals who are underserved, low-income, and have the greatest need across domains. Compass Intervention Center chooses to work with even the most challenging kids that have difficulty finding agencies that will provide assistance.

This agency effectively meets a crucial need for our community. The children and youth that they serve face an overwhelming amount of barriers to health, including greater amounts of violence and trauma exposure, higher numbers of contact with the justice system, economic and educational deficits, and a lack of appropriate treatment resources. Existing inpatient programs are consistently full and/or not accepting new patients. As we look at the mental health crisis in our country, we are reminded of the great need within our community for additional mental health services.

With effective and consistent care, children and youth can mitigate the barriers and negative effects of trauma that exist in their lives. Compass Intervention Center data reflects that their programs are focused on safety, clinical outcomes, and service to patients. Patient satisfaction and outcome measures continue to improve at the agency. The agency is committed to continual improvement of treatment outcomes to ensure the highest quality of service.

The agency specializes in children's trauma recovery and the treatment of co-occurring mental health and substance abuse disorders. Their clinical team is trained in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Within their trauma program, they have seen a

2745 HACKS CROSS ROAD GERMANTOWN, TENNESSEE 38138 901.759.0029 FAX: 901.759.1197 www.uu.edu/gtown

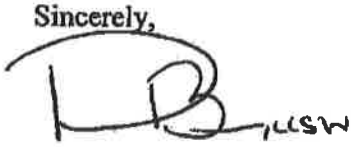
positive impact in the lives of the children they work with. In addition, they utilize innovative approaches to care and are invested in their communities. They not only serve children and youth who possess psychiatric and dual diagnosis disorders but they also provide community education and awareness to assist with eliminating the stigma of mental health.

Due to the quality of care and effective work accomplished at the agency, the School of Social Work at Union University regularly places Bachelor's of Social Work (BSW) and Master's of Social Work (MSW) students at the agency for their field placement. Students walk away from their field placement at Compassion Intervention Center armed with knowledge, skills, and a strong level of competency that helps them in successfully transitioning to their careers as social work practitioners. We are thankful for Compass Intervention Center's willingness to serve our students and assist them in preparation for social work practice.

In conclusion, we fully support the efforts of Compass Intervention Center as they seek funding to enhance and grow their services. As mentioned above, there is a critical need for more mental health services for children and youth. Compass Intervention Center has the ability to provide quality and effective care that can make a lasting positive impact on its clients, their families, and the community as a whole.

Should you have questions or need more information, feel free to contact us at 901-312-1921 or by email (rbohner@uu.edu or kmatthews@uu.edu).

Sincerely,



Rebecca Bohner, LCSW
Director of BSW Field Education
Union University, School of Social Work, Germantown Campus

Katrinna Matthews, LMSW, LAPSW
Director of MSW Field Education
Union University, School of Social Work, Germantown Campus

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

August 1, 2016

Jeremy Pitzer
Compass Intervention Center
7900 Lowrance Road
Memphis, TN 38125

RE: Certificate of Need Application -- Compass Intervention Center - CN1606-025
The establishment of a 48 bed inpatient mental health hospital for children and adolescents up to age 18 located at 7900 Lowrance Road, Memphis (Shelby County), TN 38125. The estimated project cost is $12,152,661.

Dear Mr. Pitzer:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Marthagem Whitlock at the Tennessee Department of Mental Health and Substance Abuse Services for Certificate of Need review by the Division of Planning, Research, & Forensics. You may be contacted by Ms. Whitlock or someone from her office for additional clarification while the application is under review by the Department. Ms. Whitlock's contact information is Marthagem.Whitlock@tn.gov or 615-532-6717.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on August 1, 2016. The first 60 days of the cycle are assigned to the Department of Mental Health and Substance Abuse Services, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the 60-day period, a written report from the Department of Mental Health and Substance Abuse Services or its representative will be forwarded to this office for Agency review. You will receive a copy of their findings. The Health Services and Development Agency will review your application on October 26, 2016.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

cc: Marthagem Whitlock, TDMHSAS, PRF

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Marthagem Whitlock, Assistant Commissioner
of Planning Research & Forensics
TN Department of Mental Health and Substance Abuse Services
Division of Planning, Research & Forensics
Andrew Jackson Building, 5th Floor
500 Deaderick Street
Nashville, Tennessee 37243

FROM: Melanie M. Hill
Executive Director

DATE: August 1, 2016

RE: Certificate of Need Application
Compass Intervention Center - CN1606-025

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a 60-day review period to begin on August 1, 2016 and end on October 1, 2016.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: Jeremy Pitzer

TRAUGER & TUKE
ATTORNEYS AT LAW
THE SOUTHERN TURF BUILDING
222 FOURTH AVENUE NORTH
NASHVILLE, TENNESSEE 37219-2117
TELEPHONE (615) 256-8585
TELECOPIER (615) 256-7444

June 10, 2016

By hand delivery

Melanie M. Hill
Executive Director
Tennessee Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: Keystone Memphis, LLC, a limited liability company, d/b/a Compass Intervention Center
Certificate of Need to establish a children's psychiatric hospital

Dear Ms. Hill:

Enclosed please find the original and four copies of the Letter of Intent for the referenced project on behalf of our client Keystone Memphis, LLC d/b/a Compass Intervention Center. Publication of Intent was published in this morning's *Commercial Appeal*, which is a newspaper of general circulation in Shelby County, Tennessee, and it is anticipated that the filing of the certificate of need application will occur within five days. Please date stamp two copies and return them to me.

The contact person for this application is Jeremy Pitzer, Chief Executive Officer, Compass Intervention Center. His office telephone number is 901-758-2002.

Very truly yours,

Paul W. Ambrosius

PWA:kmn

Enclosures

cc: Jeremy Pitzer, Chief Executive Officer, Compass Intervention Center
Byron R. Trauger, Esq., Trauger & Tuke

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the Commercial Appeal (Name of Newspaper) which is a newspaper of general circulation in Shelby (County), Tennessee, on or before June 10 (Month / day), 2016 (Year), for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

Compass Intervention Center (Name of Applicant) Residential Treatment Facility (Facility Type-Existing)

owned by: Keystone Memphis, LLC with an ownership type of LLC

and to be managed by: UHS of Delaware, Inc. intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]: the establishment of a children's psychiatric hospital at our existing location of 7900 Lowrance Road, Memphis, TN 38125. The facility will seek additional licensure from the Department of Mental Health and Substance Abuse Services as a 48-bed Mental Health Hospital, offering inpatient psychiatric care for children and adolescents up to age 18. This project does not initiate or discontinue any other health services, and this project does not include any major medical equipment. The proposed cost for the project is $12,152,661.

The anticipated date of filing the application is: June 15, 2016

The contact person for this project is Jeremy Pitzer (Contact Name) CEO (Title)

who may be reached at: Compass Intervention Center (Company Name) 7900 Lowrance Road (Address)

Memphis (City) Tennessee (State) 38125 (Zip Code) 901 / 758-2002 (Area Code / Phone Number)

(Signature) 06/09/16 (Date) jeremy.pitzer@uhsinc.com (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Supplemental #1
-Original-

Compass Intervention Center

CN1606-025

SUPPLEMENTAL #1
June 29, 2016
12:31 pm

TRAUGER & TUKE
ATTORNEYS AT LAW
THE SOUTHERN TURF BUILDING
222 FOURTH AVENUE NORTH
NASHVILLE, TENNESSEE 37219-2117
TELEPHONE (615) 256-8585
TELECOPIER (615) 256-7444

June 29, 2016

By hand delivery

Melanie M. Hill
Executive Director
Tennessee Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: Keystone Memphis, LLC, a limited liability company, d/b/a Compass Intervention Center Certificate of Need to establish a children's psychiatric hospital

Dear Ms. Hill:

This letter transmits the supplemental response and four copies to the referenced certificate of need application. Also enclosed is the affidavit. Please date stamp two copies and return them to me in the enclosed envelope.

The contact person for this application is Jeremy Pitzer, Chief Executive Officer, Compass Intervention Center. His office telephone number is (901) 758-2002.

As always, thank you for your courtesies.

Very truly yours,

Byron R. Trauger

Enclosures

cc: Jeremy Pitzer, Chief Executive Officer, Compass Intervention Center
Paul W. Ambrosius, Esq.

SUPPLEMENTAL #1
June 29, 2016
12:31 pm

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Shelby

NAME OF FACILITY: Compass Intervention Center

I, Jeremy Pitzer, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

CEO
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 28th day of June, 2016, witness my hand at office in the County of Shelby, State of Tennessee.

Terri Sweet
NOTARY PUBLIC

My commission expires 10/5, 2019.

HF-0043

Revised 7/02

TERRI SWEET
STATE OF TENNESSEE
NOTARY PUBLIC
SHELBY COUNTY
MY COMMISSION EXPIRES 10-5-2019

SUPPLEMENTAL #1

June 29, 2016
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1. **Section A, Applicant Profile, Item 7**
   Your response is noted. However, mental health OP, partial hospitalization, mental health intensive day treatment, and alcohol and drug residential are not CON reviewable services. Please provide a corrected page.

   Please see the following corrected page from the applicant profile with services that are not CON reviewable removed (Replacement Page 2 of the Original Application).

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5. ***Name of Management/Operating Entity (If Applicable)***

UHS of Delaware, Inc.
Name

367 South Gulph Road
Street or Route

Montgomery
County

King of Prussia
City

PA
State

19406
Zip Code

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. ***Legal Interest in the Site of the Institution (Check One)***

A.	Ownership	X	D.	Option to Lease	
B.	Option to Purchase		E.	Other (Specify)	
C.	Lease of _____ Years				

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

7. ***Type of Institution (Check as appropriate--more than one response may apply)***

A.	Hospital (Specify)_____		I.	Nursing Home	
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty		J.	Outpatient Diagnostic Center	
			K.	Recuperation Center	
C.	ASTC, Single Specialty		L.	Rehabilitation Facility	
D.	Home Health Agency		M.	Residential Hospice	
E.	Hospice		N.	Non-Residential Methadone Facility	
F.	Mental Health Hospital	X			
G.	Mental Health Residential Treatment Facility	X	O.	Birthing Center	
			P.	Other Outpatient Facility (Specify)_____	
H.	Mental Retardation Institutional Habilitation Facility (ICF/MR)		Q.	Other (Specify)	

8. ***Purpose of Review (Check) as appropriate--more than one response may apply)***

A.	New Institution	X	G.	Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation*]	X
B.	Replacement/Existing Facility				
C.	Modification/Existing Facility	X			
D.	Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify)_____		H.	Change of Location	
			I.	Other (Specify)_____	
E.	Discontinuance of OB Services				
F.	Acquisition of Equipment				

Replacement Page 2 of Original Application

2. **Section A, Applicant Profile, Item 5**

Please provide a brief description of the management/operating entity's expertise to operate this facility/service. Brief bio's outlining areas of expertise and experience of the senior management will be helpful.

Universal Health Services, Inc. is the largest facility-based behavioral health provider in the country, with its subsidiaries operating 216 behavioral health facilities in 37 states, Washington, DC, Puerto Rico, the U.S. Virgin Islands and the United Kingdom. Our facilities are consistently recognized for excellence, and in 2014 over 40 facilities were recognized by the Joint Commission as Top Performers on Key Quality Initiatives.

Jeremy Pitzer, CEO of Compass is a Licensed Clinical Social Worker and has 13 years of experience in behavioral health. Prior to coming to Compass in 2011, Jeremy was the Director of Clinical Services and Assistant Administrator at The Pavilion Behavioral Health System in Champaign, Illinois, a behavioral health facility treating children, adolescents and adults for psychiatric and substance abuse disorders. During an eight year tenure at the Pavilion, Jeremy was trusted with many roles including Mental Health Tech, Admissions Coordinator, Business Development Coordinator, Patient Advocate, Hospital Staffing, Interim Residential Director, and Interim Admissions Director.

Jeremy has two years of experience in Community Based Mental Health, leading a crisis team that provided mobile assessment and in-home services to Medicaid recipients in a seven county area. Jeremy is active in community activities, serving on a variety of committees and promoting the behavioral health field. Most recently Jeremy has been the Chair of the Region VII Policy and Planning Council for the Tennessee Department of Mental Health and Substance Abuse Services.

Fred Woods, CFO of Compass, has over 40 years of experience in Healthcare Finance. The original Comptroller at Lakeside Hospital in 1974, Fred has acquired vast experience in all aspects of hospital management. Fred has worked for several behavioral health and med/surg hospitals, as well as in the health insurance industry and private ventures. Mr. Woods was a Regional CFO with Comprehensive Care Corp. from 1991-1997 and with Tenet Healthcare from 1997-2000. He was the CFO with CAPP management, a MSO that managed approximately 2 million lives, and served as the Assistant Director/CFO for Loma Linda University Behavioral Medical Center.

The management fee is not specified in the Management/Operating Entity Agreement. Please provide a management operating entity agreement that specifies the management fee amount or percentage assigned to the proposed project.

The management fee is a variable fee because the number of facilities and the total cost allocated change each year, and is not included in the Management/Operating Entity Agreement. The management fee for Compass in 2015 was $330,480 and the management fee for 2016 will be $439,560 ($36,630/month). Future allocations will not be impacted by the proposed project.

SUPPLEMENTAL #1

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3. **Section A, Applicant Profile, Item 9**

Please total the bed complement data chart and submit.

The bed compliment data chart has been corrected. Please see the following updated Bed Compliment Data Chart (Replacement for Page 3 of the original application).

SUPPLEMENTAL #1
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9. Bed Complement Data

Please indicate current and proposed distribution and certification of facility beds.

		Current Beds Licensed	*CON	Staffed Beds	Beds Proposed	TOTAL Beds at Completion
A.	Medical					
B.	Surgical					
C.	Long-Term Care Hospital					
D.	Obstetrical					
E.	ICU/CCU					
F.	Neonatal					
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child/Adolescent Psychiatric	0	0	0	48	48
K.	Rehabilitation					
L.	Nursing Facility (non-Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P.	ICF/MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency	30	0	30	0	30
S.	Swing Beds					
T.	Mental Health Residential Treatment	78	0	62	0	78
U.	Residential Hospice					
	TOTAL	78	0	92	48	156

*CON-Beds approved but not yet in service

10. Medicare Provider Number Will apply for Medicare number and validation

Certification Type Hospital

11. Medicaid Provider Number 5441352

Certification Type Current--Psychiatric Residential Treatment Facility, will apply as Hospital

12. If this is a new facility, will certification be sought for Medicare and/or Medicaid? See A.12 next page

13. *Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.* Will this project involve the treatment of TennCare participants? YES **If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted *or plans to contract.*** See A.13 next page

4. **Section A, Applicant Profile, Item 13**
Please clarify if the applicant is contracted for Medicaid in Arkansas and Mississippi.

Compass is currently contracted with Arkansas Medicaid and will seek a contract with Mississippi Medicaid if this proposed project is approved.

Please clarify if children in state custody will be admitted to the new proposed 48 inpatient psychiatric child and adolescent units. If so, does the applicant have a letter of support from the Department of Children's Services?

Children in state custody will be admitted to the new proposed inpatient psychiatric facility. We do not currently have a letter of support from DCS.

Please clarify if a Tennessee Department of Children's Services' contract is needed to admit children in state custody for inpatient psychiatric services.

A contract with DCS may not necessarily be required, if coverage is approved through TennCare. However there are circumstances where a single-case agreement (DCS Unique Care Agreement) may be made. We have executed these single-case contracts in the past with DCS, and anticipate the need will arise with the addition of inpatient services. We are also amenable to discussing other contracting opportunities with DCS.

5. **Section B.I. Project Description**

The applicant notes Lakeside had to deflect at least 153 child and adolescent patients due to capacity. According to the 2014 Lakeside JAR the hospital only staffs 25 of the 55 inpatient psychiatric beds licensed as child and adolescent. Please discuss the reason Lakeside Behavioral Health System is not staffing all their 55 licensed inpatient child and adolescent beds.

For clarification, it should be noted that Lakeside reports (2014 data) staffing 25 adolescent beds and 24 child beds for a total of 49 staffed beds on 55 licensed beds. They are effectively able to staff all beds at this point. During 2015 and 2016, there are numerous occasions where they reach capacity of licensed beds.

It is noted both the applicant and Lakeside Behavioral Health System is owned by Universal Health Services, Inc. Since Lakeside Behavioral Health System (which is also located in Shelby County) staffs only 25 of their 55 child and adolescent inpatient psychiatric beds, has Lakeside given consideration to delicense the unstaffed 30 licensed beds if this project is approved? If not, why?

Please see above, the number 25 was referring to adolescent beds. They are licensed for 55 total child and adolescent beds. While we cannot speak for Lakeside, they are able to currently staff its beds and would not have any interest in delicensing any beds.

Please indicate the reason the applicant is not constructing a hospital in a location such as Jackson (Madison County), TN which is more centrally located in the Grand Region of West Tennessee.

We are not proposing to construct a new facility in Jackson or other centrally located area for a few reasons. First the heart of our proposal is to build a one-of-a-kind comprehensive children's psychiatric system. This inherently requires onsite integration of the proposed project into existing services and levels of care. Secondly, the undeveloped portion of our existing property allows for the construction of the propped facility without the unnecessary costs associated with identifying and acquiring property elsewhere. Lastly, onsite expansion allows for greater synergy with existing human, support, and administrative resources.

The applicant notes occupancy in the Shelby/Memphis region as a percentage of staffed beds is over 86%. What is the occupancy as a percentage of total licensed child and adolescent beds?

The overall occupancy on *licensed* beds for Mental Health Hospitals in the region is 79.5% in the Current Year combined JAR, Report 2. Lakeside reported 18,481 under 18 patient days in 2014, equating to an occupancy of over 92% of licensed child and adolescent beds (2014 Lakeside JAR). St. Francis reports 6359 under 18 patient days resulting in an occupancy on licensed beds of 50% (2014 St. Francis JAR). For these two facilities, the combined occupancy on *licensed* beds is 75.6%. There is no data for Crestwyn available yet.

How many licensed child and adolescent beds in the proposed service area are not staffed and where?

Per the Current Year JAR reports the vast majority licensed child and adolescent beds are staffed. For 2014, Lakeside reports staffing 49 of its 55 licensed beds, St. Francis reports staffing all 35 of its licensed beds. For these two facilities, the combined percentage of licensed beds that are staffed is 93.3%. There is no data for Crestwyn available yet.

The applicant notes in 2016 over 1,000 screenings and assessments were completed. However, please clarify if TennCare patients must be assessed again by the Youth Villages Crisis Team for possible inpatient placement.

Youth Villages or another designated mobile crisis teams would need to assess or approve patients for inpatient assessment. This statistic is meant to demonstrate that demand for child

and adolescent services continues to rise, and that increasing numbers of providers and families are turning to Compass for help.

The applicant notes Crestwyn Hospital project was recently implemented. Please clarify when the hospital opened.

Crestwyn Hospital began accepting patients in early May, 2016. We have been given the date of May 2, 2016, however we do not have firsthand knowledge that they were accepting patients that day.

It is noted by the applicant the current staffed beds in service often do not meet the community demand for inpatient services. Please clarify why all licensed child and adolescent inpatient beds are not totally staffed in the proposed service area if the community demand for inpatient services are not currently met.

The most recent Hospital JAR data indicates that Lakeside was able to staff 49 of its 55 licensed Child and Adolescent beds. There is every indication that they are able to fully staff all beds as they have been frequently at capacity in 2015 and 2016. St. Francis reports staffing all of its child and adolescent beds. 93.3% of licensed child and adolescent bed in the service areas are staffed. There is no data for Crestwyn available yet.

Community demand for services is not met for several reasons:

- Two historic primary providers (St. Francis and Lakeside) are frequently full or unable to accept patients.
- There are times where mobile crisis is unable to locate a bed anywhere for children in need of inpatient services. This is at best not ideal, and often creates a dangerous situation.
- Additional capacity of Crestwyn project does not fully address population based need, or the increased actual need for bed capacity.

Please specify the age range of patients who will be admitted to the two proposed units.

We will potentially accept patients ages 5-17 to both units. The design of the two distinct units allows for flexibility in managing changing patient population demographics. For clarification, the children and adolescent will participate in different programs, and each age group will room with, and in proximity to their appropriate peer group.

Please clarify if there will be separate units for male and female adolescents. If not, why?

Male and female adolescent patients will not have designated separate units. However, as discussed above, the design of the facility allows for sleeping areas to be segregated by age and/or gender. Males and Females will not share rooms. As a standard practice in behavioral health, Adolescent Males and Females will participate in programming together (classroom, groups, activities).

Please clarify if the applicant will offer inpatient chemical dependency services.

We will not be providing inpatient chemical dependency services (Medical Detox).

Please describe the 2,250 SF expansion/renovation of the existing dining services.

The dining services expansion and renovation consists of the conversion of the existing approximately 700 sq./ft. Dining Area into a new food preparation (250 sq. /ft.) area and food service area (450 sq./ft.). Serving line equipment will be upgraded to better serve the growing patient population. The existing Gymnasium (approximately 1500 sq. /ft.), which is being replaced as part of the building addition component, will be converted into expanded dining space. Finishes in both areas will be upgraded to provide greater durability, patient-friendly aesthetics and enhanced acoustical performance.

Please clarify which unit will serve those that are dually diagnosed with a psychiatric and chemical dependency diagnosis.

Adolescents that are dually diagnosed will receive appropriate treatment interventions based on needs and diagnoses, which be addressed through group, individual and family therapy. We have no plans to identify a unit specific to this population.

Please clarify if the proposed units will admit patients with intellectual disabilities.

Patients with intellectual disabilities will be admitted to the facility when appropriate. Admission criteria allows for case-by-case review of patients with an IQ below 70.

6. **Section B, Project Description Item II.A**

The square footage and cost per square footage chart is noted. However, please include the total GSF in "line E." for the renovated column.

- Please see the updated Square footage Chart on the following page

Private/Semi-Private Room and Bed Mix

Bed Type	Proposed Private Rooms/Beds		Proposed Semi-Private Rooms/Beds	
	Rooms	Beds	Rooms	Beds
Child Psych	0	0	12	24
Adolescent Psych	0	0	12	24

*The beds allocated to child and adolescent programs are not fixed and will change depending on the patient population demographics at any time. This is a common standard practice in inpatient behavioral health.

7. **Section B.II.C Applicant's Need for the Proposed Project**

The applicant notes in the first three months of 2016 Lakeside had to deflect at least 153 child and adolescent patients due to capacity and St. Francis deflected over 100 patients in March 2016 due to capacity. Please clarify if the capacity the applicant is referring to licensed capacity or staffed capacity.

For Lakeside, here we are referring to licensed capacity. They are literally full and unable to accept any more patients. For St. Francis, our understanding is that it is historically a mix a being at licensed and staffed capacity at different times. From our perspective the staffed capacity at St. Francis appears to have wide variations throughout the year. It should be noted, when these local facilities are unable to accept patients, it quickly becomes a substantial issue for providers and families with children who need inpatient care.

Please clarify what is meant by "deflections". Does this mean patients met inpatient psychiatric medical necessity criteria and was sent elsewhere for inpatient services?

Here we are referring to capacity deflections. These patients generally meet criteria and are given less-than-desirable dispositions that include being sent out of area for treatment, being managed in other settings including ERs, DCS offices, and simply put on a waiting list.

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SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
Clinical/Support Spaces						13,153	13,153		$420.34	$ 5,528,667
Admissions						1,250	1,250		$464.48	$ 580,596
Shell Space (future PHP)						988	988		$115.38	$ 113,998
Connector Corridor						1,331	1,331		$248.73	$ 331,053
New Gymnasium						3,138	3,138		$195.07	$ 612,116
Dining to Servery Renovation					707		707	229.04		$ 161,932
Gym to Dining Renovation					1,543		1,543	$227.71		$ 351,364
B. Unit/Depart. GSF Sub-Total					2,250	19,860	22,110	$228.13	$360.85	$ 7,679,726
C. Mechanical/ Electrical GSF						330	330			
D. Circulation /Structure GSF						5,734	5,734			
E. Total GSF					2,250	25,924	28,174	$228.13	$276.44	$ 7,679,726

8. **Section B, Project Description Item III.A (Plot Plan)**
The plot plan is noted. However, the labels on the buildings are not legible. Please provide a plot plan with legible enlarged building identification.

Please see the updated Plot Plan with enlarged labeling on the following page.

SUPPLEMENTAL #1

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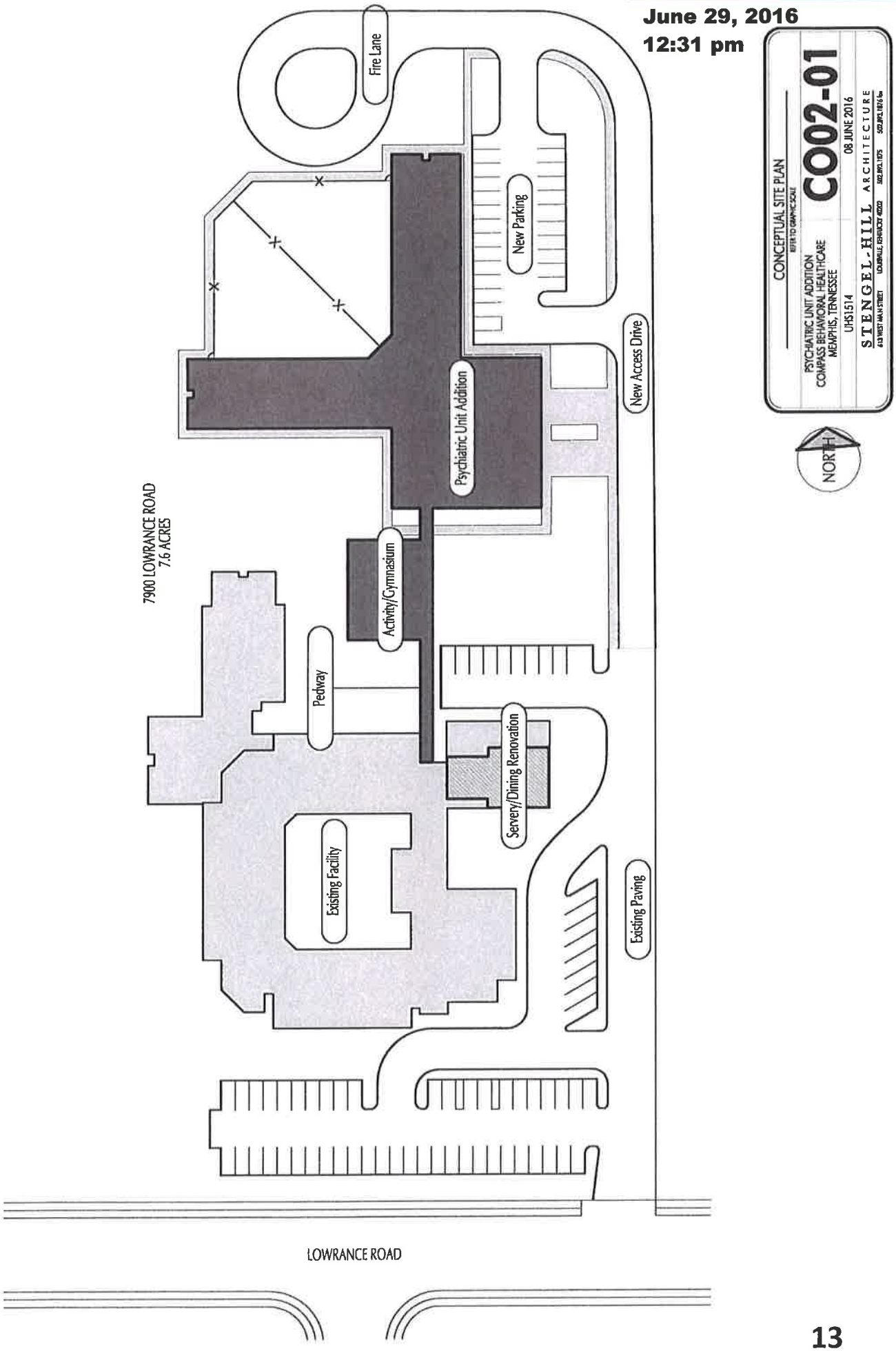

SUPPLEMENTAL #1
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9. **Section B Project Description Item B.IV**

Many of the drawings included in the application are just too small to be legible and permit the Agency a clear understanding of what the applicant is proposing. Please provide larger, more detailed images with legible room labels of your project. If needed, multiple sections of the floor plans may be submitted.

Please see the expanded floor plan images on the following several pages.

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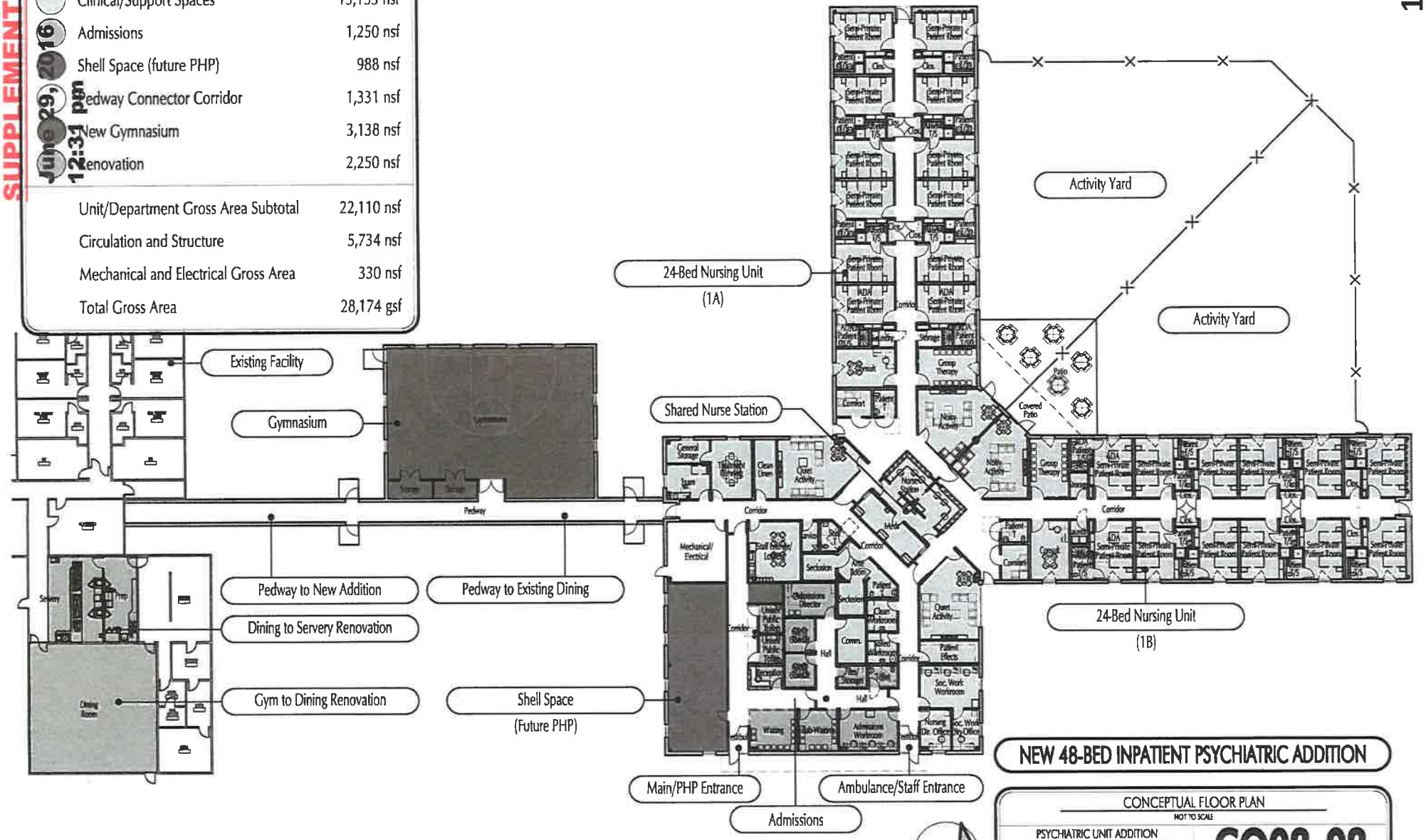
LEGEND	
Patient Beds	48 Beds
Clinical/Support Spaces	13,153 nsf
Admissions	1,250 nsf
Shell Space (future PHP)	988 nsf
Pedway Connector Corridor	1,331 nsf
New Gymnasium	3,138 nsf
Renovation	2,250 nsf
Unit/Department Gross Area Subtotal	22,110 nsf
Circulation and Structure	5,734 nsf
Mechanical and Electrical Gross Area	330 nsf
Total Gross Area	28,174 gsf



NEW 48-BED INPATIENT PSYCHIATRIC ADDITION

CONCEPTUAL FLOOR PLAN
NOT TO SCALE

PSYCHIATRIC UNIT ADDITION
COMPASS BEHAVIORAL HEALTHCARE
MEMPHIS, TENNESSEE

C002-02

UHS1514

08 JUNE 2016

STENGEL-HILL ARCHITECTURE
613 WEST MAIN STREET LOUISVILLE, KENTUCKY 40202 502.893.1875 502.893.1876 fax

SUPPLEMENTAL #1

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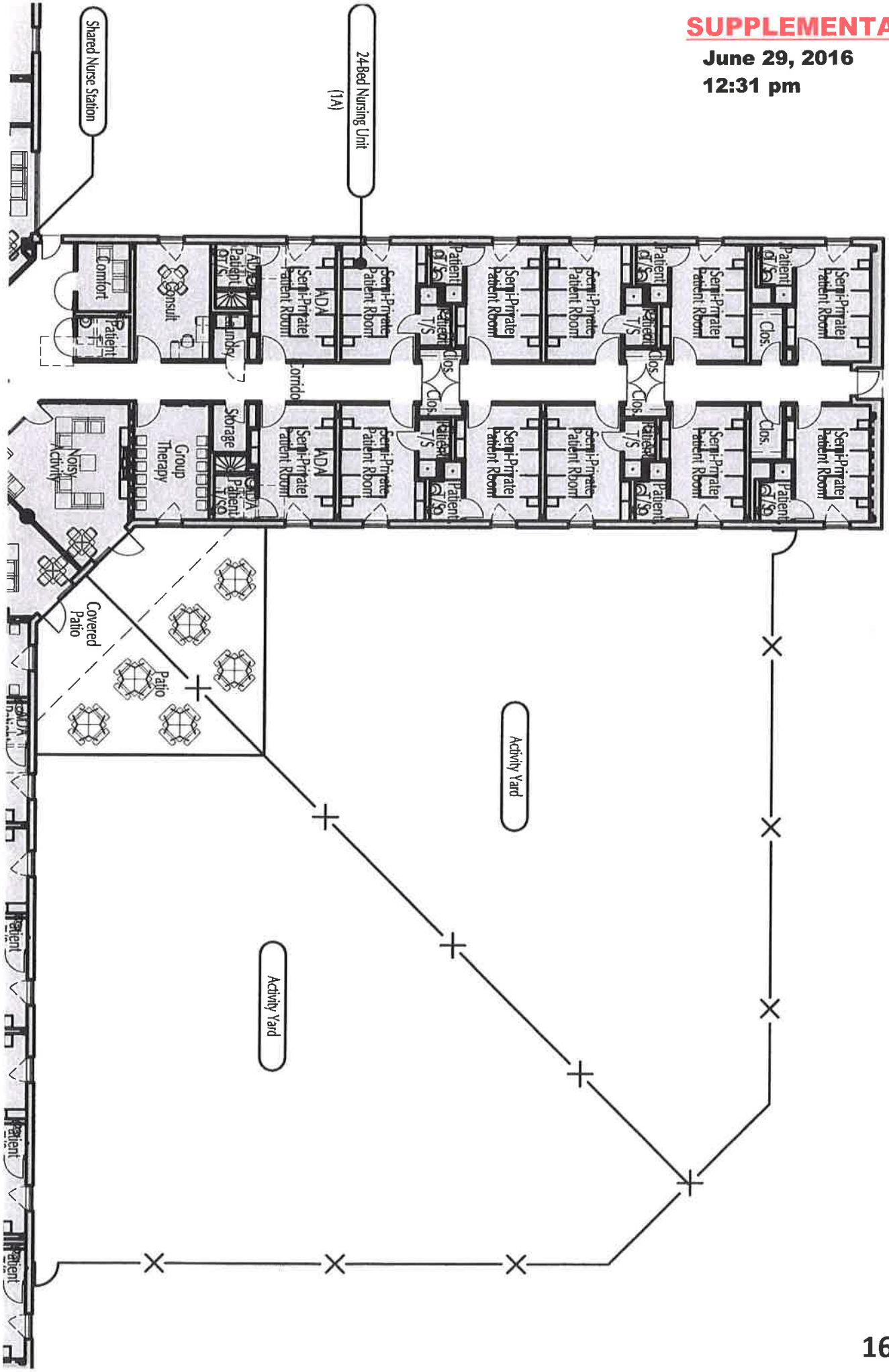

SUPPLEMENTAL #1

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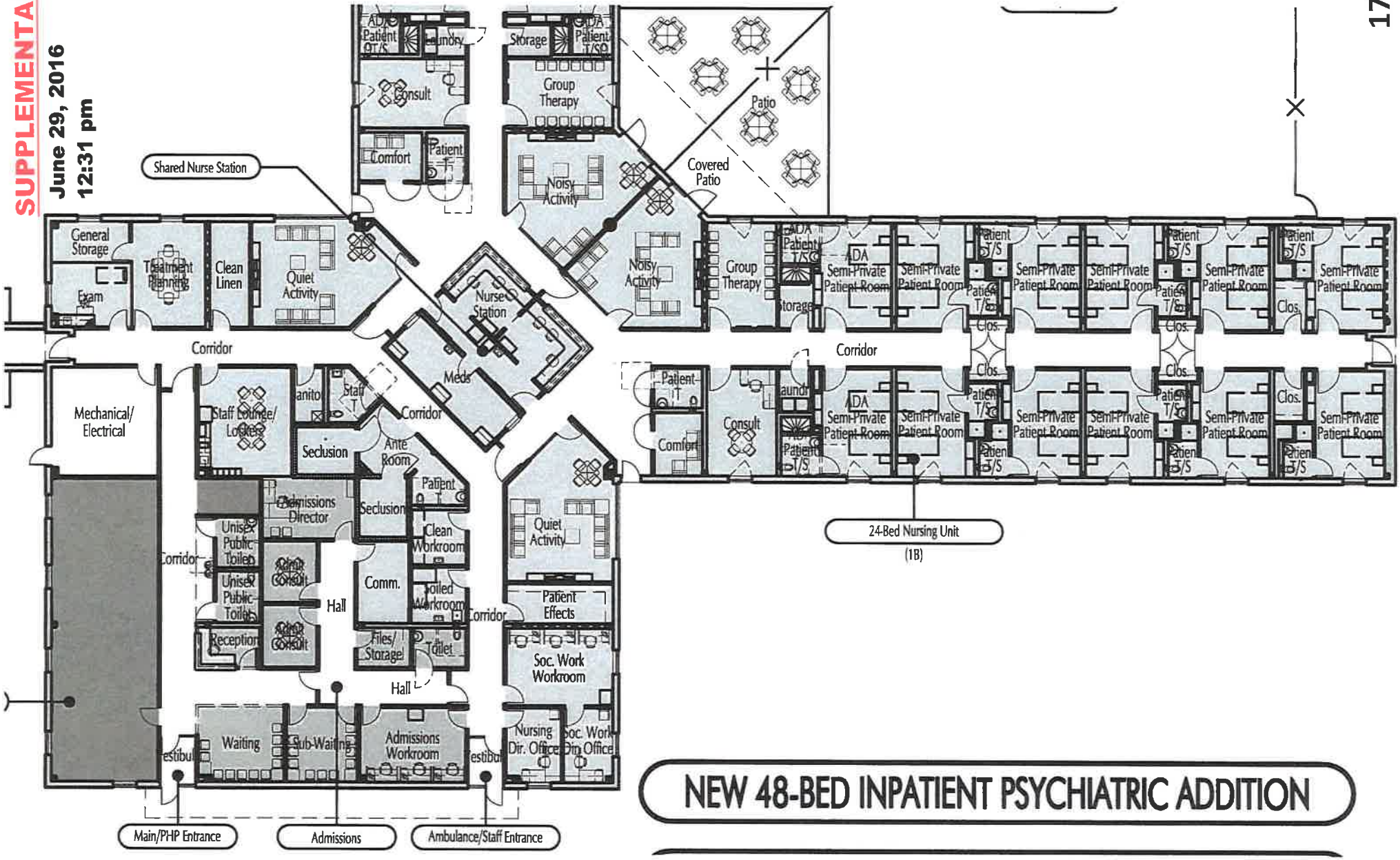
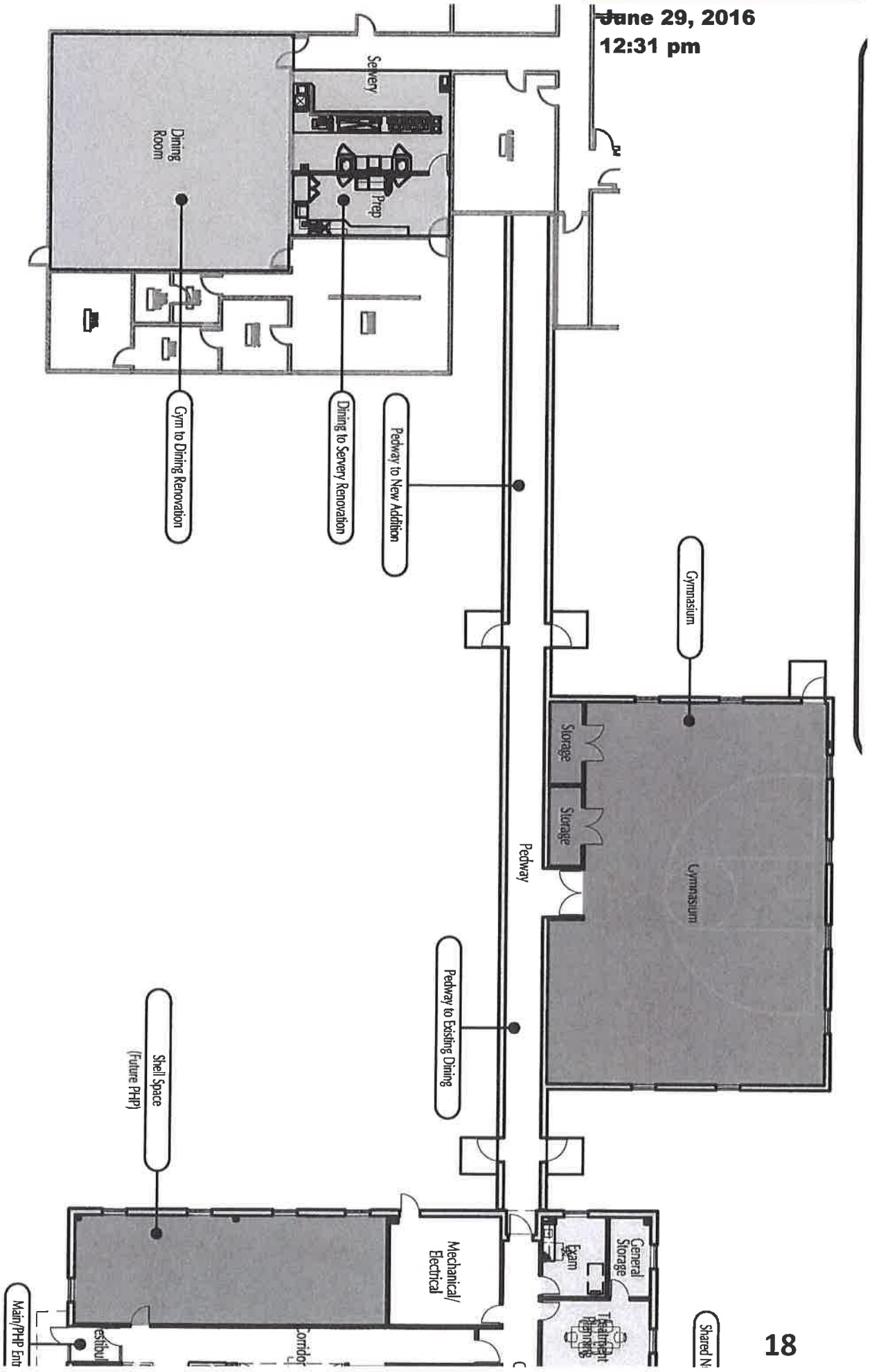


NEW 48-BED INPATIENT PSYCHIATRIC ADDITION

SUPPLEMENTAL #1

~~June~~ 29, 2016
12:31 pm



10. Section C. (Need) 1. Specific Criteria (Inpatient Psychiatric Units) Item A. Need

Please complete the following tables to determine psychiatric bed need.

	Population 2020	Gross Need Pop. X (30 beds/100,000)	Current licensed beds	Net Need
	Child and Adolescent 0-17	Child and Adolescent 0-17	Child and Adolescent 0-17	Child and Adolescent 0-17
Proposed Service Area	395,172	118.5	105 (24 Child, 81 Adolescent)	13

- The CON 2016-2020 population estimates provided by the Tennessee Department of Health provide data for 0-17, but this data does not break out for 0-12 and 13-17. Tennessee and US Census estimates have been useful in informing our bed need, however they break out data by different age groups (0-4, 4-9, 10-14, and 15-19) that do not correspond with the criteria. We have requested custom data from the Department of Health regarding this and have not yet received a response. As such, the table above is completed with total 0-17 population and bed need.
- There are 105 licensed Child and Adolescent beds (0-17) Child and Adolescent beds are not licensed separately. The numbers for "Current Licensed Beds" are based on total licensed beds and available data from children specific beds at Lakeside. Based on population estimates for 2020, the total number of child and adolescent beds needed for the service area is 118.5, with 105 licensed beds available. The "net need" will not change regardless of the data breakout, and the proposed licensed beds would be used for either age group at any given time.

(#4) Total need should be adjusted by the existent staffed beds operating in the area.

The table of beds by licensed mental health hospitals on the bottom of page 17 is noted. However, it is unclear how many beds are licensed and staffed at Lakeside Hospital. On page 25 of the application the applicant states 25 beds are staffed with a capacity of 55 at Lakeside Hospital. In the table on page 17 the staffing is noted at 49 beds. Please clarify.

For the requested clarification, Lakeside is licensed for 261 beds in the Mental Health Hospital category. Of these 55 are designated for children and adolescents (Per historical data and 2005 CON summary). Per the most recent JAR, 49 of these 55 are staffed.

11. Section C. (Need) 1. Specific Criteria (Inpatient Psychiatric Units) Item C.2.

It is noted every County in the service area is designated as a Medically Underserved in the Mental Health Category Area by the U.S. Health Resources and Services Administration. Please clarify if this applies to Child and Adolescent psychiatric inpatient.

Medically Underserved does not specifically refer to inpatient services, but a general lack of access to services due to various barriers.

12. **Section C. (Need) 1. Specific Criteria (Inpatient Psychiatric Units) Item C.4.**

    It is noted the applicant will serve primarily shorter-term acute patients. Please indicate where child and adolescent long-term mental health inpatients are sent for inpatient psychiatric treatment in the proposed service area.

    While we do expect some long-term patients, the vast majority of child and adolescent patients do not need this level of care for extended periods of time. Long-term patients are treated throughout the state in the various licensed mental health hospitals that treat children and adolescents

13. **Section C. (Need) 1. Specific Criteria (Inpatient Psychiatric Units) Item D.1.**

    It is noted the applicant responded to the question in terms of staffed inpatient child and adolescent psychiatric beds. Please also respond to the question by using licensed (not staffed) occupancy and utilization of similar services.

    The overall occupancy on *licensed* beds for Mental Health Hospitals in the region is 79.5% in the Current Year combined JAR, Report 2. Lakeside reported 18,481 under 18 patient days in 2014, equating to an occupancy of over 92% of licensed child and adolescent beds (2014 Lakeside JAR). St. Francis reports 6359 under 18 patient days resulting in an occupancy on licensed beds of 50% (2014 St. Francis JAR). For these two facilities, the combined occupancy on *licensed* beds is 75.6%. There is no data for Crestwyn available yet.

14. **Section C. Need, Item 4.**

    Please complete the following chart (following page).

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	Shelby	Madison	Tipton	Fayette	Hardeman	Lauderdale	Dyer	McNairy	Chester	Hardin	Crockett	Haywood	Gibson	Lake	Obion	Weakley	Carroll	Henry	Henderson	Total Service Area	State of TN
Total Population- Current Year - 2016	959,361	103,234	67,250	44,637	27,283	28,658	39,306	27,179	18,260	26,557	14,884	18,410	51,394	8,299	31,692	36,066	28,380	33,439	29,349	1,593,638	6,812,005
Total Population- Projected Year - 2020	981,022	106,352	71,196	48,510	27,278	29,186	39,872	27,760	18,978	26,783	15,080	18,128	52,438	8,579	31,559	36,360	28,207	34,055	30,298	1,631,641	7,108,031
Total Population-% change	2.3%	3.0%	5.9%	8.7%	0.0%	1.8%	1.4%	2.1%	3.9%	1.0%	1.3%	-1.5%	2.0%	3.4%	0.4%	-0.8%	-0.6%	1.8%	3.2%	2.4%	4.3%
Age 0-17 Population 2016	247,503	24,762	16,904	9,670	5,383	6,653	9,295	5,986	3,959	5,353	3,564	4,386	12,355	1,250	6,842	7,043	6,107	6,896	6,825	390,736	1,570,687
Age 0-17 Population 2020	252,312	25,201	17,157	10,014	5,143	6,580	9,309	5,860	3,880	5,204	3,554	4,178	12,397	1,187	6,619	6,975	5,927	6,777	6,898	395,172	1,614,001
Age 0-17 Population-% change	1.9%	1.8%	1.5%	3.6%	-4.5%	-1.1%	0.02%	-2.1%	-2.0%	-2.8%	-0.3%	-4.7%	0.3%	-5.0%	-3.3%	-1.0%	-2.9%	-1.7%	1.1%	1.1%	2.8%
Age 0-17 Population % of Total Population	25.7%	23.7%	24.1%	20.6%	18.9%	22.5%	23.3%	21.1%	20.4%	19.4%	23.6%	23.0%	23.6%	13.8%	21.0%	19.2%	21.0%	19.9%	22.8%	24.2%	26.80%
Median Age	34.6	36.8	36.6	41.9	39.2	36.4	39.3	41.6	36.2	43.5	39.6	39.2	39.9	38.3	41.4	37	42	44.3	39.7	39.34	38
Median Household Income	41,880	39,195	50,557	53,624	33,734	33,960	36.356	35,114	39,777	32,222	32,843	32,115	33,481	25,973	38,157	34,767	34,747	32,760	37,746	34,878	41,715
TennCare Enrollees	248,539	22,972	12,730	6,537	6,763	7,525	9,955	7,264	3,615	6,748	3,817	5,608	12,538	2,127	7,258	6,906	7,246	7,522	6,739	392,409	1,366,295
TennCare Enrollees as % of Total	24.3%	20.4%	20.5%	19.0%	21.5%	25.9%	23.9%	25.2%	18.2%	23.4%	22.1%	27.4%	24.5%	25.3%	20.4%	17.3%	21.1%	20.3%	21.5%	22.2%	20.0%
Persons Below Poverty Level	188,373	19,273	9,244	4,690	5,941	5,450	7,746	5,583	2,790	5,827	2,788	3,973	8,339	2,059	5,012	6,533	5,388	6,272	4,402	299,683	939,056
Persons Below Poverty Level as % of Total	20.9%	20.6%	15.8%	12.2%	25.1%	23.1%	20.8%	22.1%	18.2%	22.6%	19.7%	21.4%	17.3%	42.5%	16.2%	20.8%	19.6%	20.0%	16.5%	18.8%	17.2%

*Data from Department of Health CON Age Group Projections, Tenncare Fiscal Report 2014-2015, and US Census Bureau

15. Section C. Need, Item 5. (Utilization of other providers' services in the Applicant's service area)

Please update the following chart showing historical utilization of the primary service area.

2012-2014 Regional Area Mental Health Hospital Child and Adolescent Inpatient Psychiatric Beds

Facility	County	2014 Licensed Beds	Patient Days			Licensed Occupancy			% Change 2012-2014
			2012	2013	2014	2012	2013	2014	
Lakeside	Shelby	55	13,482	14,205	18,481	66.9%	70.7%	92.1%	25.2%
St. Francis	Shelby	35	7,113	6,200	6,359	55.5%	48.5%	49.7%	-5.8%
Crestwyn	Shelby	0	0	0	0	N/A	N/A	N/A	N/A
Total		**90**	**20,595**	**20,405**	**24,840**	**62.5%**	**62.1%**	**75.6%**	**13.1%**

All data taken from 2012-2014 individual facility JAR reports.

Lakeside has notified HSDA of its intent to increase their bed capacity by 26 beds. How many of those beds will be child/adolescent?

As the 26 beds represent 10% of their total licensed beds they could use the beds for any inpatient population consistent with their current bed profile.

The applicant states Crestwyn does not plan to treat children. What are the ages of children Crestwyn treats for inpatient psychiatric care?

Per their approved CON, Crestwyn plans to accept up to 15 adolescent patients ages 13-17.

Are their Child/Adolescent programs in the Mississippi and Arkansas portion of the service area?

Yes. Parkwood Hospital operates in Desoto County, Mississippi and has 22 child and adolescent inpatient beds. Oak Ridge Hospital operates in Crittenden County, Arkansas and has 24 inpatient child and adolescent beds.

16. Section C. (Need) Item 6. (The Applicant's Historical and Projected Utilization)

The projected utilization of 27.5% in Year Two of the proposed project is noted. However, please indicate when the applicant expects to report a yearly licensed occupancy of 80% and 90% for the proposed inpatient units?

We have projected occupancy out 5 years, with projected occupancy of 80% in year 5. Based on the growth in projections for the first five years, 90% occupancy would be achieved in year 6. It should be noted that the proposed project is conservative in its projections and assumptions, and the occupancy thresholds might be reached sooner.

Please confirm the historical utilization provided is Residential Inpatient Psychiatric Services.

The historical utilization provided is for existing Residential Services.

17. Section C. (Economic Feasibility) Items 1 and 2. Project Cost Chart

The funding of the proposed project with cash reserves is noted. However, the documentation from the applicant's financial officer notes the funding will be from cash or revolving credit. Please clarify. If necessary, please provide a revised funding letter from the applicant's financial officer.

Universal Health Services, Inc., the ultimate parent for Compass, has committed to funding the project, and may at the time of implementation of the project, will utilize cash reserves or credit, or a combination of both. The footnote mentioned in the original funding letter is including below for verification of the availability of credit. The full 2015 UHS 10-K is included as an attachment at the end of this document. Page 32 of the original application has been updated; please see the replacement on the following page.

"On August 7, 2014, we entered into a Fourth Amendment (the "Fourth Amendment") to our credit agreement dated as of November 15, 2010, as amended on March 15, 2011, September 21, 2012 and May 16, 2013, among UHS, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders ("Credit Agreement"). The Credit Agreement, as amended, which is scheduled to mature in August, 2019, consists of: (i) an $800 million revolving credit facility ($300 million of borrowings outstanding as of December 31, 2015), and; (ii) a $1.775 billion term loan A facility ($1.720 billion of borrowings outstanding as of December 31, 2015) which combined our previously outstanding term loan A and term loan A2 facilities which were scheduled to mature in 2016;"

18. Section C. (Economic Feasibility) Item 3

The applicant notes the proposed renovation costs are on target with the median and overall cost per-square-foot and falls between the Median and 3rd quartile. Please clarify if the applicant meant construction costs rather than renovation costs.

The Square Footage Chart has been updated. To clarify, the proposed renovated construction cost is $228.13 sq. /ft., slightly above the median. The new construction cost is between the 1st quartile and median at $276.44 sq. /ft. The total construction cost is $272.58 sq. /ft., falling between the median and 3rd quartile.

19. Section C. (Economic Feasibility) Item 4 Historical and Projected Data Chart

C. Economic Feasibility. 2. Identify the funding sources for this project.

Please check the applicable item(s) below and briefly summarize how the project will be financed. (Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2)

__ A. Commercial Loan—Letter form lending institution or guarantor stating favorable initial contract, proposed loan amount, expected interest rates, anticipated term of the loan and any restrictions or conditions.

__ B. Tax-exempt bonds—Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance.

__ C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.

__ D. Grants—Notification of intent form for grant application or notice of grant award; or

_X_ E. Cash Reserves—Appropriate documentation from Chief Financial Officer

_X_ F. Other—identifies and document funding from all other sources. Potential utilization of Revolver Credit Agreement.

See Attachment C, Economic Feasibility -2.

C. Economic Feasibility.3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services Development Agency.

The proposed construction costs of $7,679,726 ($272.58 sq. /ft.) are consistent with the published Hospital Construction Costs for years 2013-2015 and the CON for the recently implemented Crestwyn hospital project at $244.85 sq. /ft. The proposed renovated costs are on target with the

Please clarify the reason there was ($102,870) in Provisions for Bad Debt in 2013.

This number represents positive collections of Bed Debt Accounts that had been accrued in prior years and eventually collected in 2013.

Please complete the following for D.9 Historical Data Chart-Other Expenses

D.9 OTHER EXPENSES CATEGORIES	Year 2013	Year 2014	Year 2015
1. Employee Benefits	$345,783	$393,269	$501,097
2. Purchased Services	283,756	281,077	327,647
3. Maintenance	197,680	239,997	222,403
4. Insurance	125,554	187,828	150,661
5. Travel and Education	77,815	87,969	85,840
6. Other Expenses	210,840	231,279	225,085
7. Non-Allocated	(5,668)	18,563	28,821
Total Other Expenses	**$1,235,760**	**$1,439,982**	**$1,541,554**

Please complete the following for D.9 Projected Data Chart-Other Expenses (Proposed 48-beds only)

D.9 OTHER EXPENSES CATEGORIES	Year 1	Year 2	Year 3
1. Employee Benefits	$220,406	$297,482	$334,081
2. Purchased Services	41595	59697	86843
3. Maintenance	27357	33624	48386
4. Insurance	15,682	22505	32739
5. Travel and Education	24300	25000	25500
6. Other Expenses	123,012	123,287	125874
7. Non-Allocated	0	0	0
Total Other Expenses	**$452,352**	**$561,594**	**$653,423**

It appears there is a calculation error for total operating expenses for Year One. Please revise and submit a correct Projected Data Chart.

Thank you for identifying the error, please see the corrected Projected Data Chart on the following page.

It is noted the applicant is projecting a net loss of ($295,864) on a licensed occupancy of 27.5% in Year Two of the proposed project. Please provide a projected Data Chart for Year 3.

Please see the Year 3 data, following the corrected Projected Data Chart.

SUPPLEMENTAL #1

June 29, 2016

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PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year One	Year Two
A.	Utilization Data (Specify unit of measure) Patient Days	3356	4816
B.	Revenue from Services to Patients		
1.	Inpatient Services	$ 6,040,800	$ 8,668,800
2.	Outpatient Services	676,800	936,000
3.	Emergency Services	--	--
4.	Other Operating Revenue (Specify) Physicians Fees, Medical Records, Admin. Misc.	85,025	121,600
	Gross Operating Revenue	$ 6,802,625	$ 9,726,400
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$ 4,214,361	$ 6,029,784
2.	Provision for Charity Care	704,185	144,913
3.	Provisions for Bad Debt	132,626	189,290
	Total Deductions	$ 5,051,172	$ 6,363,987
	NET OPERATING REVENUE	$ 1,751,453	$ 3,362,413
D.	Operating Expenses		
1.	Salaries and Wages	$ 1,226,673	$ 1,655,644
2.	Physician's Salaries and Wages	304,180	421,280
3.	Supplies	103,030	147,852
4.	Taxes	157,212	185,335
5.	Depreciation	680,572	680,572
6.	Rent	6,000	6,000
7.	Interest, other than Capital	--	--
8.	Management Fees:		
a.	Fees to Affiliates	--	--
b.	Fees to Non-Affiliates	--	--
9.	Other Expenses (Specify) Benefits, Purchased Services, Maintenance, Insurance, Travel, Other Misc.	452,353	561,594
	Total Operating Expenses	$ 2,930,020	$ 3,658,277
E.	Other Revenue (Expenses) -- Net (Specify)	$ --	$ --
	NET OPERATING INCOME (LOSS)	$ (1,178,567)	$ (295,864)
F.	Capital Expenditures		
1.	Retirement of Principal	$ --	$ --
2.	Interest	--	--
	Total Capital Expenditures	$ --	$ --
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$ (1,178,567)	$ (295,864)

SUPPLEMENTAL #1

June 29, 2016
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Year 3 Projected Data

The fiscal year begins in January.

	Year Three
A. Utilization Data (Patient Days)	7006
B. Revenue from Services to Patients	
1. Inpatient Services	$12,610,800
2. Outpatient Services	1,248,000
3. Emergency Services	--
4. Other Operating Revenue (Specify)	
physician fees, medical records, miscellaneous admin	176,358
Gross Operating Revenue	**$14,035,158**
C. Deductions from Gross Operating Revenue	
1. Contractual Adjustments	$8,713,687
2. Provision for Charity Care	210,813
3. Provision for Bad Debt	272,031
Total Deductions	**$9,196,531**
Net Operating Revenue	**$4,838,627**
D. Operating Expenses	
1. Salaries and Wages	$1,859,333
2. Physicians salaries and Wages	596,510
3. Supplies	215,085
4. Taxes	185,977
5. Depreciation	680,572
6. Rent	6,000
7. Interest Other than Capital	--
8. Management Fees	
a. Fees to Affiliates	--
b. Fees to Non-Affiliates	--
9. Other Expenses (Specify)	
(See Other Expenses Years 1-3 above)	653,423
Total Operating Expenses	**$4,196,900**
E. Other Revenue (Expenses) – Net (Specify)	--
Net Operating Income (Loss)	**$ 641,727**
F. Capital Expenditures	
1. Retirement of Principal	--
2. Interest	--
Total Capital Expenditures	$ --
Net Operating Income (Loss)	
Less Capital Expenditures	**$ 641,727**

20. **Section C, Economic Feasibility, Item 5**

Your response is noted. Please complete the following table identifying the project's gross charge, average deduction from operating revenue, and average net charge per patient day. Please divide the total patient days in Year One of the Projected Data Chart into the total gross charges, deductions from operating revenue total, and total net charges to calculate the charges.

	Year One	Year Two
Average Gross Charge (Gross charges/total days)	$1824.97	$1824.97
Average Deduction (Total Deductions/total days)	$1396.17	$1216.43
Average net Charge Total Net Operating Revenue/total days)	$428.87	$608.54

21. **Section C. (Economic Feasibility) 6a. and 6.b.d**

It is noted the applicant anticipates revenue from the proposal of $1,751,453 in Year One and $3,362,413 in Year Two. However, this is the Net Revenue. Please specify and provide a replacement page 36.

Changes made, please see replacement page 36 on the following page.

Please compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency.

The proposed charges for inpatient services are comparable to Lakeside, which charges at $1,800/day. (Verified by Compass and Lakeside CFOs on 6/28/16). The Crestwyn CON proposed average gross charges of $1,438 in 2016 and $1,530 in 2017. Our charges are reasonable and consistent other providers in the service area.

C. Economic Feasibility. 5. Please identify the projects average gross charge, average deduction from operating revenue, and average net charge.

	Year One	Year Two
Average Gross Charge (Gross charges/total days)	$1824.97	$1824.97
Average Deduction (Total Deductions/total days)	$1396.17	$1216.43
Average net Charge Total Net Operating Revenue/total days)	$428.87	$608.54

C. Economic Feasibility. 6.

A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Current charges will not be impacted by the implementation of this proposal. While charges are periodically adjusted from time to time, there are no plans to change current charges in association with this proposal. The anticipated gross revenue from the proposal is $6,802,625 in Year One and $9,726,400 in Year Two and anticipated net revenue as $1,751,453 in Year One and $3,362,413 in Year Two. As a new service line, the revenues from the proposal will not have any impact on existing charges. (See following current and proposed fee schedules).

Current Schedule of Charges	
Residential Treatment	$1,000.00
Partial Hospital 4-8hrs	$600.00
Intensive Outpatient	$400.00
Psychiatric Evaluation	$185.00
History and Physical	$100.00

22. **Section C, Economic Feasibility, Item 9 and Section C, Need, Item 1. (Service Specific Criteria-Psychiatric Inpatient Services) C.5**

Please complete the following table for the payor mix in Year 1 is shown in the table below. Please use gross revenue amounts.

Payor Source, Year 1

Payor Source	Gross Revenue	As a % of Total
Medicare	0	0%
Tenncare/Medicaid	2,756,082	40.5%
Commercial	2,820,418	41.5%
Uncompensated	0	0%
Other	1,226,125	18%
Total Gross Revenue	6,802,625	100%

Please note, in the above chart there is not uncompensated care budgeted in the revenues. This is based on two factors primarily; almost all children have insurance, or are eligible for Medicaid coverage, and in our current operations uncompensated care is almost non-existent. This is stark contrast to the provision of adult services.

23. **Section C. (Economic Feasibility) Item 10**

The consolidated balance sheet for Universal Health Services, Inc. for the period ending March 31, 2016 indicates total liabilities of $1,684,400,000 exceed current assets of $1,635,438,000. Please clarify how Universal Health Services, Inc. will fund the proposed project with cash reserves while a current ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.

Universal Health Services, Inc., the ultimate parent for Compass, has committed to funding the project, and may at the time of implementation of the project, will utilize cash reserves or credit, or a combination of both. While the quarterly consolidated balances sheet does indicate liabilities in excess of assets, as a ratio this is 1:.97, less than a 3% difference between the two numbers. The footnote mentioned in the original funding letter is including below for verification of the availability of credit. The full 2015 UHS 10-K is included as an attachment at the end of this document, and demonstrates the sound fiscal ground that UHS rests upon. Page 32 of the original application has been updated; please see the replacement on page.24 above.

"On August 7, 2014, we entered into a Fourth Amendment (the "Fourth Amendment") to our credit agreement dated as of November 15, 2010, as amended on March 15, 2011, September 21, 2012 and May 16, 2013, among UHS, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders ("Credit Agreement"). The Credit Agreement, as amended, which is scheduled to mature in August, 2019, consists of: (i) an $800 million revolving credit facility ($300 million of borrowings outstanding as of December 31, 2015), and; (ii) a $1.775 billion term loan A facility ($1.720 billion of borrowings outstanding as

of December 31, 2015) which combined our previously outstanding term loan A and term loan A2 facilities which were scheduled to mature in 2016;"

24. Section C. Orderly Development, Item 3

Please complete the following table for the proposed Year One direct patient care staffing for the proposed 48 bed inpatient beds only.

Position	Child Psychiatry	Adolescent Psychiatry	Total
Director			2
Nurse Mgr.			1.9
RN			5.1
LPN			0
Patient Care Tech			5.2
Psychiatrist			**
Psychologist			**
Licensed Master's Level Therapist			2.1
Non-licensed Master's level therapist			0
Licensed alcohol and Drug Counselor			0
Other***			3.5
Total			***19.8**

It is noted the applicant will be providing programs such as outpatient, intensive outpatient, and partial hospitalization. Please list staffing of these programs by type and number, whether this staff will be shared with any other programs, especially inpatient programs, any age (adult, child/adolescent) or practice specialties. Also include physicians or advance practice nurses who will practice in these programs but will not specifically be on staff.

The direct care inpatient staffing in the grid above is completely separate from our existing facility staffing, with the following exceptions. The "Director" category includes the Director of Nursing and the Director of Clinical Services who will continue to have facility-wide responsibilities over patient care. Outpatient programs are existing services; as such the projected staffing for these programs is accounted for in our current facility staffing. One additional Licensed Master's Level Therapists will be allocated for growth in outpatient services. The remaining patient care staffing above will be exclusive the inpatient program. It should be noted that the average daily census

for the above year-one staffing is 9.2, yielding a very patient-centric direct care EPOB (employee per operating bed) of 1.93.

*In the grid above, only the total staffing is completed as the staff will overlap on children and adolescent programs. It should be noted that we will meet or exceed all staffing requirements of the Department of Mental Health and Substance Abuse Services for each program.

** Psychiatrists and Psychologist are contracted employees and not projected or budgeted as Full-Time Equivalents. For year one, we anticipate two currently contracted psychologists will be providing contracted services and two psychiatrists will be providing psychiatric services.

***Other includes Activities Therapy, staff-in-training, and teacher (specific to new beds).

Please clarify if there will be an addictionologist on staff.

Yes, one of our current physicians is Board Certified in Addiction Medicine.

25. Section C. Orderly Development, Item 8 and 9

It is noted the applicant answered N/A. Please provide a narrative response to each question. In addition, please verify legal proceedings on pages 146-150 of Universal Health Services, Inc.'s Form 10-Q do not apply to these two questions.

Item 8:
Document and explain any final orders or judgments entered in any state or county by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

Compass does not have any final orders or judgments entered in any state or county by a licensing agency or court against our licenses. Keystone Education and Youth Services, LLC, which has 100% Direct Ownership over Keystone Memphis LLC (Compass), does not have any final orders or judgments entered in any state or county by a licensing agency or court against its licenses. The legal proceedings described on pages 146-150 of the original CON application do not apply to this question as they relate to other UHS facilities.

Item 9
Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project.

SUPPLEMENTAL #1
June 29, 2016
12:31 pm

Compass does not have any final civil or criminal judgments for fraud or theft. Keystone Education and Youth Services, LLC, which has 100% Direct Ownership over Keystone Memphis LLC (Compass), does not have any final orders or judgments for fraud or theft. The legal proceedings described on pages 146-150 of the original CON application do not apply to this question as they relate to other UHS facilities.

SUPPLEMENTAL #1
June 29, 2016
12:31 pm

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

FORM 10-K

(MARK ONE)

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

For the fiscal year ended December 31, 2015

OR

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

For the transition period from _____ to _____

Commission File No. 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 Number)**
UNIVERSAL CORPORATE CENTER **367 South Gulph Road** **P.O. Box 61558** **King of Prussia, Pennsylvania** **(Address of principal executive offices)**	**19406-0958** **(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	Name of each exchange on which registered
Class B Common Stock, $.01 par value	**New York Stock Exchange**

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

Class D Common Stock, $.01 par value
(Title of each Class)

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted 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 and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

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

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

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

The aggregate market value of voting stock held by non-affiliates at June 30, 2015 was $12.9 billion. (For the purpose of this calculation, it was assumed that Class A, Class C, and Class D Common Stock, which are not traded but are convertible share-for-share into Class B Common Stock, have the same market value as Class B Common Stock. Also, for purposes of this calculation only, all directors are deemed to be affiliates.)

The number of shares of the registrant's Class A Common Stock, $.01 par value, Class B Common Stock, $.01 par value, Class C Common Stock, $.01 par value, and Class D Common Stock, $.01 par value, outstanding as of January 31, 2016, were 6,595,308; 90,384,960; 663,940 and 23,202, respectively.

DOCUMENTS INCORPORATED BY REFERENCE:

Portions of the registrant's definitive proxy statement for our 2016 Annual Meeting of Stockholders, which will be filed with the Securities and Exchange Commission within 120 days after December 31, 2015 (incorporated by reference under Part III).

SUPPLEMENTAL #1
June 29, 2016
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UNIVERSAL HEALTH SERVICES, INC.
2015 FORM 10-K ANNUAL REPORT

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Exhibit Index

This Annual Report on Form 10-K is for the year ended December 31, 2015. This Annual Report modifies and supersedes documents filed prior to this Annual 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 Annual Report.

In this Annual 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.

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PART I

ITEM 1. ***Business***

Our principal business is owning and operating, through our subsidiaries, acute care hospitals, behavioral health centers, surgical hospitals, ambulatory surgery centers and radiation oncology centers. As of February 25, 2016, we owned and/or operated 24 inpatient acute care hospitals, 3 free-standing emergency departments and 213 inpatient and 16 outpatient behavioral health care facilities located in 37 states, Washington, D.C., the United Kingdom, Puerto Rico and the U.S. Virgin Islands. In addition, we are building a newly-constructed acute care hospital located in Henderson, Nevada, that is scheduled to be completed and opened during the fourth quarter of 2016. We also manage and/or own outright or in partnerships with physicians, 4 surgical hospitals and surgery and radiation oncology centers located in 4 states.

As a percentage of our consolidated net revenues, net revenues from our acute care hospitals, surgical hospitals, commercial health insurer, surgery centers and radiation oncology centers accounted for 51% during each of 2015 and 2014 and 49% during 2013. Net revenues from our behavioral health care operations accounted for 49% of our consolidated net revenues during each of 2015 and 2014 and 51% during 2013.

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.

2015 Acquisitions of Assets and Businesses:

During 2015 we spent $534 million to:

- acquire a 46-bed behavioral health care facility located in the U.K. (acquired during the first quarter);
- acquire Alpha Hospitals Holdings Limited consisting of four behavioral health care hospitals with 305 beds located in the U.K. (acquired during the third quarter);
- acquire Foundations Recovery Network, LLC consisting of 4 inpatient facilities (322 beds) as well as 8 outpatient centers (during the fourth quarter), and;
- various other businesses, a management contract and real property assets.

Available Information

We are a Delaware corporation that was organized in 1979. Our principal executive offices are located at Universal Corporate Center, 367 South Gulph Road, P.O. Box 61558, King of Prussia, PA 19406. Our telephone number is (610) 768-3300.

Our website is located at http://www.uhsinc.com. Copies of our annual, quarterly and current reports that we file with the SEC, and any amendments to those reports, are available free of charge on our website. The information posted on our website is not incorporated into this Annual Report. Our Board of Directors' committee charters (Audit Committee, Compensation Committee and Nominating & Governance Committee), Code of Business Conduct and Corporate Standards applicable to all employees, Code of Ethics for Senior Financial Officers, Corporate Governance Guidelines and our Code of Conduct, Corporate Compliance Manual and Compliance Policies and Procedures are available free of charge on our website. Copies of such reports and charters are available in print to any stockholder who makes a request. Such requests should be made to our Secretary at our King of Prussia, PA corporate headquarters. We intend to satisfy the disclosure requirement under Item 5.05 of Form 8-K relating to amendments to or waivers of any provision of our Code of Ethics for Senior Financial Officers by promptly posting this information on our website.

In accordance with Section 303A.12(a) of the New York Stock Exchange Listed Company Manual, we submitted our CEO's certification to the New York Stock Exchange in 2015. Additionally, contained in Exhibits 31.1 and 31.2 of this Annual Report on Form 10-K, are our CEO's and CFO's certifications regarding the quality of our public disclosures under Section 302 of the Sarbanes-Oxley Act of 2002.

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Our Mission

Our mission and objective is to provide superior quality healthcare services that patients recommend to families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term returns. To achieve this, we have a commitment to:

- service excellence
- continuous improvement in measurable ways
- employee development
- ethical and fair treatment of all
- teamwork
- compassion
- innovation in service delivery

Business Strategy

We believe community-based hospitals will remain the focal point of the healthcare delivery network and we are committed to a philosophy of self-determination for both the company and our hospitals.

Acquisition of Additional Hospitals. We selectively seek opportunities to expand our base of operations by acquiring, constructing or leasing additional hospital facilities. We are committed to a program of rational growth around our core businesses, while retaining the missions of the hospitals we manage and the communities we serve. Such expansion may provide us with access to new markets and new healthcare delivery capabilities. We also continue to examine our facilities and consider divestiture of those facilities that we believe do not have the potential to contribute to our growth or operating strategy.

Improvement of Operations of Existing Hospitals and Services. We also seek to increase the operating revenues and profitability of owned hospitals by the introduction of new services, improvement of existing services, physician recruitment and the application of financial and operational controls.

We are involved in continual development activities for the benefit of our existing facilities. From time to time applications are filed with state health planning agencies to add new services in existing hospitals in states which require certificates of need, or CONs. Although we expect that some of these applications will result in the addition of new facilities or services to our operations, no assurances can be made for ultimate success by us in these efforts.

Quality and Efficiency of Services. Pressures to contain healthcare costs and technological developments allowing more procedures to be performed on an outpatient basis have led payors to demand a shift to ambulatory or outpatient care wherever possible. We are responding to this trend by emphasizing the expansion of outpatient services. In addition, in response to cost containment pressures, we continue to implement programs at our facilities designed to improve financial performance and efficiency while continuing to provide quality care, including more efficient use of professional and paraprofessional staff, monitoring and adjusting staffing levels and equipment usage, improving patient management and reporting procedures and implementing more efficient billing and collection procedures. In addition, we will continue to emphasize innovation in our response to the rapid changes in regulatory trends and market conditions while fulfilling our commitment to patients, physicians, employees, communities and our stockholders.

In addition, our aggressive recruiting of highly qualified physicians and developing provider networks help to establish our facilities as an important source of quality healthcare in their respective communities.

Hospital Utilization

We believe that the most important factors relating to the overall utilization of a hospital include the quality and market position of the hospital and the number, quality and specialties of physicians providing patient care within the facility. Generally, we believe that the ability of a hospital to meet the health care needs of its community is determined by its breadth of services, level of technology, emphasis on quality of care and convenience for patients and physicians. Other factors that affect utilization include general and local economic conditions, market penetration of managed care programs, the degree of outpatient use, the availability of reimbursement programs such as Medicare and Medicaid, and demographic changes such as the growth in local populations. Utilization across the industry also is being affected by improvements in clinical practice, medical technology and pharmacology. Current industry trends in utilization and occupancy have been significantly affected by changes in reimbursement policies of third

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party payors. We are also unable to predict the extent to which these industry trends will continue or accelerate. In addition, hospital operations are subject to certain seasonal fluctuations, such as higher patient volumes and net patient service revenues in the first and fourth quarters of the year.

The following table sets forth certain operating statistics for hospitals operated by us for the years indicated. Accordingly, information related to hospitals acquired during the five-year period has been included from the respective dates of acquisition, and information related to hospitals divested during the five year period has been included up to the respective dates of divestiture.

	2015	2014	2013	2012	2011
Average Licensed Beds:					
Acute Care Hospitals	5,832	5,776	5,652	5,682	5,726
Behavioral Health Centers	21,202	20,231	19,975	19,362	19,280
Average Available Beds (1):					
Acute Care Hospitals	5,656	5,571	5,429	5,457	5,424
Behavioral Health Centers	21,116	20,131	19,876	19,282	19,262
Admissions:					
Acute Care Hospitals	261,727	251,165	246,160	251,099	258,754
Behavioral Health Centers	447,007	426,510	402,088	374,865	352,208
Average Length of Stay (Days):					
Acute Care Hospitals	4.7	4.6	4.5	4.5	4.4
Behavioral Health Centers	13.1	12.9	13.3	14.0	14.6
Patient Days (2):					
Acute Care Hospitals (1)	1,218,991	1,167,726	1,112,541	1,122,557	1,151,183
Behavioral Health Centers	5,835,134	5,518,660	5,365,734	5,245,499	5,157,454
Occupancy Rate-Licensed Beds (3):					
Acute Care Hospitals	57%	55%	54%	54%	55%
Behavioral Health Centers	75%	75%	74%	74%	73%
Occupancy Rate-Available Beds (3):					
Acute Care Hospitals	59%	57%	56%	56%	58%
Behavioral Health Centers	76%	75%	74%	75%	73%

(1) "Average Available Beds" is the number of beds which are actually in service at any given time for immediate patient use with the necessary equipment and staff available for patient care. A hospital may have appropriate licenses for more beds than are in service for a number of reasons, including lack of demand, incomplete construction, and anticipation of future needs.

(2) "Patient Days" is the sum of all patients for the number of days that hospital care is provided to each patient.

(3) "Occupancy Rate" is calculated by dividing average patient days (total patient days divided by the total number of days in the period) by the number of average beds, either available or licensed.

Sources of Revenue

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. See *Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Sources of Revenue* for additional disclosure. Other information related to our revenues, income and other operating information for each reporting segment of our business is provided in Note 11 to our Consolidated Financial Statements, *Segment Reporting.*

Regulation and Other Factors

Overview: The healthcare industry is subject to numerous laws, regulations and rules including, among others, those related to government healthcare participation requirements, various licensure and accreditations, reimbursement for patient services, health information privacy and security rules, and Medicare and Medicaid fraud and abuse provisions (including, but not limited to, federal statutes and regulations prohibiting kickbacks and other illegal inducements to potential referral sources, false claims submitted to federal health care programs and self-referrals by physicians). Providers that are found to have violated any of these laws and regulations may be excluded from participating in government healthcare programs, subjected to significant fines or penalties and/or required to repay amounts received from the government for previously billed patient services. Although we believe our policies, procedures and practices comply with governmental regulations, no assurance can be given that we will not be subjected to additional governmental inquiries or actions, or that we would not be faced with sanctions, fines or penalties if so subjected. Even if we were to ultimately prevail, a significant governmental inquiry or action under one of the above laws, regulations or rules could have a material adverse impact on us.

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Licensing, Certification and Accreditation: All of our hospitals are subject to compliance with various federal, state and local statutes and regulations and receive periodic inspection by state licensing agencies to review standards of medical care, equipment and cleanliness. Our hospitals must also comply with the conditions of participation and licensing requirements of federal, state and local health agencies, as well as the requirements of municipal building codes, health codes and local fire departments. Various other licenses and permits are also required in order to dispense narcotics, operate pharmacies, handle radioactive materials and operate certain equipment.

All of our eligible hospitals have been accredited by The Joint Commission. All of our acute care hospitals and most of our behavioral health centers are certified as providers of Medicare and Medicaid services by the appropriate governmental authorities.

If any of our facilities were to lose its Joint Commission accreditation or otherwise lose its certification under the Medicare and Medicaid programs, the facility may be unable to receive reimbursement from the Medicare and Medicaid programs and other payors. We believe our facilities are in substantial compliance with current applicable federal, state, local and independent review body regulations and standards. The requirements for licensure, certification and accreditation are subject to change and, in order to remain qualified, it may become necessary for us to make changes in our facilities, equipment, personnel and services in the future, which could have a material adverse impact on operations.

Certificates of Need: Many of the states in which we operate hospitals have enacted certificates of need ("CON") laws as a condition prior to hospital capital expenditures, construction, expansion, modernization or initiation of major new services. Failure to obtain necessary state approval can result in our inability to complete an acquisition, expansion or replacement, the imposition of civil or, in some cases, criminal sanctions, the inability to receive Medicare or Medicaid reimbursement or the revocation of a facility's license, which could harm our business. In addition, significant CON reforms have been proposed in a number of states that would increase the capital spending thresholds and provide exemptions of various services from review requirements. In the past, we have not experienced any material adverse effects from those requirements, but we cannot predict the impact of these changes upon our operations.

Conversion Legislation: Many states have enacted or are considering enacting laws affecting the conversion or sale of not-for-profit hospitals to for-profit entities. These laws generally require prior approval from the attorney general, advance notification and community involvement. In addition, attorneys general in states without specific conversion legislation may exercise discretionary authority over these transactions. Although the level of government involvement varies from state to state, the trend is to provide for increased governmental review and, in some cases, approval of a transaction in which a not-for-profit entity sells a health care facility to a for-profit entity. The adoption of new or expanded conversion legislation and the increased review of not-for-profit hospital conversions may limit our ability to grow through acquisitions of not-for-profit hospitals.

Utilization Review: Federal regulations require that admissions and utilization of facilities by Medicare and Medicaid patients must be reviewed in order to ensure efficient utilization of facilities and services. The law and regulations require Peer Review Organizations ("PROs") to review the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, the validity of diagnosis related group ("DRG") classifications and the appropriateness of cases of extraordinary length of stay. PROs may deny payment for services provided, assess fines and also have the authority to recommend to the Department of Health and Human Services ("HHS") that a provider that is in substantial non-compliance with the standards of the PRO be excluded from participating in the Medicare program. We have contracted with PROs in each state where we do business to perform the required reviews.

Audits: Most hospitals are subject to federal audits to validate the accuracy of Medicare and Medicaid program submitted claims. If these audits identify overpayments, we could be required to pay a substantial rebate of prior years' payments subject to various administrative appeal rights. The federal government contracts with third-party "recovery audit contractors" ("RACs") and "Medicaid integrity contractors" ("MICs"), on a contingent fee basis, to audit the propriety of payments to Medicare and Medicaid providers. The Recovery Audit Prepayment Review demonstration program will enable RACs to review claims before they are paid to ensure that the provider complied with all Medicare payment rules. Currently, the demonstration program is targeting states with high populations of fraud- and error-prone providers. Similarly, Medicare zone program integrity contractors ("ZPICs") target claims for potential fraud and abuse. Additionally, Medicare administrative contractors ("MACs") must ensure they pay the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers. The Centers for Medicare and Medicaid Services ("CMS") announced its intent to consolidate many of these Medicare and Medicaid program integrity functions into new unified program integrity contractors ("UPICs"), though it remains unclear what effect, if any, this proposed consolidation may have. We have undergone claims audits related to our receipt of federal healthcare payments during the last three years, the results of which have not required material adjustments to our consolidated results of operations. However, potential liability from future federal or state audits could ultimately exceed established reserves, and any excess could potentially be substantial. Further, Medicare and Medicaid regulations also provide for withholding Medicare and Medicaid overpayments in certain circumstances, which could adversely affect our cash flow.

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Self-Referral and Anti-Kickback Legislation

The Stark Law: The Social Security Act includes a provision commonly known as the "Stark Law." This law prohibits physicians from referring Medicare and Medicaid patients to entities with which they or any of their immediate family members have a financial relationship, unless an exception is met. These types of referrals are known as "self-referrals." Sanctions for violating the Stark Law include civil penalties up to $15,000 for each violation, up to $100,000 for sham arrangements, up to $10,000 for each day an entity fails to report required information and exclusion from the federal health care programs. There are a number of exceptions to the self-referral prohibition, including an exception for a physician's ownership interest in an entire hospital as opposed to an ownership interest in a hospital department unit, service or subpart. However, federal laws and regulations now limit the ability of hospitals relying on this exception to expand aggregate physician ownership interest or to expand certain hospital facilities. This regulation also places a number of compliance requirements on physician-owned hospitals related to reporting of ownership interest. There are also exceptions for many of the customary financial arrangements between physicians and providers, including employment contracts, leases and recruitment agreements that adhere to certain enumerated requirements.

We monitor all aspects of our business and have developed a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards. Nonetheless, because the law in this area is complex and constantly evolving, there can be no assurance that federal regulatory authorities will not determine that any of our arrangements with physicians violate the Stark Law.

Anti-kickback Statute: A provision of the Social Security Act known as the "anti-kickback statute" prohibits healthcare providers and others from directly or indirectly soliciting, receiving, offering or paying money or other remuneration to other individuals and entities in return for using, referring, ordering, recommending or arranging for such referrals or orders of services or other items covered by a federal or state health care program. However, changes to the anti-kickback statute have reduced the intent required for violation; one is no longer 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 anti-kickback statute contains certain exceptions, and the Office of the Inspector General of the Department of Health and Human Services ("OIG") has issued regulations that provide for "safe harbors," from the federal anti-kickback statute for various activities. These activities, which must meet certain requirements, include (but are not limited to) the following: investment interests, space rental, equipment rental, practitioner recruitment, personnel services and management contracts, sale of practice, referral services, warranties, discounts, employees, group purchasing organizations, waiver of beneficiary coinsurance and deductible amounts, managed care arrangements, obstetrical malpractice insurance subsidies, investments in group practices, freestanding surgery centers, donation of technology for electronic health records and referral agreements for specialty services. The fact that conduct or a business arrangement does not fall within a safe harbor or exception does not automatically render the conduct or business arrangement illegal under the anti-kickback statute. However, such conduct and business arrangements may lead to increased scrutiny by government enforcement authorities.

Although we believe that our arrangements with physicians and other referral sources have been structured to comply with current law and available interpretations, there can be no assurance that all arrangements comply with an available safe harbor or that regulatory authorities enforcing these laws will determine these financial arrangements do not violate the anti-kickback statute or other applicable laws. Violations of the anti-kickback statute may be punished by a criminal fine of up to $25,000 for each violation or imprisonment, however, under 18 U.S.C. Section 3571, this fine may be increased to $250,000 for individuals and $500,000 for organizations. Civil money penalties may include fines of up to $50,000 per violation and damages of up to three times the total amount of the remuneration and/or exclusion from participation in Medicare and Medicaid.

Similar State Laws: Many of the states in which we operate have adopted laws that prohibit payments to physicians in exchange for referrals similar to the anti-kickback statute and the Stark Law, some of which apply regardless of the source of payment for care. These statutes typically provide criminal and civil penalties as well as loss of licensure. In many instances, the state statutes provide that any arrangement falling in a federal safe harbor will be immune from scrutiny under the state statutes. However, in most cases, little precedent exists for the interpretation or enforcement of these state laws.

These laws and regulations are extremely complex and, in many cases, we don't have the benefit of regulatory or judicial interpretation. It is possible that different interpretations or enforcement of these laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. A determination that we have violated one or more of these laws, or the public announcement that we are being investigated for possible violations of one or more of these laws (see Item 3. Legal Proceedings), could have a material adverse effect on our business, financial condition or results of operations and our business reputation could suffer significantly. In addition, we cannot predict whether other legislation or regulations at the federal or state level will be adopted, what form such legislation or regulations may take or what their impact on us may be.

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If we are deemed to have failed to comply with the anti-kickback statute, the Stark Law or other applicable laws and regulations, we could be subjected to liabilities, including criminal penalties, civil penalties (including the loss of our licenses to operate one or more facilities), and exclusion of one or more facilities from participation in the Medicare, Medicaid and other federal and state health care programs. The imposition of such penalties could have a material adverse effect on our business, financial condition or results of operations.

Federal False Claims Act and Similar State Regulations: A current trend affecting the health care industry is the increased use of the federal False Claims Act, and, in particular, actions being brought by individuals on the government's behalf under the False Claims Act's qui tam, or whistleblower, provisions. Whistleblower provisions allow private individuals to bring actions on behalf of the government by alleging that the defendant has defrauded the Federal government.

When a defendant is determined by a court of law to have violated the False Claims Act, the defendant may be liable for up to three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 to $11,000 for each separate false claim. There are many potential bases for liability under the False Claims Act. Liability often arises when an entity knowingly submits a false claim for reimbursement to the federal government. The Fraud Enforcement and Recovery Act of 2009 ("FERA") has expanded the number of actions for which liability may attach under the False Claims Act, eliminating requirements that false claims be presented to federal officials or directly involve federal funds. FERA also clarifies that a false claim violation occurs upon the knowing retention, as well as the receipt, of overpayments. In addition, recent changes to the anti-kickback statute have made violations of that law punishable under the civil False Claims Act. Further, a number of states have adopted their own false claims provisions as well as their own whistleblower provisions whereby a private party may file a civil lawsuit on behalf of the state in state court. Recent changes to the False Claims Act require that federal healthcare program overpayments be returned within 60 days from the date the overpayment was identified, or by the date any corresponding cost report was due, whichever is later. Failure to return an overpayment within this period may result in additional civil False Claims Act liability.

Other Fraud and Abuse Provisions: The Social Security Act also imposes criminal and civil penalties for submitting false claims to Medicare and Medicaid. False claims include, but are not limited to, billing for services not rendered, billing for services without prescribed documentation, misrepresenting actual services rendered in order to obtain higher reimbursement and cost report fraud. Like the anti-kickback statute, these provisions are very broad.

Further, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") broadened the scope of the fraud and abuse laws by adding several criminal provisions for health care fraud offenses that apply to all health benefit programs, whether or not payments under such programs are paid pursuant to federal programs. HIPAA also introduced enforcement mechanisms to prevent fraud and abuse in Medicare. There are civil penalties for prohibited conduct, including, but not limited to billing for medically unnecessary products or services.

HIPAA Administrative Simplification and Privacy Requirements: The administrative simplification provisions of HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH"), require the use of uniform electronic data transmission standards for health care claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the health care industry. HIPAA also established federal rules protecting the privacy and security of personal health information. The privacy and security regulations address the use and disclosure of individual health care information and the rights of patients to understand and control how such information is used and disclosed. Violations of HIPAA can result in both criminal and civil fines and penalties.

We believe that we are in material compliance with the privacy regulations of HIPAA, as we continue to develop training and revise procedures to address ongoing compliance. The HIPAA security regulations require health care providers to implement administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of patient information. HITECH has since strengthened certain HIPAA rules regarding the use and disclosure of protected health information, extended certain HIPAA provisions to business associates, and created new security breach notification requirements. HITECH has also extended the ability to impose civil money penalties on providers not knowing that a HIPAA violation has occurred. We believe that we have been in substantial compliance with HIPAA and HITECH requirements to date. Recent changes to the HIPAA regulations may result in greater compliance requirements for healthcare providers, including expanded obligations to report breaches of unsecured patient data, as well as create new liabilities for the actions of parties acting as business associates on our behalf.

Red Flags Rule: In addition, the Federal Trade Commission ("FTC") Red Flags Rule requires financial institutions and businesses maintaining accounts to address the risk of identity theft. The Red Flag Program Clarification Act of 2010, signed on December 18, 2010, appears to exclude certain healthcare providers from the Red Flags Rule, but permits the FTC or relevant agencies to designate additional creditors subject to the Red Flags Rule through future rulemaking if the agencies determine that the person in question maintains accounts subject to foreseeable risk of identity theft. Compliance with any such future rulemaking may require additional expenditures in the future.

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Patient Safety and Quality Improvement Act of 2005: On July 29, 2005, the Patient Safety and Quality Improvement Act of 2005 was enacted, which has the goal of reducing medical errors and increasing patient safety. This legislation establishes a confidential reporting structure in which providers can voluntarily report "Patient Safety Work Product" ("PSWP") to "Patient Safety Organizations" ("PSOs"). Under the system, PSWP is made privileged, confidential and legally protected from disclosure. PSWP does not include medical, discharge or billing records or any other original patient or provider records but does include information gathered specifically in connection with the reporting of medical errors and improving patient safety. This legislation does not preempt state or federal mandatory disclosure laws concerning information that does not constitute PSWP. PSOs are certified by the Secretary of the HHS for three-year periods and analyze PSWP, provide feedback to providers and may report non-identifiable PSWP to a database. In addition, PSOs are expected to generate patient safety improvement strategies.

Environmental Regulations: Our healthcare operations generate medical waste that must be disposed of in compliance with federal, state and local environmental laws, rules and regulations. Infectious waste generators, including hospitals, face substantial penalties for improper disposal of medical waste, including civil penalties of up to $25,000 per day of noncompliance, criminal penalties of up to $50,000 per day, imprisonment, and remedial costs. In addition, our operations, as well as our purchases and sales of facilities are subject to various other environmental laws, rules and regulations. We believe that our disposal of such wastes is in material compliance with all state and federal laws.

Corporate Practice of Medicine: Several states, including Florida, Nevada, California and Texas, have laws and/or regulations that prohibit corporations and other entities from employing physicians and practicing medicine for a profit or that prohibit certain direct and indirect payments or fee-splitting arrangements between health care providers that are designed to induce or encourage the referral of patients to, or the recommendation of, particular providers for medical products and services. Possible sanctions for violation of these restrictions include loss of license and civil and criminal penalties. In addition, agreements between the corporation and the physician may be considered void and unenforceable. These statutes and/or regulations vary from state to state, are often vague and have seldom been interpreted by the courts or regulatory agencies. We do not expect these state corporate practice of medicine proscriptions to significantly affect our operations. Many states have laws and regulations which prohibit payments for referral of patients and fee-splitting with physicians. We do not make any such payments or have any such arrangements.

EMTALA: All of our hospitals are subject to the Emergency Medical Treatment and Active Labor Act ("EMTALA"). This federal law generally requires hospitals that are certified providers under Medicare to conduct a medical screening examination of every person who visits the hospital's emergency room for treatment and, if the patient is suffering from a medical emergency, to either stabilize the patient's condition or transfer the patient to a facility that can better handle the condition. Our obligation to screen and stabilize emergency medical conditions exists regardless of a patient's ability to pay for treatment. There are severe penalties under EMTALA if a hospital fails to screen or appropriately stabilize or transfer a patient or if the hospital delays appropriate treatment in order to first inquire about the patient's ability to pay. Penalties for violations of EMTALA include civil monetary penalties and exclusion from participation in the Medicare program. In addition to any liabilities that a hospital may incur under EMTALA, an injured patient, the patient's family or a medical facility that suffers a financial loss as a direct result of another hospital's violation of the law can bring a civil suit against the hospital unrelated to the rights granted under that statute.

The federal government broadly interprets EMTALA to cover situations in which patients do not actually present to a hospital's emergency room, but present for emergency examination or treatment to the hospital's campus, generally, or to a hospital-based clinic that treats emergency medical conditions or are transported in a hospital-owned ambulance, subject to certain exceptions. EMTALA does not generally apply to patients admitted for inpatient services; however, CMS has recently sought industry comments on the potential applicability of EMTALA to hospital inpatients and the responsibilities of hospitals with specialized capabilities, respectively. CMS has not yet issued regulations or guidance in response to that request for comments. The government also has expressed its intent to investigate and enforce EMTALA violations actively in the future. We believe that we operate in substantial compliance with EMTALA.

Health Care Industry Investigations: We are subject to claims and suits in the ordinary course of business, including those arising from care and treatment afforded by our hospitals and are party to various government investigations and litigation. Please see *Item 3. Legal Proceedings* included herein for additional disclosure. In addition, currently, and from time to time, some of our facilities are subjected to inquiries and/or actions and receive notices of potential non-compliance of laws and regulations from various federal and state agencies. Providers that are found to have violated these laws and regulations may be excluded from participating in government healthcare programs, subjected to potential licensure, certification, and/or accreditation revocation, subjected to fines or penalties or required to repay amounts received from the government for previously billed patient services.

We monitor all aspects of our business and have developed a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards. Because the law in this area is complex and constantly evolving, governmental investigation or litigation may result in interpretations that are inconsistent with industry practices, including ours. Although we believe our policies, procedures and practices comply with governmental regulations, no assurance can be given that we will not be subjected to inquiries or actions, or that we will not be faced with sanctions, fines or penalties in connection with the

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investigations. Even if we were to ultimately prevail, the government's inquiry and/or action in connection with these matters could have a material adverse effect on our future operating results.

Our substantial Medicare, Medicaid and other governmental billings may result in heightened scrutiny of our operations. It is possible that governmental entities could initiate additional investigations or litigation in the future and that such matters could result in significant penalties as well as adverse publicity. It is also possible that our executives and/or managers could be included as targets or witnesses in governmental investigations or litigation and/or named as defendants in private litigation.

Revenue Rulings 98-15 and 2004-51: In March 1998 and May 2004, the IRS issued guidance regarding the tax consequences of joint ventures between for-profit and not-for-profit hospitals. As a result of the tax rulings, the IRS has proposed, and may in the future propose, to revoke the tax-exempt or public charity status of certain not-for-profit entities which participate in such joint ventures or to treat joint venture income as unrelated business taxable income to them. The tax rulings have limited development of joint ventures and any adverse determination by the IRS or the courts regarding the tax-exempt or public charity status of a not-for-profit partner or the characterization of joint venture income as unrelated business taxable income could further limit joint venture development with not-for-profit hospitals, and/or require the restructuring of certain existing joint ventures with not-for-profits.

State Rate Review: Some states where we operate hospitals have adopted legislation mandating rate or budget review for hospitals or have adopted taxes on hospital revenues, assessments or licensure fees to fund indigent health care within the state. In the aggregate, state rate reviews and indigent tax provisions have not materially, adversely affected our results of operations.

Medical Malpractice Tort Law Reform: Medical malpractice tort law has historically been maintained at the state level. All states have laws governing medical liability lawsuits. Over half of the states have limits on damages awards. Almost all states have eliminated joint and several liability in malpractice lawsuits, and many states have established limits on attorney fees. Many states had bills introduced in their legislative sessions to address medical malpractice tort reform. Proposed solutions include enacting limits on non-economic damages, malpractice insurance reform, and gathering lawsuit claims data from malpractice insurance companies and the courts for the purpose of assessing the connection between malpractice settlements and premium rates. Reform legislation has also been proposed, but not adopted, at the federal level that could preempt additional state legislation in this area.

Compliance Program: Our company-wide compliance program has been in place since 1998. Currently, the program's elements include a Code of Conduct, risk area specific policies and procedures, employee education and training, an internal system for reporting concerns, auditing and monitoring programs, and a means for enforcing the program's policies.

Since its initial adoption, the compliance program continues to be expanded and developed to meet the industry's expectations and our needs. Specific written policies, procedures, training and educational materials and programs, as well as auditing and monitoring activities have been prepared and implemented to address the functional and operational aspects of our business. Specific areas identified through regulatory interpretation and enforcement activities have also been addressed in our program. Claims preparation and submission, including coding, billing, and cost reports, comprise the bulk of these areas. Financial arrangements with physicians and other referral sources, including compliance with anti-kickback and Stark laws and emergency department treatment and transfer requirements are also the focus of policy and training, standardized documentation requirements, and review and audit.

Employees and Medical Staff

Our facilities located in the U.S. had approximately 72,600 employees as of December 31, 2015, of whom approximately 52,400 were employed full-time. In addition, our facilities located in the U.K. had approximately 2,000 employees as of December 31, 2015. Our hospitals are staffed by licensed physicians who have been admitted to the medical staff of individual hospitals. In a number of our markets, physicians may have admitting privileges at other hospitals in addition to ours. Within our acute care division, approximately 190 physicians are employed by physician practice management subsidiaries of ours either directly or through contracts with affiliated group practices structured as 501A corporations. Members of the medical staffs of our hospitals also serve on the medical staffs of hospitals not owned by us and may terminate their affiliation with our hospitals at any time. In addition, within our behavioral health division, approximately 435 psychiatrists are employed by subsidiaries of ours either directly or through contracts with affiliated group practices structured as 501A corporations. Each of our hospitals is managed on a day-to-day basis by a managing director employed by a subsidiary of ours. In addition, a Board of Governors, including members of the hospital's medical staff, governs the medical, professional and ethical practices at each hospital. We believe that our relations with our employees are satisfactory.

Approximately 1,875 of our employees at six of our hospitals are unionized. At Valley Hospital Medical Center, unionized employees belong to the Culinary Workers and Bartenders Union, the International Union of Operating Engineers and the Service Employees International Union ("SEIU"). Nurses and technicians at Desert Springs Hospital are represented by the SEIU and International Union of Operating Engineers. At The George Washington University Hospital, unionized employees are represented by

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the SEIU or the Hospital Police Association. At the Psychiatric Institute of Washington, clinical, clerical, support and maintenance employees are represented by the Communication Workers of America (AFL-CIO). In February, 2016, nurses at Corona Regional Medical Center ("Corona"), who were previously represented by the United Nurses Associations of California/Union of Health Care Professionals ("UNAC/UHCP"), submitted to the hospital objective evidence that the union no longer had majority support of the nurses. The nurses requested that the hospital withdraw recognition of UNAC/UHCP as their bargaining representative. After verification of the evidence presented, Corona granted the request of the nurses. UNAC/UHCP has the right to challenge the withdrawal of recognition. Registered Nurses, Licensed Practical Nurses, certain technicians and therapists, pharmacy assistants, and some clerical employees at HRI Hospital in Boston are represented by the SEIU. At Brooke Glen Behavioral Hospital, unionized employees are represented by the Teamsters and the Northwestern Nurses Association/Pennsylvania Association of Staff Nurses and Allied Professionals.

Competition

The health care industry is highly competitive. In recent years, competition among healthcare providers for patients has intensified in the United States due to, among other things, regulatory and technological changes, increasing use of managed care payment systems, cost containment pressures and a shift toward outpatient treatment. In all of the geographical areas in which we operate, there are other hospitals that provide services comparable to those offered by our hospitals. In addition, some of our competitors include hospitals that are owned by tax-supported governmental agencies or by nonprofit corporations and may be supported by endowments and charitable contributions and exempt from property, sale and income taxes. Such exemptions and support are not available to us.

In some markets, certain of our competitors may have greater financial resources, be better equipped and offer a broader range of services than us. Certain hospitals that are located in the areas served by our facilities are specialty or large hospitals that provide medical, surgical and behavioral health services, facilities and equipment that are not available at our hospitals. The increase in outpatient treatment and diagnostic facilities, outpatient surgical centers and freestanding ambulatory surgical also increases competition for us.

The number and quality of the physicians on a hospital's staff are important factors in determining a hospital's success and competitive advantage. Typically, physicians are responsible for making hospital admissions decisions and for directing the course of patient treatment. We believe that physicians refer patients to a hospital primarily on the basis of the patient's needs, the quality of other physicians on the medical staff, the location of the hospital and the breadth and scope of services offered at the hospital's facilities. We strive to retain and attract qualified doctors by maintaining high ethical and professional standards and providing adequate support personnel, technologically advanced equipment and facilities that meet the needs of those physicians.

In addition, we depend on the efforts, abilities, and experience of our medical support personnel, including our nurses, pharmacists and lab technicians and other health care professionals. We compete with other health care providers in recruiting and retaining qualified hospital management, nurses and other medical personnel. Our acute care and behavioral health care facilities are experiencing the effects of a shortage of skilled nursing staff nationwide, which has caused and may continue to cause an increase in salaries, wages and benefits expense in excess of the inflation rate. In addition, in some markets like California, there are requirements to maintain specified nurse-staffing levels. To the extent we cannot meet those levels, we may by required to limit the healthcare services provided in these markets which would have a corresponding adverse effect on our net operating revenues.

Many states in which we operate hospitals have CON laws. The application process for approval of additional covered services, new facilities, changes in operations and capital expenditures is, therefore, highly competitive in these states. In those states that do not have CON laws or which set relatively high levels of expenditures before they become reviewable by state authorities, competition in the form of new services, facilities and capital spending is more prevalent. See "Regulation and Other Factors."

Our ability to negotiate favorable service contracts with purchasers of group health care services also affects our competitive position and significantly affects the revenues and operating results of our hospitals. Managed care plans attempt to direct and control the use of hospital services and to demand that we accept lower rates of payment. In addition, employers and traditional health insurers are increasingly interested in containing costs through negotiations with hospitals for managed care programs and discounts from established charges. In return, hospitals secure commitments for a larger number of potential patients. Generally, hospitals compete for service contracts with group health care service purchasers on the basis of price, market reputation, geographic location, quality and range of services, quality of the medical staff and convenience. The importance of obtaining contracts with managed care organizations varies from market to market depending on the market strength of such organizations.

A key element of our growth strategy is expansion through the acquisition of additional hospitals in select markets. The competition to acquire hospitals is significant. We face competition for acquisition candidates primarily from other for-profit health care companies, as well as from not-for-profit entities. Some of our competitors have greater resources than we do. We intend to

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selectively seek opportunities to expand our base of operations by adhering to our disciplined program of rational growth, but may not be successful in accomplishing acquisitions on favorable terms.

Relationship with Universal Health Realty Income Trust

At December 31, 2015, we held approximately 5.9% 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. In December, 2015, the advisory agreement was renewed by the Trust for 2016 pursuant to the same terms in place during each of the last three years. During 2015, 2014 and 2013, the advisory fee was computed at 0.70% of the Trust's average invested real estate assets. In addition, certain of our officers and directors are also officers and/or directors of the Trust. Management believes that it has the ability to exercise significant influence over the Trust, therefore we account for our investment in the Trust using the equity method of accounting. We earned an advisory fee from the Trust, which is included in net revenues in the accompanying consolidated statements of income, of approximately $2.8 million during 2015, $2.5 million during 2014 and $2.4 million during 2013.

Our pre-tax share of income from the Trust was $1.4 million during 2015, $3.2 million during 2014 and $842,000 during 2013, and is included in net revenues in the accompanying consolidated statements of income for each year. Included in our share of the Trust's income was approximately $500,000 in 2015, and $2.3 million in 2014, related to our share of gains on various transactions recorded by the Trust.

The carrying value of our investment in the Trust was $8.7 million and $9.3 million at December 31, 2015 and 2014, respectively, and is included in other assets in the accompanying consolidated balance sheets. The market value of our investment in the Trust was $39.4 million at December 31, 2015 and $37.9 million at December 31, 2014, based on the closing price of the Trust's stock on the respective dates.

Total rent expense under the operating leases on the three hospital facilities with the Trust during 2015 was $15.6 million. Total rent expense under the operating leases on the four hospital facilities with the Trust during 2014 and 2013 (as discussed below) was $16.8 million and $16.4 million, respectively. In addition, certain of our subsidiaries are tenants in several medical office buildings owned by the Trust or by limited liability companies in which the Trust holds 100% of the ownership interest.

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

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

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

The table below details the renewal options and terms for each of our three hospital facilities leased from the Trust:

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

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

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

Executive Officers of the Registrant

The executive officers, whose terms will expire at such time as their successors are elected, are as follows:

Name and Age	Present Position with the Company
Alan B. Miller (78)	Chairman of the Board and Chief Executive Officer
Marc D. Miller (45)	President and Director
Steve G. Filton (58)	Senior Vice President, Chief Financial Officer and Secretary
Debra K. Osteen (60)	Senior Vice President, President of Behavioral Health Care Division
Marvin G. Pember (62)	Senior Vice President, President of Acute Care Division

Mr. Alan B. Miller has been Chairman of the Board and Chief Executive Officer since inception and also served as President from inception until May, 2009. Prior thereto, he was President, Chairman of the Board and Chief Executive Officer of American Medicorp, Inc. He currently serves as Chairman of the Board, Chief Executive Officer and President of Universal Health Realty Income Trust. He is the father of Marc D. Miller, our President and Director.

Mr. Marc D. Miller was elected President in May, 2009 and prior thereto served as Senior Vice President and co-head of our Acute Care Hospitals since 2007. He was elected a Director in May, 2006 and Vice President in 2005. He has served in various capacities related to our acute care division since 2000. He was elected to the Board of Trustees of Universal Health Realty Income Trust in December, 2008. In August, 2015, he was appointed to the Board of Directors of Premier, Inc., a publicly traded healthcare performance improvement alliance. See Note 9 to the Consolidated Financial Statements-*Relationship with Universal Health Realty Income Trust and Other Related Party Transactions* for additional disclosure regarding the Company's group purchasing organization agreement with Premier, Inc. Marc D. Miller is the son of Alan B. Miller, our Chairman of the Board and Chief Executive Officer.

Mr. Filton was elected Senior Vice President and Chief Financial Officer in 2003 and he was elected Secretary in 1999. He had served as Vice President and Controller since 1991 and Director of Corporate Accounting since 1985.

Ms. Osteen was elected Senior Vice President in 2005 and serves as President of our Behavioral Health Care Division. She was elected Vice President in 2000 and has served in various capacities related to our Behavioral Health Care facilities since 1984.

Mr. Pember commenced employment with us in August, 2011 and serves as President of our Acute Care Division. He was formerly employed for 12 years at Indiana University Health, Inc. (formerly known as Clarian Health Partners, Inc.), a nonprofit hospital system that operates multiple facilities in Indiana, where he served as Executive Vice President and Chief Financial Officer.

ITEM 1A. ***Risk Factors***

We are subject to numerous known and unknown risks, many of which are described below and elsewhere in this Annual Report. Any of the events described below could have a material adverse effect on our business, financial condition and results of operations. Additional risks and uncertainties that we are not aware of, or that we currently deem to be immaterial, could also impact our business and results of operations.

A significant portion of our revenue is produced by facilities located in Texas, Nevada and California.

Texas: We own 7 inpatient acute care hospitals and 24 inpatient behavioral healthcare facilities as listed in *Item 2. Properties*. On a combined basis, these facilities contributed 17% in 2015 and 18% in both 2014 and 2013 of our consolidated net revenues. On a

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combined basis, after deducting an allocation for corporate overhead expense, these facilities generated 11% in 2015, 17% in 2014, and 15% in 2013 of our income from operations after net income attributable to noncontrolling interest.

Nevada: We own 6 inpatient acute care hospitals and 4 inpatient behavioral healthcare facilities as listed in *Item 2. Properties*. On a combined basis, these facilities contributed 15% in 2015, 16% in 2014, and 15% in 2013 of our consolidated net revenues. On a combined basis, after deducting an allocation for corporate overhead expense, these facilities generated 10% in 2015, 11% in 2014, and 6% in 2013 of our income from operations after net income attributable to noncontrolling interest.

California: We own 5 inpatient acute care hospitals and 8 inpatient behavioral healthcare facilities as listed in *Item 2. Properties*. On a combined basis, these facilities contributed 11% in 2015, 10% in 2014, and 9% in 2013 of our consolidated net revenues. On a combined basis, after deducting an allocation for corporate overhead expense, these facilities generated 11% in 2015, 8% in 2014, and 4% in 2013 of our income from operations after net income attributable to noncontrolling interest.

The significant portion of our revenues and earnings derived from these facilities makes us particularly sensitive to legislative, regulatory, economic, environmental and competition changes in Texas, Nevada and California. Any material change in the current payment programs or regulatory, economic, environmental or competitive conditions in these states could have a disproportionate effect on our overall business results.

Our revenues and results of operations are significantly affected by payments received from the government and other third party payors.

We derive a significant portion of our revenue from third-party payors, including the Medicare and Medicaid programs. Changes in these government programs in recent years have resulted in limitations on reimbursement and, in some cases, reduced levels of reimbursement for healthcare services. Payments from federal and state government programs are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations, requirements for utilization review, and federal and state funding restrictions, all of which could materially increase or decrease program payments, as well as affect the cost of providing service to patients and the timing of payments to facilities. We are unable to predict the effect of recent and future policy changes on our operations. In addition, the uncertainty and fiscal pressures placed upon federal and state governments as a result of, among other things, the substantial deterioration in general economic conditions and the funding requirements from the federal healthcare reform legislation, may affect the availability of taxpayer funds for Medicare and Medicaid programs. In addition, the vast majority of the net revenues generated at our behavioral health facilities located in the United Kingdom are derived from governmental payors. If the rates paid or the scope of services covered by governmental payors in the United States or United Kingdom are reduced, there could be a material adverse effect on our business, financial position and results of operations.

We receive Medicaid revenues in excess of $90 million annually from each of Texas, Washington, D.C., California, Nevada, Illinois, Pennsylvania, Virginia, Massachusetts and Florida, making us particularly sensitive to reductions in Medicaid and other state based revenue programs as well as regulatory, economic, environmental and competitive changes in those states.

In addition to changes in government reimbursement programs, our ability to negotiate favorable contracts with private payors, including managed care providers, significantly affects the revenues and operating results of our hospitals. Private payors, including managed care providers, increasingly are demanding that we accept lower rates of payment.

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

Reductions or changes in Medicare funding could have a material adverse effect on our future results of operations.

On January 3, 2013, President Obama signed into law the American Taxpayer Relief Act of 2012 (the "2012 Act"). The 2012 Act postponed for two months sequestration cuts mandated under the Budget Control Act of 2011. The postponed sequestration cuts include a 2% annual reduction over ten years in Medicare spending to providers. Medicaid is exempt from sequestration. In order to offset the costs of the legislation, the 2012 Act reduces payments to other providers totaling almost $26 billion over ten years. Approximately half of those funds will come from reductions in Medicare reimbursement to hospitals. Although the Bipartisan Budget Act of 2013 has reduced certain sequestration-related budgetary cuts, spending reductions related to the Medicare program remain in place. On December 26, 2013, President Obama signed into law H.J. Res. 59, the Bipartisan Budget Act of 2013, which includes the Pathway for SGR Reform Act of 2013 ("the Act"). In addition, on February 15, 2014, Public Law 113-082 was enacted. The Act and subsequent federal legislation achieves new savings by extending sequestration for mandatory programs—including Medicare—for another three years, through 2024. Please see *Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations, Sources of Revenue-Medicare*, for additional disclosure.

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The 2012 Act includes a document and coding ("DCI") adjustment and a reduction in Medicaid disproportionate share hospital ("DSH") payments. Expected to save $10.5 billion over 10 years, the DCI adjustment decreases projected Medicare hospital payments for inpatient and overnight care through a downward adjustment in annual base payment increases. These reductions are meant to recoup what Medicare authorities consider to be "overpayments" to hospitals that occurred as a result of the transition to Medicare Severity Diagnosis Related Groups. The reduction in Medicaid DSH payments is expected to save $4.2 billion over 10 years. This provision extends the changes regarding DSH payments established by the Legislation and determines future allotments off of the rebased level.

We are subject to uncertainties regarding health care reform.

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (the "PPACA"). The Healthcare and Education Reconciliation Act of 2010 (the "Reconciliation Act"), which contains a number of amendments to the PPACA, was signed into law on March 30, 2010. Two primary goals of the PPACA, combined with the Reconciliation Act (collectively referred to as the "Legislation"), are to provide for increased access to coverage for healthcare and to reduce healthcare-related expenses.

Although it is expected that as a result of the Legislation there may be a reduction in uninsured patients, which should reduce our expense from uncollectible accounts receivable, the Legislation makes a number of other changes to Medicare and Medicaid which we believe may have an adverse impact on us. It has been projected that the Legislation will result in a net reduction in Medicare and Medicaid payments to hospitals totaling $155 billion over 10 years. 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 with no material adverse impact to the reimbursements we receive expected until 2015 while Medicaid DSH reimbursements would not be adversely impacted until 2016. The Legislation implements 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 program by reducing their existing Medicaid funding. Therefore, states can choose to accept or not to participate 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.

There have been several attempts in Congress to repeal or modify various provisions of the Legislation. We cannot predict whether or not any of these proposed changes to the PPACA will become law and therefore can provide no assurance that changes to the Legislation, as currently implemented, will not have a material adverse effect on our future results of operations.

In addition, in *King vs. Burwell*, the Supreme Court decided in favor of the federal government's ability to subsidize premiums paid by certain eligible individuals that obtain health insurance policies through federally facilitated exchanges. A number of our hospitals operate in states that utilize federally facilitated exchanges. The Supreme Court's decision in this case ultimately preserved the viability of federally facilitated exchanges. A different decision by the Supreme Court could have resulted in an increased number of uninsured patients generally, including an increase of uninsured patients treated at our hospitals located in these states.

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 those creating the Medicare Shared Savings Program and the Independent Payment Advisory Board, create 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

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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, although final regulations implementing this statutory requirement remain pending. 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.

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. We cannot predict the impact the Legislation may have on our business, results of operations, cash flow, capital resources and liquidity, or whether we will be able to successfully adapt to the changes required by the Legislation.

We are required to treat patients with emergency medical conditions regardless of ability to pay.

In accordance with our internal policies and procedures, as well as the Emergency Medical Treatment and Active Labor Act, or EMTALA, we provide a medical screening examination to any individual who comes to one of our hospitals while in active labor and/or seeking medical treatment (whether or not such individual is eligible for insurance benefits and regardless of ability to pay) to determine if such individual has an emergency medical condition. If it is determined that such person has an emergency medical condition, we provide such further medical examination and treatment as is required to stabilize the patient's medical condition, within the facility's capability, or arrange for transfer of such individual to another medical facility in accordance with applicable law and the treating hospital's written procedures. Our obligations under EMTALA may increase substantially going forward; CMS has sought stakeholder comments concerning the potential applicability of EMTALA to hospital inpatients and the responsibilities of hospitals with specialized capabilities, respectively, but has yet to issue further guidance in response to that request. If the number of indigent and charity care patients with emergency medical conditions we treat increases significantly, or if regulations expanding our obligations to inpatients under EMTALA is proposed and adopted, our results of operations will be harmed.

If we are not able to provide high quality medical care at a reasonable price, patients may choose to receive their health care from our competitors.

In recent years, the number of quality measures that hospitals are required to report publicly has increased. CMS publishes performance data related to quality measures and data on patient satisfaction surveys that hospitals submit in connection with the Medicare program. Federal law provides for the future expansion of the number of quality measures that must be reported. Additionally, the Legislation requires all hospitals to annually establish, update and make public a list of their standard charges for products and services. If any of our hospitals achieve poor results on the quality measures or patient satisfaction surveys (or results that are lower than our competitors) or if our standard charges are higher than our competitors, our patient volume could decline because patients may elect to use competing hospitals or other health care providers that have better metrics and pricing. This circumstance could harm our business and results of operations.

An increase in uninsured and underinsured patients in our acute care facilities or the deterioration in the collectability of the accounts of such patients could harm our results of operations.

Collection of receivables from third-party payors and patients is our primary source of cash and is critical to our operating performance. Our primary collection risks relate to uninsured patients and the portion of the bill that is the patient's responsibility, which primarily includes co-payments and deductibles. However, we also have substantial receivables due to us as of December 31, 2015 (a significant portion of which is past due) from certain state-based funding programs, most particularly Illinois and Texas as discussed herein. We estimate our provisions for doubtful accounts based on general factors such as payor mix, the agings of the receivables, historical collection experience and assessment of probability of future collections. We routinely review accounts receivable balances in conjunction with these factors and other economic conditions that might ultimately affect the collectability of the patient accounts and make adjustments to our allowances as warranted. Significant changes in business office operations, payor mix, economic conditions or trends in federal and state governmental health coverage could affect our collection of accounts receivable, cash flow and results of operations. If we experience unexpected increases in the growth of uninsured and underinsured patients or in bad debt expenses, our results of operations will be harmed.

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Our hospitals face competition for patients from other hospitals and health care providers.

The healthcare industry is highly competitive, and competition among hospitals, and other healthcare providers for patients and physicians has intensified in recent years. In all of the geographical areas in which we operate, there are other hospitals that provide services comparable to those offered by our hospitals. Some of our competitors include hospitals that are owned by tax-supported governmental agencies or by nonprofit corporations and may be supported by endowments and charitable contributions and exempt from property, sales and income taxes. Such exemptions and support are not available to us.

In some markets, certain of our competitors may have greater financial resources, be better equipped and offer a broader range of services than we. The number of inpatient facilities, as well as outpatient surgical and diagnostic centers, many of which are fully or partially owned by physicians, in the geographic areas in which we operate has increased significantly. As a result, most of our hospitals operate in an increasingly competitive environment.

If our competitors are better able to attract patients, recruit physicians and other healthcare professionals, expand services or obtain favorable managed care contracts at their facilities, we may experience a decline in patient volume and our business may be harmed.

Our performance depends on our ability to recruit and retain quality physicians.

Typically, physicians are responsible for making hospital admissions decisions and for directing the course of patient treatment. As a result, the success and competitive advantage of our hospitals depends, in part, on the number and quality of the physicians on the medical staffs of our hospitals, the admitting practices of those physicians and our maintenance of good relations with those physicians. Physicians generally are not employees of our hospitals, and, in a number of our markets, physicians have admitting privileges at other hospitals in addition to our hospitals. They may terminate their affiliation with us at any time. If we are unable to provide high ethical and professional standards, adequate support personnel and technologically advanced equipment and facilities that meet the needs of those physicians, they may be discouraged from referring patients to our facilities and our results of operations may decline.

It may become difficult for us to attract and retain an adequate number of physicians to practice in certain of the non-urban communities in which our hospitals are located. Our failure to recruit physicians to these communities or the loss of physicians in these communities could make it more difficult to attract patients to our hospitals and thereby may have a material adverse effect on our business, financial condition and results of operations.

Generally, the top ten attending physicians within each of our facilities represent a large share of our inpatient revenues and admissions. The loss of one or more of these physicians, even if temporary, could cause a material reduction in our revenues, which could take significant time to replace given the difficulty and cost associated with recruiting and retaining physicians.

If we do not continually enhance our hospitals with the most recent technological advances in diagnostic and surgical equipment, our ability to maintain and expand our markets will be adversely affected.

The technology used in medical equipment and related devices is constantly evolving and, as a result, manufacturers and distributors continue to offer new and upgraded products to health care providers. To compete effectively, we must continually assess our equipment needs and upgrade when significant technological advances occur. If our facilities do not stay current with technological advances in the health care industry, patients may seek treatment from other providers and/or physicians may refer their patients to alternate sources, which could adversely affect our results of operations and harm our business.

If we fail to continue to meet the meaningful use criteria related to electronic health record systems ("EHR"), our operations could be harmed.

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

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Our performance depends on our ability to attract and retain qualified nurses and medical support staff and we face competition for staffing that may increase our labor costs and harm our results of operations.

We depend on the efforts, abilities, and experience of our medical support personnel, including our nurses, pharmacists and lab technicians and other healthcare professionals. We compete with other healthcare providers in recruiting and retaining qualified hospital management, nurses and other medical personnel.

The nationwide shortage of nurses and other medical support personnel has been a significant operating issue facing us and other healthcare providers. This shortage may require us to enhance wages and benefits to recruit and retain nurses and other medical support personnel or require us to hire expensive temporary personnel. In addition, in some markets like California, there are requirements to maintain specified nurse-staffing levels. To the extent we cannot meet those levels, we may be required to limit the healthcare services provided in these markets, which would have a corresponding adverse effect on our net operating revenues.

We cannot predict the degree to which we will be affected by the future availability or cost of attracting and retaining talented medical support staff. If our general labor and related expenses increase, we may not be able to raise our rates correspondingly. Our failure to either recruit and retain qualified hospital management, nurses and other medical support personnel or control our labor costs could harm our results of operations.

Increased labor union activity is another factor that could adversely affect our labor costs. Union organizing activities and certain potential changes in federal labor laws and regulations could increase the likelihood of employee unionization in the future, to the extent a greater portion of our employee base unionized, it is possible our labor costs could increase materially.

If we fail to comply with extensive laws and government regulations, we could suffer civil or criminal penalties or be required to make significant changes to our operations that could reduce our revenue and profitability.

The healthcare industry is required to comply with extensive and complex laws and regulations at the federal, state and local government levels relating to, among other things: hospital billing practices and prices for services; relationships with physicians and other referral sources; adequacy of medical care and quality of medical equipment and services; ownership of facilities; qualifications of medical and support personnel; confidentiality, maintenance, privacy and security issues associated with health-related information and patient medical records; the screening, stabilization and transfer of patients who have emergency medical conditions; certification, licensure and accreditation of our facilities; operating policies and procedures, and; construction or expansion of facilities and services.

Among these laws are the federal False Claims Act, the Health Insurance Portability and Accountability Act of 1996, ("HIPAA"), the federal anti-kickback statute and the provision of the Social Security Act commonly known as the "Stark Law." These laws, and particularly the anti-kickback statute and the Stark Law, impact the relationships that we may have with physicians and other referral sources. We have a variety of financial relationships with physicians who refer patients to our facilities, including employment contracts, leases and professional service agreements. We also provide financial incentives, including minimum revenue guarantees, to recruit physicians into communities served by our hospitals. The Office of the Inspector General of the Department of Health and Human Services, or OIG, has enacted safe harbor regulations that outline practices that are deemed protected from prosecution under the anti-kickback statute. A number of our current arrangements, including financial relationships with physicians and other referral sources, may not qualify for safe harbor protection under the anti-kickback statute. Failure to meet a safe harbor does not mean that the arrangement necessarily violates the anti-kickback statute, but may subject the arrangement to greater scrutiny. We cannot assure that practices that are outside of a safe harbor will not be found to violate the anti-kickback statute. CMS published a Medicare self-referral disclosure protocol, which is intended to allow providers to self-disclose actual or potential violations of the Stark law. Because there are only a few judicial decisions interpreting the Stark law, there can be no assurance that our hospitals will not be found in violation of the Stark Law or that self-disclosure of a potential violation would result in reduced penalties.

Federal regulations issued under HIPAA contain provisions that require us to implement and, in the future, may require us to implement additional costly electronic media security systems and to adopt new business practices designed to protect the privacy and security of each of our patient's health and related financial information. Such privacy and security regulations impose extensive administrative, physical and technical requirements on us, restrict our use and disclosure of certain patient health and financial information, provide patients with rights with respect to their health information and require us to enter into contracts extending many of the privacy and security regulatory requirements to third parties that perform duties on our behalf. Additionally, recent changes to HIPAA regulations may result in greater compliance requirements, including obligations to report breaches of unsecured patient data, as well as create new liabilities for the actions of parties acting as business associates on our behalf.

These laws and regulations are extremely complex, and, in many cases, we do not have the benefit of regulatory or judicial interpretation. In the future, it is possible that different interpretations or enforcement of these laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment,

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personnel, services, capital expenditure programs and operating expenses. A determination that we have violated one or more of these laws (see *Item 3—Legal Proceedings*), or the public announcement that we are being investigated for possible violations of one or more of these laws, could have a material adverse effect on our business, financial condition or results of operations and our business reputation could suffer significantly. In addition, we cannot predict whether other legislation or regulations at the federal or state level will be adopted, what form such legislation or regulations may take or what their impact on us may be. See *Item 1 Business—Self-Referral and Anti-Kickback Legislation.*

If we are deemed to have failed to comply with the anti-kickback statute, the Stark Law or other applicable laws and regulations, we could be subjected to liabilities, including criminal penalties, civil penalties (including the loss of our licenses to operate one or more facilities), and exclusion of one or more facilities from participation in the Medicare, Medicaid and other federal and state healthcare programs. The imposition of such penalties could have a material adverse effect on our business, financial condition or results of operations.

We also operate health care facilities in the United Kingdom and have operations and commercial relationships with companies in other foreign jurisdictions and, as a result, are subject to certain U.S. and foreign laws applicable to businesses generally, including anti-corruption laws. The Foreign Corrupt Practices Act regulates U.S. companies in their dealings with foreign officials, prohibiting bribes and similar practices, and requires that they maintain records that fairly and accurately reflect transactions and appropriate internal accounting controls. In addition, the United Kingdom Bribery Act has wide jurisdiction over certain activities that affect the United Kingdom.

We are subject to occupational health, safety and other similar regulations and failure to comply with such regulations could harm our business and results of operations.

We are subject to a wide variety of federal, state and local occupational health and safety laws and regulations. Regulatory requirements affecting us include, but are not limited to, those covering: (i) air and water quality control; (ii) occupational health and safety (e.g., standards regarding blood-borne pathogens and ergonomics, etc.); (iii) waste management; (iv) the handling of asbestos, polychlorinated biphenyls and radioactive substances; and (v) other hazardous materials. If we fail to comply with those standards, we may be subject to sanctions and penalties that could harm our business and results of operations.

We may be subject to liabilities from claims brought against our facilities.

We are subject to medical malpractice lawsuits, product liability lawsuits, class action lawsuits and other legal actions in the ordinary course of business. Some of these actions may involve large claims, as well as significant defense costs. We cannot predict the outcome of these lawsuits or the effect that findings in such lawsuits may have on us. In an effort to resolve one or more of these matters, we may choose to negotiate a settlement. Amounts we pay to settle any of these matters may be material. All professional and general liability insurance we purchase is subject to policy limitations. We believe that, based on our past experience and actuarial estimates, our insurance coverage is adequate considering the claims arising from the operations of our hospitals. While we continuously monitor our coverage, our ultimate liability for professional and general liability claims could change materially from our current estimates. If such policy limitations should be partially or fully exhausted in the future, or payments of claims exceed our estimates or are not covered by our insurance, it could have a material adverse effect on our operations.

We may be subject to governmental investigations, regulatory actions and whistleblower lawsuits.

The federal False Claims Act permits private parties to bring qui tam, or whistleblower, lawsuits against companies. Whistleblower provisions allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. These private parties are entitled to share in any amounts recovered by the government, and, as a result, the number of whistleblower lawsuits that have been filed against providers has increased significantly in recent years. Because qui tam lawsuits are filed under seal, we could be named in one or more such lawsuits of which we are not aware. Please see *Item 3. Legal Proceedings* for disclosure of current related matters.

The failure of certain employers, or the closure of certain facilities, could have a disproportionate impact on our hospitals.

The economies in the non-urban communities in which our hospitals operate are often dependent on a small number of large employers. Those employers often provide income and health insurance for a disproportionately large number of community residents who may depend on our hospitals and other health care facilities for their care. The failure of one or more large employer or the closure or substantial reduction in the number of individuals employed at facilities located in or near the communities where our hospitals operate, could cause affected employees to move elsewhere to seek employment or lose insurance coverage that was otherwise available to them. The occurrence of these events could adversely affect our revenue and results of operations, thereby harming our business.

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If any of our existing health care facilities lose their accreditation or any of our new facilities fail to receive accreditation, such facilities could become ineligible to receive reimbursement under Medicare or Medicaid.

The construction and operation of healthcare facilities are subject to extensive federal, state and local regulation relating to, among other things, the adequacy of medical care, equipment, personnel, operating policies and procedures, fire prevention, rate-setting and compliance with building codes and environmental protection. Additionally, such facilities are subject to periodic inspection by government authorities to assure their continued compliance with these various standards.

All of our hospitals are deemed certified, meaning that they are accredited, properly licensed under the relevant state laws and regulations and certified under the Medicare program. The effect of maintaining certified facilities is to allow such facilities to participate in the Medicare and Medicaid programs. We believe that all of our healthcare facilities are in material compliance with applicable federal, state, local and other relevant regulations and standards. However, should any of our healthcare facilities lose their deemed certified status and thereby lose certification under the Medicare or Medicaid programs, such facilities would be unable to receive reimbursement from either of those programs and our business could be materially adversely effected.

Our growth strategy depends, in part, on acquisitions, and we may not be able to continue to acquire hospitals that meet our target criteria. We may also have difficulties acquiring hospitals from not-for-profit entities due to regulatory scrutiny.

Acquisitions of hospitals in select markets are a key element of our growth strategy. We face competition for acquisition candidates primarily from other for-profit healthcare companies, as well as from not-for-profit entities. Some of our competitors have greater resources than we do. Also, suitable acquisitions may not be accomplished due to unfavorable terms.

In addition, many states have enacted, or are considering enacting, laws that affect the conversion or sale of not-for-profit hospitals to for-profit entities. These laws generally require prior approval from the state attorney general, advance notification and community involvement. In addition, attorneys general in states without specific conversion legislation may exercise discretionary authority over such transactions. Although the level of government involvement varies from state to state, the trend is to provide for increased governmental review and, in some cases, approval of a transaction in which a not-for-profit entity sells a healthcare facility to a for-profit entity. The adoption of new or expanded conversion legislation, increased review of not-for-profit hospital conversions or our inability to effectively compete against other potential purchasers could make it more difficult for us to acquire additional hospitals, increase our acquisition costs or make it difficult for us to acquire hospitals that meet our target acquisition criteria, any of which could adversely affect our growth strategy and results of operations.

Further, the cost of an acquisition could result in a dilutive effect on our results of operations, depending on various factors, including the amount paid for the acquisition, the acquired hospital's results of operations, allocation of the purchase price, effects of subsequent legislation and limits on rate increases.

We may fail to improve or integrate the operations of the hospitals we acquire, which could harm our results of operations and adversely affect our growth strategy.

We may be unable to timely and effectively integrate the hospitals that we acquire with our ongoing operations. We may experience delays in implementing operating procedures and systems in newly acquired hospitals. Integrating a new hospital could be expensive and time consuming and could disrupt our ongoing business, negatively affect cash flow and distract management and other key personnel. In addition, acquisition activity requires transitions from, and the integration of, operations and, usually, information systems that are used by acquired hospitals. In addition, some of the hospitals we acquire had significantly lower operating margins than the hospitals we operate prior to the time of our acquisition. If we fail to improve the operating margins of the hospitals we acquire, operate such hospitals profitably or effectively integrate the operations of acquired hospitals, our results of operations could be harmed.

The trend toward value-based purchasing may negatively impact our revenues.

We believe that value-based purchasing initiatives of both governmental and private payers tying financial incentives to quality and efficiency of care will increasingly affect the results of operations of our hospitals and other healthcare facilities and may negatively impact our revenues if we are unable to meet expected quality standards. The Affordable Care Act contains a number of provisions intended to promote value-based purchasing in federal healthcare programs. Medicare now requires providers to report certain quality measures in order to receive full reimbursement increases for inpatient and outpatient procedures that were previously awarded automatically. In addition, hospitals that meet or exceed certain quality performance standards will receive increased reimbursement payments, and hospitals that have "excess readmissions" for specified conditions will receive reduced reimbursement. Furthermore, Medicare no longer pays hospitals additional amounts for the treatment of certain hospital-acquired conditions unless the conditions were present at admission. Beginning in federal fiscal year 2015, hospitals that rank in the worst 25% of all hospitals nationally for hospital acquired conditions in the previous year will receive reduced Medicare reimbursements. The ACA also

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prohibits the use of federal funds under the Medicaid program to reimburse providers for treating certain provider-preventable conditions.

There is a trend among private payers toward value-based purchasing of healthcare services, as well. Many large commercial payers require hospitals to report quality data, and several of these payers will not reimburse hospitals for certain preventable adverse events. We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. We are unable at this time to predict how this trend will affect our results of operations, but it could negatively impact our revenues if we are unable to meet quality standards established by both governmental and private payers.

If we acquire hospitals with unknown or contingent liabilities, we could become liable for material obligations.

Hospitals that we acquire may have unknown or contingent liabilities, including, but not limited to, liabilities for failure to comply with applicable laws and regulations. Although we typically attempt to exclude significant liabilities from our acquisition transactions and seek indemnification from the sellers of such hospitals for these matters, we could experience difficulty enforcing those obligations or we could incur material liabilities for the past activities of hospitals we acquire. Such liabilities and related legal or other costs and/or resulting damage to a facility's reputation could harm our business.

Our subsidiaries, PSI, and its subsidiaries, are subject to pending legal actions, governmental investigations and regulatory actions.

Our subsidiaries, PSI, and its subsidiaries, are subject to pending legal actions, governmental investigations and regulatory actions (see *Item 3-Legal Proceedings*). In addition, we are and may become subject to other loss contingencies, both known and unknown, which may relate to past, present and future facts, events, circumstances and occurrences. Should an unfavorable outcome occur in some or all of our legal proceedings or other loss contingencies, or if successful claims and other actions are brought against us in the future, there could be a material adverse impact on our financial position, results of operations and liquidity following the merger and our ability to achieve expected benefits of the merger.

In particular, government investigations, as well as qui tam lawsuits, may lead to material fines, penalties, damages payments or other sanctions, including exclusion from government healthcare programs. Settlements of lawsuits involving Medicare and Medicaid issues routinely require both monetary payments and corporate integrity agreements, each of which could have a material adverse effect on our business, financial condition, results of operations and/or cash flows.

State efforts to regulate the construction or expansion of health care facilities could impair our ability to expand.

Many of the states in which we operate hospitals have enacted Certificates of Need, or CON, laws as a condition prior to hospital capital expenditures, construction, expansion, modernization or initiation of major new services. Our failure to obtain necessary state approval could result in our inability to complete a particular hospital acquisition, expansion or replacement, make a facility ineligible to receive reimbursement under the Medicare or Medicaid programs, result in the revocation of a facility's license or impose civil or criminal penalties on us, any of which could harm our business.

In addition, significant CON reforms have been proposed in a number of states that would increase the capital spending thresholds and provide exemptions of various services from review requirements. In the past, we have not experienced any material adverse effects from those requirements, but we cannot predict the impact of these changes upon our operations.

Controls designed to reduce inpatient services may reduce our revenues.

Controls imposed by third-party payors designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Utilization review entails the review of the admission and course of treatment of a patient by managed care plans. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payor-required preadmission authorization and utilization review and by payor pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Efforts to impose more stringent cost controls are expected to continue. Although we cannot predict the effect these changes will have on our operations, significant limits on the scope of services reimbursed and on reimbursement rates and fees could have a material adverse effect on our business, financial position and results of operations.

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Our revenues and volume trends may be adversely affected by certain factors over which we have no control.

Our revenues and volume trends are dependent on many factors, including physicians' clinical decisions and availability, payor programs shifting to a more outpatient-based environment, whether or not certain services are offered, seasonal and severe weather conditions, including the effects of extreme low temperatures, hurricanes and tornados, earthquakes, current local economic and demographic changes. In addition, technological developments and pharmaceutical improvements may reduce the demand for healthcare services or the profitability of the services we offer.

A pandemic, epidemic or outbreak of a contagious disease in the markets in which we operate or that otherwise impacts our facilities could adversely impact our business.

If a pandemic or other public health crisis were to affect our markets, our business could be adversely affected. Such a crisis could diminish the public trust in healthcare facilities, especially hospitals that fail to accurately or timely diagnose, or that are treating (or have treated) patients affected by contagious diseases. If any of our facilities were involved in treating patients for such a contagious disease, other patients might cancel elective procedures or fail to seek needed care at our facilities. Further, a pandemic might adversely impact our business by causing a temporary shutdown or diversion of patients, by disrupting or delaying production and delivery of materials and products in the supply chain or by causing staffing shortages in our facilities. Although we have disaster plans in place and operate pursuant to infectious disease protocols, the potential impact of a pandemic, epidemic or outbreak of a contagious disease with respect to our markets or our facilities is difficult to predict and could adversely impact our business.

A worsening of the economic and employment conditions in the United States could materially affect our business and future results of operations.

Our patient volumes, revenues and financial results depend significantly on the universe of patients with health insurance, which to a large extent is dependent on the employment status of individuals in our markets. Worsening of economic conditions may result in a higher unemployment rate which may increase the number of individuals without health insurance. As a result, our facilities may experience a decrease in patient volumes, particularly in less intense, more elective service lines, or an increase in services provided to uninsured patients. These factors could have a material unfavorable impact on our future patient volumes, revenues and operating results.

In addition, as of December 31, 2015, we had approximately $3.60 billion of goodwill recorded on our consolidated balance sheet. Should the revenues and financial results of our acute care and/or behavioral health care facilities be materially, unfavorably impacted due to, among other things, a worsening of the economic and employment conditions in the United States that could negatively impact our patient volumes and reimbursement rates, a continued rise in the unemployment rate and continued increases in the number of uninsured patients treated at our facilities, we may incur future charges to recognize impairment in the carrying value of our goodwill and other intangible assets, which could have a material adverse effect on our financial results.

Fluctuations in our operating results, quarter to quarter earnings and other factors may result in decreases in the price of our common stock.

The stock markets have experienced volatility that has often been unrelated to operating performance. These broad market fluctuations may adversely affect the trading price of our common stock and, as a result, there may be significant volatility in the market price of our common stock. If we are unable to operate our hospitals as profitably as we have in the past or as our stockholders expect us to in the future, the market price of our common stock will likely decline as stockholders could sell shares of our common stock when it becomes apparent that the market expectations may not be realized.

In addition to our operating results, many economic and seasonal factors outside of our control could have an adverse effect on the price of our common stock and increase fluctuations in our quarterly earnings. These factors include certain of the risks discussed herein, demographic changes, operating results of other hospital companies, changes in our financial estimates or recommendations of securities analysts, speculation in the press or investment community, the possible effects of war, terrorist and other hostilities, adverse weather conditions, the level of seasonal illnesses, managed care contract negotiations and terminations, changes in general conditions in the economy or the financial markets, or other developments affecting the health care industry.

Our financial results may be adversely affected by fluctuations in foreign currency exchange rates.

We are exposed to currency exchange risk with respect to the U.S. Dollar in relation to the Pound sterling, because a portion of our revenue and expenses are denominated in Pounds. We monitor changes in our exposure to exchange rate risk. While we may elect to enter into hedging arrangements to protect our business against certain currency fluctuations, these hedging arrangements do not provide comprehensive protection, and our results of operations could be adversely affected by foreign exchange fluctuations.

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We are subject to significant corporate regulation as a public company and failure to comply with all applicable regulations could subject us to liability or negatively affect our stock price.

As a publicly traded company, we are subject to a significant body of regulation, including the Sarbanes-Oxley Act of 2002. While we have developed and instituted a corporate compliance program based on what we believe are the current best practices in corporate governance and continue to update this program in response to newly implemented or changing regulatory requirements, we cannot provide assurance that we are or will be in compliance with all potentially applicable corporate regulations. For example, we cannot provide assurance that, in the future, our management will not find a material weakness in connection with its annual review of our internal control over financial reporting pursuant to Section 404 of the Sarbanes-Oxley Act. We also cannot provide assurance that we could correct any such weakness to allow our management to assess the effectiveness of our internal control over financial reporting as of the end of our fiscal year in time to enable our independent registered public accounting firm to state that such assessment will have been fairly stated in our Annual Report on Form 10-K or state that we have maintained effective internal control over financial reporting as of the end of our fiscal year. If we fail to comply with any of these regulations, we could be subject to a range of regulatory actions, fines or other sanctions or litigation. If we must disclose any material weakness in our internal control over financial reporting, our stock price could decline.

A cyber security incident could cause a violation of HIPAA, breach of member privacy, or other negative impacts.

We rely extensively on our information technology ("IT") systems to manage clinical and financial data, communicate with our patients, payors, vendors and other third parties and summarize and analyze operating results. In addition, we have made significant investments in technology to adopt and utilize electronic health records and to become meaningful users of health information technology pursuant to the American Recovery and Reinvestment Act of 2009. A cyber-attack that bypasses our IT security systems causing an IT security breach, loss of protected health information or other data subject to privacy laws, loss of proprietary business information, or a material disruption of our IT business systems, could have a material adverse impact on our business and result of operations. In addition, our future results of operations, as well as our reputation, could be adversely impacted by theft, destruction, loss, or misappropriation of public health information, other confidential data or proprietary business information.

Different interpretations of accounting principles could have a material adverse effect on our results of operations or financial condition.

Generally accepted accounting principles are complex, continually evolving and may be subject to varied interpretation by us, our independent registered public accounting firm and the SEC. Such varied interpretations could result from differing views related to specific facts and circumstances. Differences in interpretation of generally accepted accounting principles could have a material adverse effect on our financial position or results of operations.

We continue to see rising costs in construction materials and labor. Such increased costs could have an adverse effect on the cash flow return on investment relating to our capital projects.

The cost of construction materials and labor has significantly increased. As we continue to invest in modern technologies, emergency rooms and operating room expansions, the construction of medical office buildings for physician expansion and reconfiguring the flow of patient care, we spend large amounts of money generated from our operating cash flow or borrowed funds. Although we evaluate the financial feasibility of such projects by determining whether the projected cash flow return on investment exceeds our cost of capital, such returns may not be achieved if the cost of construction continues to rise significantly or the expected patient volumes are not attained.

The deterioration of credit and capital markets may adversely affect our access to sources of funding and we cannot be certain of the availability and terms of capital to fund the growth of our business when needed.

We require substantial capital resources to fund our acquisition growth strategy and our ongoing capital expenditure programs for renovation, expansion, construction and addition of medical equipment and technology. We believe that our capital expenditure program is adequate to expand, improve and equip our existing hospitals. We cannot predict, however, whether financing for our growth plans and capital expenditure programs will be available to us on satisfactory terms when needed, which could harm our business.

To fund all or a portion of our future financing needs, we rely on borrowings from various sources including fixed rate, long-term debt as well as borrowings pursuant to our revolving credit facility and accounts receivable securitization program. If any of the lenders were unable to fulfill their future commitments, our liquidity could be impacted, which could have a material unfavorable impact our results of operations and financial condition.

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In addition, global capital markets have experienced volatility that has tightened access to capital markets and other sources of funding. 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.

We depend heavily on key management personnel and the departure of one or more of our key executives or a significant portion of our local hospital management personnel could harm our business.

The expertise and efforts of our senior executives and key members of our local hospital management personnel are critical to the success of our business. The loss of the services of one or more of our senior executives or of a significant portion of our local hospital management personnel could significantly undermine our management expertise and our ability to provide efficient, quality healthcare services at our facilities, which could harm our business.

The number of outstanding shares of our Class B Common Stock is subject to potential increases or decreases.

At December 31, 2015, 24.1 million shares of Class B Common Stock were reserved for issuance upon conversion of shares of Class A, C and D Common Stock outstanding, for issuance upon exercise of options to purchase Class B Common Stock and for issuance of stock under other incentive plans. Class A, C and D Common Stock are convertible on a share for share basis into Class B Common Stock. To the extent that these shares were converted into or exercised for shares of Class B Common Stock, the number of shares of Class B Common Stock available for trading in the public market place would increase substantially and the current holders of Class B Common Stock would own a smaller percentage of that class.

In addition, from time-to-time our Board of Directors approve stock repurchase programs authorizing us to purchase shares of our Class B Common Stock on the open market at prevailing market prices or in negotiated transactions off the market. Such repurchases decrease the number of outstanding shares of our Class B Common Stock. Conversely, as a potential means of generating additional funds to operate and expand our business, we may from time-to-time issue equity through the sale of stock which would increase the number of outstanding shares of our Class B Common Stock. Based upon factors such as, but not limited to, the market price of our stock, interest rate on borrowings and uses or potential uses for cash, repurchase or issuance of our stock could have a dilutive effect on our future basic and diluted earnings per share.

The right to elect the majority of our Board of Directors and the majority of the general shareholder voting power resides with the holders of Class A and C Common Stock, the majority of which is owned by Alan B. Miller, our Chief Executive Officer and Chairman of our Board of Directors.

Our Restated Certificate of Incorporation provides that, with respect to the election of directors, holders of Class A Common Stock vote as a class with the holders of Class C Common Stock, and holders of Class B Common Stock vote as a class with holders of Class D Common Stock, with holders of all classes of our Common Stock entitled to one vote per share.

As of March 26, 2015, the shares of Class A and Class C Common Stock constituted 7.3% of the aggregate outstanding shares of our Common Stock, had the right to elect five members of the Board of Directors and constituted 86.1% of our general voting power as of that date. As of March 26, 2015, the shares of Class B and Class D Common Stock (excluding shares issuable upon exercise of options) constituted 92.7% of the outstanding shares of our Common Stock, had the right to elect two members of the Board of Directors and constituted 13.9% of our general voting power as of that date.

As to matters other than the election of directors, our Restated Certificate of Incorporation provides that holders of Class A, Class B, Class C and Class D Common Stock all vote together as a single class, except as otherwise provided by law.

Each share of Class A Common Stock entitles the holder thereof to one vote; each share of Class B Common Stock entitles the holder thereof to one-tenth of a vote; each share of Class C Common Stock entitles the holder thereof to 100 votes (provided the holder of Class C Common Stock holds a number of shares of Class A Common Stock equal to ten times the number of shares of Class C Common Stock that holder holds); and each share of Class D Common Stock entitles the holder thereof to ten votes (provided the holder of Class D Common Stock holds a number of shares of Class B Common Stock equal to ten times the number of shares of Class D Common Stock that holder holds).

In the event a holder of Class C or Class D Common Stock holds a number of shares of Class A or Class B Common Stock, respectively, less than ten times the number of shares of Class C or Class D Common Stock that holder holds, then that holder will be entitled to only one vote for every share of Class C Common Stock, or one-tenth of a vote for every share of Class D Common Stock, which that holder holds in excess of one-tenth the number of shares of Class A or Class B Common Stock, respectively, held by that holder. The Board of Directors, in its discretion, may require beneficial owners to provide satisfactory evidence that such owner holds

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ten times as many shares of Class A or Class B Common Stock as Class C or Class D Common Stock, respectively, if such facts are not apparent from our stock records.

Since a substantial majority of the Class A shares and Class C shares are controlled by Mr. Alan B. Miller and members of his family, one of whom (Marc D. Miller) is also a director and officer of our company, and they can elect a majority of our company's directors and effect or reject most actions requiring approval by stockholders without the vote of any other stockholders, there are potential conflicts of interest in overseeing the management of our company.

In addition, because this concentrated control could discourage others from initiating any potential merger, takeover or other change of control transaction that may otherwise be beneficial to our businesses, our business and prospects and the trading price of our securities could be adversely affected.

ITEM 1B. *Unresolved Staff Comments*

None.

ITEM 2. *Properties*

Executive and Administrative Offices and Commercial Health Insurer

We own office buildings in King of Prussia and Wayne, Pennsylvania, Brentwood, Tennessee, Denton, Texas and Reno, Nevada.

Facilities

The following tables set forth the name, location, type of facility and, for acute care hospitals and behavioral health care facilities, the number of licensed beds:

Acute Care Hospitals

Name of Facility	Location	Number of Beds	Real Property Ownership Interest
Aiken Regional Medical Centers	Aiken, South Carolina	183	Owned
Aurora Pavilion	Aiken, South Carolina	62	Owned
Centennial Hills Hospital Medical Center (1)	Las Vegas, Nevada	190	Owned
Corona Regional Medical Center	Corona, California	238	Owned
Desert Springs Hospital (1)	Las Vegas, Nevada	293	Owned
Doctors' Hospital of Laredo (8)	Laredo, Texas	183	Owned
Doctor's Hospital ER South	Laredo, Texas	—	Leased
Fort Duncan Regional Medical Center	Eagle Pass, Texas	101	Owned
The George Washington University Hospital (2)	Washington, D.C.	385	Owned
Henderson Hospital (1) (10)	Henderson, Nevada	142	Owned
Lakewood Ranch Medical Center	Bradenton, Florida	120	Owned
Manatee Memorial Hospital	Bradenton, Florida	319	Owned
Northern Nevada Medical Center	Sparks, Nevada	108	Owned
Northwest Texas Healthcare System	Amarillo, Texas	405	Owned
The Pavilion at Northwest Texas Healthcare System	Amarillo, Texas	90	Owned
Palmdale Regional Medical Center	Palmdale, California	157	Owned
South Texas Health System (4)			
Edinburg Regional Medical Center/Children's Hospital	Edinburg, Texas	213	Owned
McAllen Medical Center (3)	McAllen, Texas	441	Leased
McAllen Heart Hospital	McAllen, Texas	60	Owned
South Texas Behavioral Health Center	McAllen, Texas	134	Owned
STHS ER at Mission (3)	Mission, Texas	—	Leased
STHS ER at Weslaco (3)	Weslaco, Texas	—	Leased
Southwest Healthcare System			
Inland Valley Campus (3)	Wildomar, California	132	Leased

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Name of Facility	Location	Number of Beds	Real Property Ownership Interest
Rancho Springs Campus	Murrieta, California	120	Owned
Spring Valley Hospital Medical Center (1)	Las Vegas, Nevada	237	Owned
St. Mary's Regional Medical Center	Enid, Oklahoma	229	Owned
Summerlin Hospital Medical Center (1)	Las Vegas, Nevada	454	Owned
Temecula Valley Hospital	Temecula, California	140	Owned
Texoma Medical Center	Denison, Texas	266	Owned
TMC Behavioral Health Center	Denison, Texas	60	Owned
Valley Hospital Medical Center (1)	Las Vegas, Nevada	301	Owned
Wellington Regional Medical Center (3)	West Palm Beach, Florida	233	Leased

Inpatient Behavioral Health Care Facilities

Name of Facility	Location	Number of Beds	Real Property Ownership Interest
Alabama Clinical Schools	Birmingham, Alabama	80	Owned
Alhambra Hospital	Rosemead, California	103	Owned
Alliance Health Center	Meridian, Mississippi	214	Owned
Anchor Hospital	Atlanta, Georgia	122	Owned
The Arbour Hospital	Boston, Massachusetts	136	Owned
Arbour-Fuller Hospital	South Attleboro, Massachusetts	103	Owned
Arbour-HRI Hospital	Brookline, Massachusetts	62	Owned
Arrowhead Behavioral Health	Maumee, Ohio	48	Owned
Atlantic Shores Hospital	Fort Lauderdale, Florida	72	Owned
Austin Lakes Hospital	Austin, Texas	58	Leased
Austin Oaks Hospitals	Austin, Texas	80	Owned
Behavioral Hospital of Bellaire	Houston, Texas	124	Leased
Belmont Pines Hospital	Youngstown, Ohio	102	Owned
Benchmark Behavioral Health System	Woods Cross, Utah	94	Owned
Black Bear Treatment Center	Sautee, Georgia	115	Owned
Bloomington Meadows Hospital	Bloomington, Indiana	78	Owned
Boulder Creek Academy	Bonners Ferry, Idaho	96	Owned
Brentwood Behavioral Health of Mississippi	Flowood, Mississippi	105	Owned
Brentwood Hospital	Shreveport, Louisiana	200	Owned
The Bridgeway	North Little Rock, Arkansas	127	Owned
Brook Hospital—Dupont	Louisville, Kentucky	88	Owned
Brook Hospital—KMI	Louisville, Kentucky	110	Owned
Brooke Glen Behavioral Hospital	Fort Washington, Pennsylvania	146	Owned
Brynn Marr Hospital	Jacksonville, North Carolina	102	Owned
Bury Hospital	Bury, UK	164	Owned
Calvary Addiction Recovery Center	Phoenix, Arizona	68	Owned
The Canyon at Peace Park	Malibu, California	16	Leased
Canyon Ridge Hospital	Chino, California	106	Owned
The Carolina Center for Behavioral Health	Greer, South Carolina	130	Owned
Cedar Grove Residential Treatment Center	Murfreesboro, Tennessee	36	Owned
Cedar Hills Hospital (9)	Beaverton, Oregon	89	Owned
Cedar Ridge	Oklahoma City, Oklahoma	60	Owned
Cedar Ridge Residential Treatment Center	Oklahoma City, Oklahoma	56	Owned
Cedar Springs Behavioral Health	Colorado Springs, Colorado	110	Owned
Centennial Peaks	Louisville, Colorado	72	Owned
Center for Change	Orem, Utah	58	Owned

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Name of Facility	Location	Number of Beds	Real Property Ownership Interest
Central Florida Behavioral Hospital	Orlando, Florida	126	Owned
Chicago Children's Center for Behavioral Health	Chicago, Illinois	40	Leased
Chris Kyle Patriots Hospital	Anchorage, Alaska	36	Owned
Clarion Psychiatric Center	Clarion, Pennsylvania	74	Owned
Coastal Behavioral Health	Savannah, Georgia	50	Owned
Coastal Harbor Treatment Center	Savannah, Georgia	145	Owned
Columbus Behavioral Center for Children and Adolescents	Columbus, Indiana	56	Owned
Compass Intervention Center	Memphis, Tennessee	108	Owned
Copper Hills Youth Center	West Jordan, Utah	197	Owned
Crescent Pines	Stockbridge, Georgia	50	Owned
Cumberland Hall	Hopkinsville, Kentucky	97	Owned
Cumberland Hospital	New Kent, Virginia	118	Owned
Cypress Creek Hospital	Houston, Texas	96	Owned
Cygnet Hospital—Beckton	Beckton, UK	62	Owned
Cygnet Hospital—Bierley	Bierley, UK	63	Owned
Cygnet Wing—Blackheath	Blackheath, UK	32	Leased
Cygnet Lodge—Brighouse	Brighouse, UK	25	Owned
Cygnet Hospital—Derby	Derby, UK	47	Owned
Cygnet Hospital—Ealing	Ealing, UK	26	Leased
Cygnet Hospital—Godden Green	Godden Green, UK	39	Owned
Cygnet Hospital—Harrogate	Harrogate, UK	36	Owned
Cygnet Hospital—Harrow	Harrow, UK	44	Owned
Cygnet Hospital—Kewstoke	Kewstoke, UK	69	Owned
Cygnet Lodge—Lewisham	Lewisham, UK	20	Owned
Cygnet Hospital—Stevenage	Stevenage, UK	88	Owned
Cygnet Hospital—Taunton	Taunton, UK	46	Owned
Cygnet Lodge—Westlands	Westlands, UK	15	Owned
Cygnet Hospital—Wyke	Wyke, UK	47	Owned
Del Amo Hospital	Torrance, California	166	Owned
Diamond Grove Center	Louisville, Mississippi	55	Owned
Dover Behavioral Health	Dover, Delaware	80	Owned
El Paso Behavioral Health System	El Paso, Texas	163	Owned
Emerald Coast Behavioral Hospital	Panama City, Florida	86	Owned
Fairmount Behavioral Health System	Philadelphia, Pennsylvania	239	Owned
Fairfax Hospital	Kirkland, Washington	157	Owned
Fairfax Hospital—Everett	Everett, Washington	30	Leased
First Hospital Panamericano—Cidra	Cidra, Puerto Rico	165	Owned
First Hospital Panamericano—San Juan	San Juan, Puerto Rico	45	Owned
First Hospital Panamericano—Ponce	Ponce, Puerto Rico	30	Owned
Forest View Hospital	Grand Rapids, Michigan	108	Owned
Fort Lauderdale Hospital	Fort Lauderdale, Florida	100	Leased
Foundations Behavioral Health	Doylestown, Pennsylvania	106	Leased
Foundations for Living	Mansfield, Ohio	84	Owned
Fox Run Hospital	St. Clairsville, Ohio	100	Owned
Fremont Hospital	Fremont, California	148	Owned
Friends Hospital	Philadelphia, Pennsylvania	219	Owned
Garfield Park Hospital	Chicago, Illinois	88	Owned
Glen Oaks Hospital	Greenville, Texas	54	Owned
Gulf Coast Youth Services	Fort Walton Beach, Florida	24	Owned
Hampton Behavioral Health Center	Westhampton, New Jersey	110	Owned
Harbour Point (Pines)	Portsmouth, Virginia	186	Owned
Hartgrove Hospital	Chicago, Illinois	150	Owned

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Name of Facility	Location	# of Beds	Real Property Ownership Interest
Havenwyck Hospital	Auburn Hills, Michigan	251	Owned
Heartland Behavioral Health Services	Nevada, Missouri	151	Owned
Hermitage Hall	Nashville, Tennessee	100	Owned
Heritage Oaks Hospital	Sacramento, California	125	Owned
Hickory Trail Hospital	DeSoto, Texas	86	Owned
Highlands Behavioral Health System	Highlands Ranch, Colorado	86	Owned
Hill Crest Behavioral Health Services	Birmingham, Alabama	219	Owned
Holly Hill Hospital	Raleigh, North Carolina	228	Owned
The Horsham Clinic	Ambler, Pennsylvania	206	Owned
Hughes Center	Danville, Virginia	56	Owned
Intermountain Hospital	Boise, Idaho	155	Owned
Kempsville Center of Behavioral Health	Norfolk, Virginia	82	Owned
KeyStone Center	Wallingford, Pennsylvania	146	Owned
Kingwood Pines Hospital	Kingwood, Texas	116	Owned
La Amistad Behavioral Health Services	Maitland, Florida	80	Owned
Lake Bridge Behavioral Health	Macon, Georgia	70	Owned
Lakeside Behavioral Health System	Memphis, Tennessee	319	Owned
Laurel Heights Hospital	Atlanta, Georgia	108	Owned
Laurel Oaks Behavioral Health Center	Dothan, Alabama	124	Owned
Laurel Ridge Treatment Center	San Antonio, Texas	250	Owned
Liberty Point Behavioral Health	Stauton, Virginia	50	Owned
Lighthouse Care Center of Augusta	Augusta, Georgia	115	Owned
Lighthouse Care Center of Conway	Conway, South Carolina	96	Owned
Lincoln Prairie Behavioral Health Center	Springfield, Illinois	97	Owned
Lincoln Trail Behavioral Health System	Radcliff, Kentucky	140	Owned
Mayhill Hospital	Denton, Texas	59	Leased
McDowell Center for Children	Dyersburg, Tennessee	32	Owned
The Meadows Psychiatric Center	Centre Hall, Pennsylvania	107	Owned
Meridell Achievement Center	Austin, Texas	134	Owned
Mesilla Valley Hospital	Las Cruces, New Mexico	120	Owned
Michael's House	Palm Springs, California	87	Owned
Michiana Behavioral Health Center	Plymouth, Indiana	80	Owned
Midwest Center for Youth and Families	Kouts, Indiana	74	Owned
Millwood Hospital	Arlington, Texas	122	Leased
Mountain Youth Academy	Mountain City, Tennessee	72	Owned
Natchez Trace Youth Academy	Waverly, Tennessee	117	Owned
NDA Behavioral Health System	Mount Dora, Florida	132	Owned
Newport News Behavioral Health Center	Newport News, Virginia	132	Owned
North Spring Behavioral Healthcare	Leesburg, Virginia	100	Leased
North Star Hospital	Anchorage, Alaska	74	Owned
North Star Bragaw	Anchorage, Alaska	30	Owned
North Star DeBarr Residential Treatment Center	Anchorage, Alaska	30	Owned
North Star Palmer Residential Treatment Center	Palmer, Alaska	30	Owned
Northwest Academy	Bonners Perry, Idaho	82	Owned
Oak Plains Academy	Ashland City, Tennessee	90	Owned
The Oaks Treatment Center	Memphis, Tennessee	71	Owned
Okaloosa Youth Academy	Crestview, Florida	163	Leased
Old Vineyard Behavioral Health	Winston-Salem, North Carolina	104	Owned
Palmetto Lowcountry Behavioral Health	North Charleston, South Carolina	108	Owned
Palmetto Pee Dee Behavioral Health	Florence, South Carolina	59	Leased
Palmetto Summerville	Summerville, South Carolina	60	Leased
Palm Shores Behavioral Health Center	Bradenton, Florida	62	Owned

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Name of Facility	Location	# of Beds	Real Property Ownership Interest
Palo Verde Behavioral Health	Tucson, Arizona	84	Leased
Park Grange	Knaphill, UK	29	Owned
Parkwood Behavioral Health System	Olive Branch, Mississippi	148	Owned
The Pavilion	Champaign, Illinois	103	Owned
Peachford Behavioral Health System of Atlanta	Atlanta, Georgia	246	Owned
Pembroke Hospital	Pembroke, Massachusetts	120	Owned
Pinnacle Pointe Hospital	Little Rock, Arkansas	124	Owned
Poplar Springs Hospital	Petersburg, Virginia	208	Owned
Prairie St John's	Fargo, North Dakota	158	Owned
Pride Institute	Eden Prairie, Minnesota	42	Owned
Provo Canyon School	Provo, Utah	274	Owned
Provo Canyon Behavioral Hospital	Orem, Utah	80	Owned
Psychiatric Institute of Washington	Washington, D.C.	124	Leased
Quail Run Behavioral Health	Phoenix, Arizona	102	Owned
The Recovery Center	Wichita Falls, Texas	34	Leased
The Ridge Behavioral Health System	Lexington, Kentucky	110	Owned
Rivendell Behavioral Health Services of Arkansas	Benton, Arkansas	77	Owned
Rivendell Behavioral Health Services of Kentucky	Bowling Green, Kentucky	125	Owned
River Crest Hospital	San Angelo, Texas	80	Owned
Riveredge Hospital	Forest Park, Illinois	210	Owned
River Oaks Hospital	New Orleans, Louisiana	126	Owned
River Park Hospital	Huntington, West Virginia	187	Owned
River Point Behavioral Health	Jacksonville, Florida	93	Owned
Rockford Center	Newark, Delaware	118	Owned
Rolling Hills Hospital	Franklin, Tennessee	85	Owned
Roxbury	Shippensburg, Pennsylvania	112	Owned
Salt Lake Behavioral Health	Salt Lake City, Utah	118	Leased
San Marcos Treatment Center	San Marcos, Texas	265	Owned
SandyPines Hospital	Tequesta, Florida	130	Owned
Schick Shadel Hospital	Burin, Washington	60	Owned
Shadow Mountain Behavioral Health System	Tulsa, Oklahoma	249	Owned
Sheffield Hospital	Sheffield, UK	55	Owned
Sierra Vista Hospital	Sacramento, California	120	Owned
St. Simons by the Sea	St. Simons, Georgia	101	Owned
Spring Mountain Sahara	Las Vegas, Nevada	30	Owned
Spring Mountain Treatment Center	Las Vegas, Nevada	110	Owned
Springwoods	Fayetteville, Arkansas	80	Owned
Stonington Institute	North Stonington, Connecticut	68	Owned
Streamwood Behavioral Health	Streamwood, Illinois	178	Owned
Summit Oaks Hospital	Summit, New Jersey	126	Owned
SummitRidge	Lawrenceville, Georgia	86	Owned
Suncoast Behavioral Health Center	Bradenton, Florida	60	Owned
Tabley Nursing Home—Tabley	Tabley, UK	51	Leased
Texas NeuroRehab Center	Austin, Texas	151	Owned
Three Rivers Behavioral Health	West Columbia, South Carolina	118	Owned
Three Rivers Residential Treatment-Midlands Campus	West Columbia, South Carolina	59	Owned
Timberlawn of Garland	Garland, Texas	72	Leased
Timberlawn Mental Health System	Dallas, Texas	144	Owned
Tupwood Gate Nursing Home	Caterham, UK	30	Owned
Turning Point Hospital	Moultrie, Georgia	59	Owned
Turning Point Youth Center	St. Johns, Michigan	60	Owned
Two Rivers Psychiatric Hospital	Kansas City, Missouri	105	Owned

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Name of Facility	Location	Number of Beds	Real Property Ownership Interest
University Behavioral Center	Orlando, Florida	112	Owned
University Behavioral Health of Denton	Denton, Texas	104	Owned
Valle Vista Hospital	Greenwood, Indiana	102	Owned
Valley Hospital	Phoenix, Arizona	122	Owned
Vines Hospital	Ocala, Florida	98	Owned
Virgin Islands Behavioral Services	St. Croix, Virgin Islands	30	Owned
Virginia Beach Psychiatric Center	Virginia Beach, Virginia	100	Owned
Wekiva Springs	Jacksonville, Florida	120	Owned
Wellstone Regional Hospital	Jeffersonville, Indiana	100	Owned
West Hills Hospital	Reno, Nevada	95	Owned
West Oaks Hospital	Houston, Texas	160	Owned
Westwood Lodge Hospital	Westwood, Massachusetts	130	Owned
Willow Springs Center	Reno, Nevada	116	Owned
Windmoor Healthcare	Clearwater, Florida	144	Owned
Windsor—Laurelwood Center	Willoughby, Ohio	159	Leased
Woking Hospital	Woking, UK	57	Owned
Wyoming Behavioral Institute	Casper, Wyoming	129	Owned

Outpatient Behavioral Health Care Facilities

Name of Facility	Location	Real Property Ownership Interest
Arbour Counseling Services	Rockland, Massachusetts	Owned
Arbour Senior Care	Rockland, Massachusetts	Owned
Behavioral Educational Services	Riverdale, Florida	Leased
The Canyon at Santa Monica	Santa Monica, California	Leased
Community Cornerstones	Rio Piedras, Puerto Rico	Leased
First Home Care (VA)	Portsmouth, Virginia	Leased
Foundations Atlanta	Atlanta, Georgia	Leased
Foundations Memphis	Memphis, Tennessee	Leased
Foundations Nashville	Nashville, Tennessee	Leased
Foundations Roswell	Roswell, Georgia	Leased
Foundations San Diego	San Diego, California	Leased
Foundations San Francisco	San Francisco, California	Leased
Good Samaritan Counseling Center	Anchorage, Alaska	Owned
Michael's House Outpatient	Palm Springs, California	Leased
St. Louis Behavioral Medicine Institute	St. Louis, Missouri	Owned
Talbott Recovery	Atlanta, Georgia	Owned

Surgical Hospitals, Ambulatory Surgery Centers and Radiation Oncology Centers

Name of Facility	Location	Real Property Ownership Interest
Cancer Care Institute of Carolina	Aiken, South Carolina	Owned
Cornerstone Regional Hospital (5)	Edinburg, Texas	Leased
Palms Westside Clinic ASC (7)	Royal Palm Beach, Florida	Leased
Temecula Valley Day Surgery and Pain Therapy Center (6)	Murrieta, California	Leased

(1) Desert Springs Hospital, Summerlin Hospital Medical Center, Valley Hospital Medical Center, Spring Valley Hospital Medical Center, Centennial Hills Hospital Medical Center and Henderson Hospital (currently being constructed) are owned by limited

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liability companies ("LLCs") in which we hold controlling, majority ownership interests of approximately 72%. The remaining minority ownership interests in these facilities are held by unaffiliated third-parties. All hospitals are managed by us.

(2) We hold an 80% ownership interest in this facility through a general partnership interest in a limited partnership. The remaining 20% ownership interest is held by an unaffiliated third-party.
(3) Real property leased from Universal Health Realty Income Trust.
(4) Edinburg Regional Medical Center/Children's Hospital, McAllen Medical Center, McAllen Heart Hospital, South Texas Behavioral Health Center, STHS ER at Mission and STHS ER at Weslaco are consolidated under one license operating as the South Texas Health System.
(5) We manage and own a noncontrolling interest of approximately 50% in the entity that operates this facility.
(6) We own minority interests in an LLC that owns and operates this center which is managed by a third-party.
(7) We own a noncontrolling ownership interest of approximately 50% in the entity that operates this facility that is managed by a third-party.
(8) We hold an 89% ownership interest in this facility through both general and limited partnership interests. The remaining 11% ownership interest is held by unaffiliated third parties.
(9) Land of this facility is leased.
(10) Newly constructed facility that is expected to be completed and opened during the fourth quarter of 2016.

We own or lease medical office buildings adjoining some of our hospitals. We believe that the leases on the facilities, medical office buildings and other real estate leased or owned by us do not impose any material limitation on our operations. The aggregate lease payments on facilities leased by us were $69 million in 2015, $66 million in 2014 and $60 million in 2013.

ITEM 3. *Legal Proceedings*

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

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

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

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

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

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

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

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

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

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

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

In December, 2015, we were notified by the DOJ Civil Division that the civil investigation also includes Arbour Hospital, Arbour-Fuller Hospital, Pembroke Hospital and Westwood Lodge located in Massachusetts. To date, these facilities have not received any requests for documentation or other information.

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

In December, 2015, we were advised that the DOJ opened an investigation involving the El Paso Behavioral Health System in El Paso, Texas. The DOJ is investigating potential Stark law violations relating to arrangements between the facility and physician(s) at the facility. These agreements were entered into before we acquired the facility as a part of our acquisition of Ascend Health Corporation in October, 2012. To our knowledge, this matter is not a part of the omnibus investigation referenced above. At present, we are uncertain as to potential liability and/or financial exposure, if any, which may be associated with this matter.

In January, 2016, we were notified that the Department of Justice opened an investigation of the South Texas Health System of a potential False Claim Act case regarding compensation paid to cardiologists pursuant to employment agreements entered into in 2005. At present, we are uncertain as to potential liability and/or financial exposure, if any, which may be associated with this matter.

Regulatory Matters:

On July 23, 2015, Timberlawn Mental Health System ("Timberlawn") received notification from CMS of its intent to terminate Timberlawn's Medicare provider agreement effective August 7, 2015. This notification resulted from surveys conducted which alleged that Timberlawn was out of compliance with conditions of participation required for participation in the Medicare/Medicaid program. We filed a request for expedited administrative appeal with the U.S. Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, seeking review and reversal of the termination action. In conjunction with the administrative appeal, we filed litigation in the U.S District Court for the Northern District of Texas seeking a temporary restraining order and preliminary injunction to have the termination stayed pending the conclusion of the administrative appeal. The trial court denied Timberlawn's request for a temporary restraining order and dismissed the case. Timberlawn's provider agreement was terminated effective August 14, 2015. In September, 2015 Timberlawn reached an agreement with CMS relative to its reapplication to the Medicare/Medicaid program. In exchange, Timberlawn agreed to dismiss its administrative appeal as well as not to pursue an appeal of the decision of the trial court. During this time, Timberlawn has remained open. In December, 2015, Timberlawn received notice from the Texas Department of State Health Services of its intent to revoke Timberlawn's license and impose an administrative penalty. We have appealed and are contesting the proposed revocation and fine. In January, 2016, Timberlawn submitted its application for re-enrollment into the Medicare/Medicaid program. Although the operating results of Timberlawn did not have a material impact on our consolidated results of operations or financial condition for the years ended December 31, 2015 or 2014, the termination of Timberlawn's provider agreement has had a material adverse effect on the facility's results of operations and financial condition.

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

Other Matters:

In late September, 2015, many hospitals in Pennsylvania, including seven of our behavioral health care hospitals located in the state, received letters from the Pennsylvania Department of Public Welfare ("DPW") demanding repayment of allegedly excess Medicaid Disproportionate Share Hospital payments ("DSH") for the federal fiscal year 2011 ("FFY2011") amounting to approximately $4 million in the aggregate. We have filed administrative appeals for all of our facilities contesting the recoupment efforts since we believe DPW's calculation methodology is inaccurate and conflicts with applicable federal and state laws and regulations. DPW has agreed to postpone the recoupment of the state's share of the DSH payments until all hospital appeals are resolved. DPW also extended the deadline to recoup the federal share (2011 federal share is 55%) until April 30, 2016. However, if DPW is ultimately successful in its demand related to FFY2011, it could take similar action with regards to FFY2012 through FFY2014. Due to a change in the Pennsylvania Medicaid State Plan and implementation of a CMS-approved Medicaid Section 1115 Waiver, we do not believe the methodology applied by DPW to FFY2011 is applicable to reimbursements received for Medicaid services provided after January 1, 2015 by our behavioral health care facilities located in Pennsylvania. We can provide no assurance that we will ultimately be successful in our legal and administrative appeals related to DPW'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.

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

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

Department of Justice Investigation of Friends Hospital:

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

Department of Justice Investigation of Riveredge Hospital:

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

General:

We operate in a highly regulated and litigious industry which subjects us to various claims and lawsuits in the ordinary course of business as well as regulatory proceedings and government investigations. These claims or suits include claims for damages for personal injuries, medical malpractice, commercial/contractual disputes, wrongful restriction of, or interference with, physicians' staff privileges, and employment related claims, In addition, health care companies are subject to investigations and/or actions by various state and federal governmental agencies or those bringing claims on their behalf. Government action has increased with respect to investigations and/or allegations against healthcare providers concerning possible violations of fraud and abuse and false claims statutes as well as compliance with clinical and operational regulations. Currently, and from time to time, we and some of our facilities are subjected to inquiries in the form of subpoenas, Civil Investigative Demands, audits and other document requests from various federal and state agencies. These inquiries can lead to notices and/or actions including repayment obligations from state and federal government agencies associated with potential non-compliance with laws and regulations. Further, the federal False Claim Act allows private individuals to bring lawsuits (qui tam actions) against healthcare providers that submit claims for payments to the government. Various states have also adopted similar statutes. When such a claim is filed, the government will investigate the matter and decide if they are going to intervene in the pending case. These qui tam lawsuits are placed under seal by the court to comply with

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the False Claims Act's requirements. If the government chooses not to intervene, the private individual(s) can proceed independently on behalf of the government. Health care providers that are found to violate the False Claims Act may be subject to substantial monetary fines/penalties as well as face potential exclusion from participating in government health care programs or be required to comply with Corporate Integrity Agreements as a condition of a settlement of a False Claim Act matter. In September 2014, the Criminal Division of the DOJ, announced that all qui tam cases will be shared with their Division to determine if a parallel criminal investigation should be opened. The 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 Affordable Care Act has added additional obligations on healthcare providers to report and refund overpayments by government healthcare programs and authorizes the suspension of Medicare and Medicaid payments "pending an investigation of a credible allegation of fraud." We monitor our business and have developed an ethics and compliance program with respect to these complex laws, rules and regulations. Although we believe our policies, procedures and practices comply with government regulations, there is no assurance that we will not be faced with the sanctions referenced above which include fines, penalties and/or substantial damages, repayment obligations, payment suspensions, licensure revocation, and expulsion from government healthcare programs. Even if we were to ultimately prevail in any action brought against us or our facilities or in responding to any inquiry, such action or inquiry could have a material adverse effect on us.

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

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

ITEM 4. ***Mine Safety Disclosures***

Not applicable.

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PART II

ITEM 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Our Class B Common Stock is traded on the New York Stock Exchange. Shares of our Class A, Class C and Class D Common Stock are not traded in any public market, but are each convertible into shares of our Class B Common Stock on a share-for-share basis.

The table below sets forth, for the quarters indicated, the high and low reported closing sales prices per share reported on the New York Stock Exchange for our Class B Common Stock for the years ended December 31, 2015 and 2014:

	2015 High-Low Sales Price	2014 High-Low Sales Price
Quarter:		
1st	$121.33-$102.53	$85.80-$74.35
2nd	$142.69-$112.96	$98.75-$74.61
3rd	$146.24-$121.16	$114.84-$91.83
4th	$130.32-$111.73	$112.32-$97.81

The number of stockholders of record as of January 31, 2016, were as follows:

Class A Common	16
Class B Common	233
Class C Common	3
Class D Common	108

Stock Repurchase Programs

In July, 2014, our Board of Directors authorized a stock repurchase program whereby, from time to time as conditions allow, we may spend up to $400 million to purchase shares of our Class B Common Stock on the open market at prevailing market prices or in negotiated private transactions. There is no expiration date for our stock repurchase programs. As reflected below, during the three-month period ended December 31, 2015, 478,118 shares ($57.8 million in the aggregate, of which $14.5 million was accrued at December 31, 2015 and paid in January, 2016) were repurchased pursuant to the terms of our stock repurchase program and 211,122 shares were repurchased in connection with income tax withholding obligations resulting from the exercise of stock options and the vesting of restricted stock grants.

During the period of October 1, 2015 through December 31, 2015, we repurchased the following shares:

	Additional Dollars Authorized For Repurchase (in thousands)	Total number of shares purchased	Total number of shares cancelled	Average price paid per share for forfeited restricted shares	Total Number of shares purchased as part of publicly announced programs	Average price paid per share for shares purchased as part of publicly announced program	Aggregate purchase price paid (in thousands)	Maximum number of dollars that may yet be purchased under the program (in thousands)
October, 2015	—	42,452	—	N/A	40,000	$ 125.67	$ 5,027	$ 228,612
November, 2015	—	118,194	—	N/A	115,700	$ 121.96	$ 14,111	$ 214,501
December, 2015	—	528,594	—	N/A	322,418	$ 119.95	$ 38,673	$ 175,828
Total October through December	—	689,240	—	N/A	478,118	$ 120.91	$ 57,811	

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Dividends

During the two years ending December 31, 2015, dividends per share were declared and paid as follows:

	2015	2014
First quarter	$ .10	$ .05
Second quarter	$ .10	$ .05
Third quarter	$ .10	$ .10
Fourth quarter	$ .10	$ .10
Total	$ .40	$ .30

Our Credit Agreement contains covenants that include limitations on, among other things, dividends and stock repurchases (see below in *Capital Resources-Credit Facilities and Outstanding Debt Securities*).

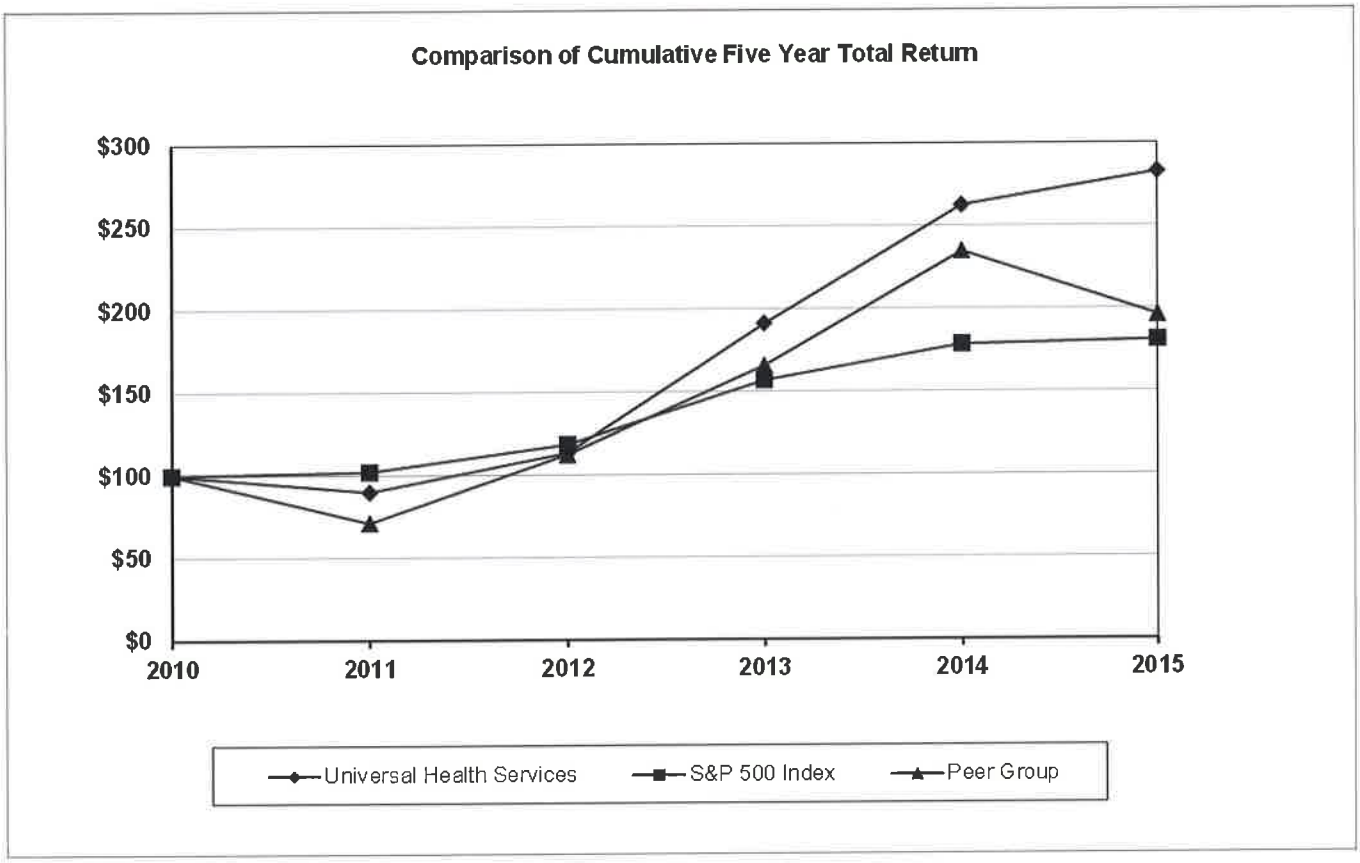
Equity Compensation

Refer to Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters, of this report for information regarding securities authorized for issuance under our equity compensation plans.

Stock Price Performance Graph

The following graph compares the cumulative total stockholder return on our common stock with the cumulative total return on the stock included in the Standard & Poor's 500 Index and a Peer Group Index during the five year period ended December 31, 2015. The graph assumes an investment of $100 made in our common stock and each Index as of January 1, 2011 and has been weighted based on market capitalization. Note that our common stock price performance shown below should not be viewed as being indicative of future performance.

Companies in the peer group, which consist of companies in the S&P 500 Index or S&P MidCap 400 Index (in which we are also included), are as follows: Community Health Systems, Inc., Health Management Associates, Inc. (included until January, 2014 when it was acquired by Community Health Systems, Inc.), LifePoint Hospitals, Inc., Tenet Healthcare Corporation and HCA Holdings, Inc. (included from March, 2011 at which time the company's stock began publicly trading).



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Company Name / Index	2010	2011	2012	2013	2014	2015
Universal Health Services, Inc.	$ 100.00	$ 89.90	$ 113.32	$ 191.00	$ 262.31	$ 282.62
S&P 500 Index	$ 100.00	$ 102.11	$ 118.45	$ 156.82	$ 178.29	$ 180.75
Peer Group	$ 100.00	$ 71.27	$ 112.40	$ 165.54	$ 234.59	$ 196.01

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ITEM 6. Selected Financial Data

The following table contains our selected financial data for, or as of the end of, each of the five years ended December 31, 2015. You should read this table in conjunction with the consolidated financial statements and related notes included elsewhere in this report and in Part II, *Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations.*

	Year Ended December 31,				
	2015	2014	2013	2012	2011
Summary of Operations (in thousands)					
Net revenues	$9,043,451	$8,205,088	$7,367,873	$7,054,182	$6,812,056
Income before income taxes	$1,145,901	$ 929,667	$ 869,332	$ 763,663	$ 696,336
Net income attributable to UHS	$ 680,528	$ 545,343	$ 510,733	$ 443,446	$ 398,167
Net margin	7.5%	6.6%	6.9%	6.3%	5.8%
Return on average equity	16.6%	15.3%	16.8%	17.2%	18.1%
Financial Data (in thousands)					
Cash provided by operating activities	$1,020,898	$1,035,876	$ 884,241	$ 799,231	$ 710,683
Capital expenditures, net (1)	$ 379,321	$ 391,150	$ 358,493	$ 363,192	$ 285,682
Total assets	$9,634,113	$8,974,443	$8,311,723	$8,200,843	$7,665,245
Long-term borrowings	$3,387,303	$3,210,215	$3,209,762	$3,727,431	$3,651,428
UHS's common stockholders' equity	$4,249,647	$3,735,946	$3,249,979	$2,713,345	$2,296,352
Percentage of total debt to total capitalization	45%	47%	51%	58%	61%
Operating Data—Acute Care Hospitals (2)					
Average licensed beds	5,832	5,776	5,652	5,563	5,567
Average available beds	5,656	5,571	5,429	5,338	5,265
Inpatient admissions	261,727	251,165	246,160	245,234	250,278
Average length of patient stay	4.7	4.6	4.5	4.5	4.5
Patient days	1,218,991	1,167,726	1,112,541	1,095,790	1,114,807
Occupancy rate for licensed beds	57%	55%	54%	54%	55%
Occupancy rate for available beds	59%	57%	56%	56%	58%
Operating Data—Behavioral Health Facilities (2)					
Average licensed beds	21,202	20,231	19,940	19,258	19,178
Average available beds	21,116	20,131	19,841	19,178	19,160
Inpatient admissions	447,007	426,510	401,565	373,437	351,086
Average length of patient stay	13.1	12.9	13.3	14.0	14.6
Patient days	5,835,134	5,518,660	5,354,334	5,212,800	5,130,245
Occupancy rate for licensed beds	75%	75%	74%	74%	73%
Occupancy rate for available beds	76%	75%	74%	74%	73%
Per Share Data					
Net income attributable to UHS—basic	$ 6.89	$ 5.52	$ 5.21	$ 4.57	$ 4.09
Net income attributable to UHS—diluted	$ 6.76	$ 5.42	$ 5.14	$ 4.53	$ 4.04
Dividends declared	$ 0.40	$ 0.30	$ 0.20	$ 0.60	$ 0.20
Other Information (in thousands)					
Weighted average number of shares outstanding—basic	98,797	98,826	98,033	96,821	97,199
Weighted average number of shares and share equivalents outstanding—diluted	100,694	100,544	99,361	97,711	98,537

(1) Amounts exclude non-cash capital lease obligations, if any.
(2) Excludes statistical information related to divested facilities.

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ITEM 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

Overview

Our principal business is owning and operating, through our subsidiaries, acute care hospitals, behavioral health centers, surgical hospitals, ambulatory surgery centers and radiation oncology centers. As of February 25, 2016, we owned and/or operated 24 inpatient acute care hospitals, 3 free-standing emergency departments and 213 inpatient and 16 outpatient behavioral health care facilities located in 37 states, Washington, D.C., the United Kingdom, Puerto Rico and the U.S. Virgin Islands. In addition, we are building a newly-constructed acute care hospital located in Henderson, Nevada, that is scheduled to be completed and opened during the fourth quarter of 2016. We also manage and/or own outright or in partnerships with physicians, 4 surgical hospitals and surgery and radiation oncology centers located in 4 states.

As a percentage of our consolidated net revenues, net revenues from our acute care hospitals, surgical hospitals, commercial health insurer, surgery centers and radiation oncology centers accounted for 51% during each of 2015 and 2014 and 49% during 2013. Net revenues from our behavioral health care operations accounted for 49% of our consolidated net revenues during each of 2015 and 2014 and 51% during 2013.

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 Annual Report, and should particularly consider any risk factors that we set forth in this Annual Report and in other reports or documents that we file from time to time with the Securities and Exchange Commission (the "SEC"). In this Annual Report, we state our beliefs of future events and of our future financial performance. This Annual 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*.

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

- our ability to comply with the existing laws and government regulations, and/or changes in laws and government regulations;
- an increasing number of legislative initiatives have been passed into law that may result in major changes in the health care delivery system on a national or state level. No assurances can be given that the implementation of these laws will not have a material adverse effect on our business, financial condition or results of operations;
- possible unfavorable changes in the levels and terms of reimbursement for our charges by third party payors or government based payors, including Medicare or Medicaid in the United States, and government based payors in the United Kingdom;
- our ability to enter into managed care provider agreements on acceptable terms and the ability of our competitors to do the same, including contracts with United/Sierra Healthcare in Las Vegas, Nevada;
- the outcome of known and unknown litigation, government investigations, false claim act allegations, and liabilities and other claims asserted against us and other matters as disclosed in *Item 3. Legal Proceedings;*

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

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- in August, 2011, the Budget Control Act of 2011 (the "2011 Act") was enacted into law. The 2011 Act imposed annual spending limits for most federal agencies and programs aimed at reducing budget deficits by $917 billion between 2012 and 2021, according to a report released by the Congressional Budget Office. Among 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 (annual reduction of approximately $36 million to our Medicare net revenues) 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. 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;
- our accounts receivable as of December 31, 2015 and December 31, 2014 include amounts due from Illinois of approximately $28 million and $44 million, respectively. Collection of the outstanding receivables continues to be delayed due to state budgetary and funding pressures. Approximately $12 million as of December 31, 2015 and $23 million as of December 31, 2014, of the receivables due from Illinois were outstanding in excess of 60 days, as of each respective date. In addition, our accounts receivable as of December 31, 2015 and December 31, 2014 includes approximately $80 million and $102 million, respectively, due from Texas in connection with Medicaid supplemental payment programs. The $80 million due from Texas as of December 31, 2015 consists of $47 million related to uncompensated care program revenues, $9 million related to disproportionate share hospital program revenues and $24 million related to Delivery Service Reform Incentive Payment program ("DSRIP") revenues. The above-mentioned Texas DSRIP receivables outstanding as of December 31, 2015 were collected in January, 2016. Although the accounts receivable due from Illinois and Texas could remain outstanding for the foreseeable future, since we expect to eventually collect all amounts due to us, no related reserves have been established in our consolidated financial statements. However, we can provide no assurance that we will eventually collect all amounts due to us from Illinois and/or Texas. Failure to ultimately collect all outstanding amounts due from these states would have an adverse impact on our future consolidated results of operations and cash flows;
- there have been several attempts in Congress to repeal or modify various provisions of the Patient Protection and Affordable Care Act (the "PPACA"). We cannot predict whether or not any of these proposed changes to the PPACA will become law and therefore can provide no assurance that changes to the PPACA, as currently implemented, will not have a material adverse effect on our future results of operations;
- uninsured and self-pay patients treated at our acute care facilities unfavorably impact our ability to satisfactorily and timely collect our self-pay patient accounts;
- the ability to obtain adequate levels of general and professional liability insurance on current terms;
- changes in our business strategies or development plans;
- fluctuations in the value of our common stock, and;
- other factors referenced herein or in our other filings with the Securities and Exchange Commission.

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

Critical Accounting Policies and Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires us to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes.

A summary of our significant accounting policies is outlined in Note 1 to the financial statements. We consider our critical accounting policies to be those that require us to make significant judgments and estimates when we prepare our financial statements, including the following:

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Revenue Recognition: We record revenues and related receivables for health care services at the time the services are provided. Medicare and Medicaid revenues represented 35% of our net patient revenues during 2015, 36% during 2014 and 39% during 2013. Revenues from managed care entities, including health maintenance organizations and managed Medicare and Medicaid programs accounted for 52% of our net patient revenues during 2015, 50% during 2014 and 49% during 2013.

We report net patient service revenue at the estimated net realizable amounts from patients and third-party payors and others for services rendered. We have agreements with third-party payors that provide for payments to us at amounts different from our established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments. Estimates of contractual allowances under managed care plans are based upon the payment terms specified in the related contractual agreements. We closely monitor our historical collection rates, as well as changes in applicable laws, rules and regulations and contract terms, to assure that provisions are made using the most accurate information available. However, due to the complexities involved in these estimations, actual payments from payors may be different from the amounts we estimate and record.

We estimate our Medicare and Medicaid revenues using the latest available financial information, patient utilization data, government provided data and in accordance with applicable Medicare and Medicaid payment rules and regulations. The laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation and as a result, there is at least a reasonable possibility that recorded estimates will change by material amounts in the near term. Certain types of payments by the Medicare program and state Medicaid programs (e.g. Medicare Disproportionate Share Hospital, Medicare Allowable Bad Debts and Inpatient Psychiatric Services) are subject to retroactive adjustment in future periods as a result of administrative review and audit and our estimates may vary from the final settlements. Such amounts are included in accounts receivable, net, on our Consolidated Balance Sheets. The funding of both federal Medicare and state Medicaid programs are subject to legislative and regulatory changes. As such, we cannot provide any assurance that future legislation and regulations, if enacted, will not have a material impact on our future Medicare and Medicaid reimbursements. Adjustments related to the final settlement of these retrospectively determined amounts did not materially impact our results in 2015, 2014 and 2013. If it were to occur, each 1% adjustment to our estimated net Medicare revenues that are subject to retrospective review and settlement as of December 31, 2015, would change our after-tax net income by approximately $1 million.

We provide care to patients who meet certain financial or economic criteria without charge or at amounts substantially less than our established rates. Because we do not pursue collection of amounts determined to qualify as charity care, they are not reported in net revenues or in accounts receivable, net. See additional disclosure below in *Charity Care, Uninsured Discounts and Provision for Doubtful Accounts* for our estimated uncompensated care provided and estimated cost of providing uncompensated care.

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

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

A portion of the accounts receivable at our acute care facilities are comprised of Medicaid accounts that are pending approval from third-party payers but we also have smaller amounts due from other miscellaneous payers such as county indigent programs in certain states. Our patient registration process includes an interview of the patient or the patient's responsible party at the time of registration. At that time, an insurance eligibility determination is made and an insurance plan code is assigned. There are various pre-established insurance profiles in our patient accounting system which determine the expected insurance reimbursement for each patient based on the insurance plan code assigned and the services rendered. Certain patients may be classified as Medicaid pending at

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registration based upon a screening evaluation if we are unable to definitively determine if they are currently Medicaid eligible. When a patient is registered as Medicaid eligible or Medicaid pending, our patient accounting system records net revenues for services provided to that patient based upon the established Medicaid reimbursement rates, subject to the ultimate disposition of the patient's Medicaid eligibility. When the patient's ultimate eligibility is determined, reclassifications may occur which impacts the reported amounts in future periods for the provision for doubtful accounts and other accounts such as Medicaid pending. Although the patient's ultimate eligibility determination may result in amounts being reclassified among these accounts from period to period, these reclassifications did not have a material impact on our results of operations in 2015, 2014 or 2013 since our facilities make estimates at each financial reporting period to reserve for amounts that are deemed to be uncollectible.

We also provide discounts to uninsured patients (included in "uninsured discounts" amounts below) who do not qualify for Medicaid or charity care. Because we do not pursue collection of amounts classified as uninsured discounts, they are not reported in our net revenues or in our net accounts receivable. In implementing the discount policy, we first attempt to qualify uninsured patients for governmental programs, charity care or any other discount program. If an uninsured patient does not qualify for these programs, the uninsured discount is applied. Effective January 1, 2014, in response to market conditions and other considerations, we modified our uninsured discount policy and increased the discount to 60% of gross charges from 30% previously. Since we expect to collect only a small portion of amounts due from our uninsured patients, the increase in the uninsured discount as of January 1, 2014 had no material impact on our 2015 and 2014 net revenues, net income attributable to UHS or net accounts receivable, as compared to 2013. However, this change resulted in an increase in uninsured discounts and a decrease in the provision for doubtful accounts. Our accounts receivable are recorded net of allowance for doubtful accounts of $399 million and $325 million at December 31, 2015 and 2014, respectively.

Approximately 85% during 2015 and 84% during 2014 of our consolidated provision for doubtful accounts, was incurred by our acute care hospitals. Shown below is our payer mix concentrations and related aging of our billed accounts receivable, net of contractual allowances, for our acute care hospitals as of December 31, 2015 and 2014:

As of December 31, 2015:

	Days			
Payer	0-60	61-120	121-180	over 180
Medicare	$ 71,364	$ 5,189	$ 1,837	$ 4,743
Medicaid	11,817	7,630	3,418	8,419
Commercial insurance and other	315,674	120,896	59,765	143,736
Private pay	101,927	62,356	22,000	25,437
Total	$ 500,782	$ 196,071	$ 87,020	$ 182,335

As of December 31, 2014:

	Days			
Payer	0-60	61-120	121-180	over 180
Medicare	$ 65,854	$ 3,988	$ 1,780	$ 9,138
Medicaid	11,049	7,226	4,306	11,354
Commercial insurance and other	283,565	96,973	46,344	111,875
Private pay	81,376	48,112	8,642	17,788
Total	$ 441,844	$ 156,299	$ 61,072	$ 150,155

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

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

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recognize Medicare EHR incentive income for each hospital during the fourth quarter of the year in which the facility meets the "meaningful use" criteria and during the fourth quarter of each applicable subsequent year.

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

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

See *Note 8 to the Consolidated Financial Statements-Commitments and Contingencies*, for additional disclosure related to our professional and general liability, workers' compensation liability and property insurance.

Long-Lived Assets: We review our long-lived assets, including intangible assets, for impairment whenever events or circumstances indicate that the carrying value of these assets may not be recoverable. The assessment of possible impairment is based on our ability to recover the carrying value of our asset based on our estimate of its undiscounted future cash flow. If the analysis indicates that the carrying value is not recoverable from future cash flows, the asset is written down to its estimated fair value and an impairment loss is recognized. Fair values are determined based on estimated future cash flows using appropriate discount rates.

Goodwill and Intangible Assets: Goodwill and indefinite-lived intangible assets are reviewed for impairment at the reporting unit level on an annual basis or sooner if the indicators of impairment arise. Our judgments regarding the existence of impairment indicators are based on market conditions and operational performance of each reporting unit. During the quarter ended September 30, 2015, we changed our annual goodwill and indefinite-lived intangibles testing date from September 1st to October 1st. Management believes that this voluntary change in accounting method is preferable as it aligns the annual impairment testing date with our annual budgeting process. In connection with this change, we first performed an impairment test as of September 1, 2015, which indicated no impairment of goodwill or indefinite-lived intangible assets. We performed an additional impairment test as of October 1, 2015 which also indicated no impairment of goodwill or indefinite-lived intangible assets. There were also no impairments during 2014 or 2013. The 2015 change in annual testing date does not delay, accelerate or avoid an impairment charge. Future changes in the estimates used to conduct the impairment review, including profitability and market value projections, could indicate impairment in future periods potentially resulting in a write-off of a portion or all of our goodwill or indefinite-lived intangible assets.

Income Taxes: Deferred tax assets and liabilities are recognized for the amount of taxes payable or deductible in future years as a result of differences between the tax bases of assets and liabilities and their reported amounts in the financial statements. We believe that future income will enable us to realize our deferred tax assets net of recorded valuation allowances relating to state net operating loss carry-forwards.

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.

See *Provision for Income Taxes and Effective Tax Rates* below for discussion of our effective tax rates during each of the last three years.

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Recent Accounting Pronouncements: For a summary of recent accounting pronouncements, please see *Note 1 to the Consolidated Financial Statements-Accounting Standards* as included in this Report on Form 10-K for the year ended December 31, 2015.

Results of Operations

The following table summarizes our results of operations, and is used in the discussion below, for the years ended December 31, 2015, 2014 and 2013 (dollar amounts in thousands):

	Year Ended December 31,					
	2015		2014		2013	
	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$9,784,724		$8,904,071		$8,495,089	
Less: Provision for doubtful accounts	741,273		698,983		1,127,216	
Net revenues	9,043,451	100.0%	8,205,088	100.0%	7,367,873	100.0%
Operating charges:						
Salaries, wages and benefits	4,212,387	46.6%	3,845,461	46.9%	3,604,620	48.9%
Other operating expenses	2,119,805	23.4%	1,922,743	23.4%	1,552,795	21.1%
Supplies expense	974,088	10.8%	895,693	10.9%	821,089	11.1%
Depreciation and amortization	398,618	4.4%	375,624	4.6%	337,172	4.6%
Lease and rental expense	94,973	1.1%	93,993	1.1%	97,758	1.3%
Electronic health records incentive income	(15,815)	-0.2%	(27,902)	-0.3%	(61,024)	-0.8%
Costs related to extinguishment of debt	0	0.0%	36,171	0.4%	0	0.0%
Subtotal-operating expenses	7,784,056	86.1%	7,141,783	87.0%	6,352,410	86.2%
Income from operations	1,259,395	13.9%	1,063,305	13.0%	1,015,463	13.8%
Interest expense, net	113,494	1.3%	133,638	1.6%	146,131	2.0%
Income before income taxes	1,145,901	12.7%	929,667	11.3%	869,332	11.8%
Provision for income taxes	395,203	4.4%	324,671	4.0%	315,309	4.3%
Net income	750,698	8.3%	604,996	7.4%	554,023	7.5%
Less: Income attributable to noncontrolling interests	70,170	0.8%	59,653	0.7%	43,290	0.6%
Net income attributable to UHS	$ 680,528	7.5%	$ 545,343	6.6%	$ 510,733	6.9%

Year Ended December 31, 2015 as compared to the Year Ended December 31, 2014:

Net revenues increased 10% or $838 million to $9.04 billion during 2015 as compared to $8.21 billion during 2014. The increase was primarily attributable to:

- a $552 million or 7% increase in net revenues generated from our acute care and behavioral health care operations owned during both periods (which we refer to as "same facility"), and;
- other combined net increase of $286 million consisting primarily of: (i) the revenues generated at 21 behavioral health care facilities acquired in the U.K. since September of 2014; (ii) a full year of revenues generated at a commercial health insurer headquartered in Reno, Nevada, that was acquired in June, 2014, and; (iii) the revenues generated at the 4 inpatient facilities and 8 outpatient centers acquired in October, 2015 as part of our acquisition of Foundations Recovery Network, LLC.

Income before income taxes (before deduction for income attributable to noncontrolling interests) increased $216 million to $1.15 billion during 2015 as compared to $930 million during 2014. Included in our income before income taxes during 2015, as compared to 2014, was the following:

a. an increase of $77 million at our acute care facilities as discussed below in Acute Care Hospital Services, excluding the EHR impact (as mentioned in g. below) and excluding the change resulting from the reduction to our prior year professional and general liability self-insurance reserves recorded during 2014 (as mentioned in c. below);

b. an increase of $86 million at our behavioral health care facilities, as discussed below in Behavioral Health Services, excluding the change resulting from the reduction to our prior year professional and general liability self-insurance reserves during 2014 (as mentioned in c. below);

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c. a net decrease of $20 million resulting from the reduction recorded during 2014 to our professional and general liability self-insurance reserves based upon a reserve analysis, as discussed in *Note 8 to the Consolidated Financial Statements-Commitments and Contingencies* ($11 million of which was applicable to our acute care hospitals and $9 million was applicable to our behavioral health care facilities);

d. an increase of $20 million resulting from a reduction in interest expense due primarily to decreases in interest rate swap expense and amortization of financing fees;

e. an increase of $48 million resulting from a charge incurred during 2014 in connection with the settlement of the *Garden City Employees' Retirement System v. Psychiatric Solutions, Inc.* legal matter;

f. an increase of $36 million resulting from a charged incurred during the third quarter of 2014 in connection with the costs related to extinguishment of debt resulting from various financing transaction that occurred at that time;

g. a decrease of $12 million related to the incentive income ($16 million in 2015 and $28 million in 2014), net of related depreciation and amortization expense ($37 million in each of 2015 and 2014), recorded during each year in connection with the implementation of EHR applications at our acute care hospitals;

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

i. $9 million of other combined net decreases.

Net income attributable to UHS increased $135 million to $681 million during 2015 as compared to $545 million during 2014. The increase consisted of:

- an increase of $216 million in income before income taxes, as discussed above;
- a decrease of $10 million resulting from an increase in the income attributable to noncontrolling interests, and;
- a decrease of $71 million resulting from an increase in the provision for income taxes resulting primarily from the income tax provision on the $206 million increase in pre-tax income ($216 million increase in income before income taxes less the $10 million decrease in income resulting from an increase in the income attributable to noncontrolling interests).

Year Ended December 31, 2014 as compared to the Year Ended December 31, 2013:

Net revenues increased 11% or $837 million to $8.21 billion during 2014 as compared to $7.37 billion during 2013. The increase was primarily attributable to:

- a $557 million or 8% increase in net revenues generated at our acute care and behavioral health care operations, on a same facility basis, and;
- other combined net increase of $280 million consisting primarily of the net revenues generated during 2014 related to acquisitions made during the year including: (i) a commercial health insurer headquartered in Reno, Nevada; (ii) the behavioral health facilities located in the U.K. acquired as part of our acquisition of Cygnet Health Care Limited, and; (iii) a 124-bed behavioral health care facility and outpatient treatment center located in Washington, D.C. Also contributing to the increase in net revenues was a full year of net revenues generated during 2014 at Temecula Valley Hospital, a 140-bed, newly constructed acute care facility that was completed and opened during the fourth quarter of 2013.

Income before income taxes (before deduction for income attributable to noncontrolling interests) increased $60 million to $930 million during 2014 as compared to $869 million during 2013. Included in our income before income taxes during 2014, as compared to 2013, was the following:

a. an increase of $202 million at our acute care facilities as discussed below in Acute Care Hospital Services, excluding the EHR impact (as mentioned in f. below) and excluding the change resulting from the reductions to our prior year professional and general liability self-insurance reserves recorded during 2014 and 2013 (as mentioned in c. below);

b. an increase of $57 million at our behavioral health care facilities, as discussed below in Behavioral Health Services, excluding the change resulting from the reductions to our prior year professional and general liability self-insurance reserves during 2014 and 2013 (as mentioned in c. below);

c. a net decrease of $61 million resulting from the change in the reductions to our professional and general liability self-insurance reserves recorded during 2014 and 2013 based upon reserve analyses, as discussed in *Note 8 to the Consolidated Financial Statements-Commitments and Contingencies* ($20 million reduction recorded during 2014 of which $11 million was applicable to our acute care hospitals and $9 million was applicable to our behavioral health care

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facilities, as compared to an $81 million reduction recorded during 2013 of which $63 million was applicable to our acute care hospitals and $18 million was applicable to our behavioral health care facilities);

d. a decrease of $48 million resulting from a charge incurred in connection with the settlement of the *Garden City Employees' Retirement System v. Psychiatric Solutions, Inc.* legal matter;

e. a decrease of $36 million recorded during the third quarter of 2014 in connection with the costs related to extinguishment of debt resulting from various financing transactions that occurred at that time;

f. a decrease of $27 million related to the incentive income ($28 million in 2014 and $61 million in 2013), net of related expenses ($37 million in 2014 and $43 million in 2013), recorded during each year in connection with the implementation of EHR applications at our acute care hospitals;

g. an increase of $10 million due to the pre-tax gain realized during 2014 resulting from the divestiture of a non-operating investment, and;

h. $37 million of other combined net decreases.

Net income attributable to UHS increased $35 million to $545 million during 2014 as compared to $511 million during 2013. The increase consisted of:

- an increase of $60 million in income before income taxes, as discussed above;
- a decrease of $16 million resulting from an increase in the income attributable to noncontrolling interests, and;
- a decrease of $9 million resulting from an increase in the provision for income taxes resulting primarily from: (i) the income tax provision on the $44 million increase in pre-tax income ($60 million increase in income before income taxes less the $16 million decrease in income resulting from an increase in the income attributable to noncontrolling interests), partially offset by; (ii) the income tax provision recorded during 2013 on the sale of Peak Behavioral Health Services (the tax basis gain realized on the sale in 2013 exceeded the gain recorded pursuant to generally accepted accounting principles), and; (iii) a decrease during 2014, as compared to 2013, to our blended effective state income tax rate.

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Acute Care Hospital Services

Year Ended December 31, 2015 as compared to the Year Ended December 31, 2014:

Acute Care Hospital Services-Same Facility Basis

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

The following table summarizes the results of operations for our acute care facilities on a same facility basis and is used in the discussions below for the years ended December 31, 2015 and 2014 (dollar amounts in thousands):

	Year Ended December 31, 2015		Year Ended December 31, 2014	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$ 5,080,467		$ 4,695,474	
Less: Provision for doubtful accounts	618,011		590,384	
Net revenues	4,462,456	100.0%	4,105,090	100.0%
Operating charges:				
Salaries, wages and benefits	1,876,794	42.1%	1,728,808	42.1%
Other operating expenses	983,448	22.0%	930,796	22.7%
Supplies expense	778,787	17.5%	709,725	17.3%
Depreciation and amortization	226,412	5.1%	216,496	5.3%
Lease and rental expense	49,817	1.1%	50,794	1.2%
Subtotal-operating expenses	3,915,258	87.7%	3,636,619	88.6%
Income from operations	547,198	12.3%	468,471	11.4%
Interest expense, net	3,776	0.1%	4,302	0.1%
Income before income taxes	543,422	12.2%	464,169	11.3%

On a same facility basis during 2015, as compared to 2014, net revenues at our acute care hospitals increased $357 million or 9%. Income before income taxes increased $79 million or 17% to $543 million or 12.2% of net revenues during 2015 as compared to $464 million or 11.3% of net revenues during 2014.

Inpatient admissions to these facilities increased 4.2% during 2015, as compared to 2014, while patient days increased 4.4%. Adjusted admissions (adjusted for outpatient activity) increased 5.4% and adjusted patient days increased 5.5% during 2015, as compared to 2014. The average length of inpatient stay at these facilities was 4.7 days during 2015 and 4.6 days during 2014. The occupancy rate, based on the average available beds at these facilities, was 59% during 2015 and 58% during 2014. On a same facility basis, net revenue per adjusted admission at these facilities increased 3.9% during 2015, as compared to 2014, and net revenue per adjusted patient day increased 3.7% during 2015, as compared to 2014.

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All Acute Care Hospitals Services

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

	Year Ended December 31, 2015		Year Ended December 31, 2014	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$ 5,263,577		$ 4,768,487	
Less: Provision for doubtful accounts	631,013		590,384	
Net revenues	4,632,564	100.0%	4,178,103	100.0%
Operating charges:				
Salaries, wages and benefits	1,896,002	40.9%	1,728,973	41.4%
Other operating expenses	1,131,481	24.4%	993,063	23.8%
Supplies expense	780,019	16.8%	709,776	17.0%
Depreciation and amortization	266,912	5.8%	253,769	6.1%
Lease and rental expense	50,121	1.1%	50,794	1.2%
Electronic health records incentive income	(15,815)	-0.3%	(27,902)	-0.7%
Subtotal-operating expenses	4,108,720	88.7%	3,708,473	88.8%
Income from operations	523,844	11.3%	469,630	11.2%
Interest expense, net	4,214	0.1%	4,302	0.1%
Income before income taxes	519,630	11.2%	465,328	11.1%

During 2015, as compared to 2014, net revenues at our acute care hospitals increased $454 million or 11% to $4.63 billion due primarily to: (i) a $357 million, or 9%, increase same facility revenues, as discussed above, and; (ii) other combined net increase of $97 million consisting primarily of a full year of revenues related to a commercial health insurer headquartered in Reno, Nevada, that was acquired in June of 2014.

Income before income taxes increased $54 million to $520 million or 11.2% of net revenues during 2015 as compared to $465 million or 11.1% of net revenues during 2014.

Included in these results are the following:

- the $79 million increase in income before income taxes experienced during 2015, as compared to 2014, from our acute care hospitals services, on a same facility basis, as discussed above;
- a net decrease of $11 million resulting from a reduction recorded during 2014 to our professional and general liability self-insurance reserves attributable to our acute care hospitals;
- a net decrease of $12 million related to the incentive income ($16 million in 2015 and $28 million in 2014), net of related depreciation and amortization expense ($37 million in each of 2015 and 2014), recorded in connection with the implementation of EHR applications at our acute care hospitals, and;
- a net other combined decrease of $2 million.

Uncompensated care (charity care and uninsured discounts):

The following table shows the amounts recorded at our acute care hospitals for charity care and uninsured discounts, based on charges at established rates, for the years ended December 31, 2015, 2014 and 2013:

	(dollar amounts in thousands)					
	2015		2014		2013	
	Amount	%	Amount	%	Amount	%
Charity care	$ 506,571	42%	$ 515,435	45%	$ 593,474	59%
Uninsured discounts	696,463	58%	620,587	55%	405,296	41%
Total uncompensated care	$1,203,034	100%	$1,136,022	100%	$ 998,770	100%

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The provision for doubtful accounts at our acute care hospitals was approximately $631 million during 2015, $590 million during 2014 and $1.02 billion during 2013. The decrease in the provision for doubtful accounts during 2014 compared to 2013, was primarily due to the increase in the uninsured discount (effective January 1, 2014, as discussed above in *Charity Care, Uninsured discounts and Provision for Doubtful Accounts)*, and reclassifications among provision for doubtful accounts and other accounts such as Medicaid pending based upon our patients' ultimate eligibility determination, as discussed above.

The estimated cost of providing uncompensated care:

The estimated cost 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. An increase in the level of uninsured patients to our facilities and the resulting adverse trends in the provision for doubtful accounts and uncompensated care provided could have a material unfavorable impact on our future operating results.

	(amounts in thousands)		
	2015	2014	2013
Estimated cost of providing charity care	$ 77,557	$ 78,475	$ 95,675
Estimated cost of providing uninsured discounts related care	106,630	94,484	65,338
Estimated cost of providing uncompensated care	$ 184,187	$ 172,959	$ 161,013

Year Ended December 31, 2014 as compared to the Year Ended December 31, 2013:

Acute Care Hospital Services-Same Facility Basis

The following table summarizes the results of operations for our acute care facilities on a same facility basis and is used in the discussions below for the years ended December 31, 2014 and 2013 (dollar amounts in thousands):

	Year Ended December 31, 2014		Year Ended December 31, 2013	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$ 4,504,887		$ 4,581,280	
Less: Provision for doubtful accounts	582,986		1,014,455	
Net revenues	3,921,901	100.0%	3,566,825	100.0%
Operating charges:				
Salaries, wages and benefits	1,684,286	42.9%	1,614,276	45.3%
Other operating expenses	799,805	20.4%	781,812	21.9%
Supplies expense	698,860	17.8%	641,078	18.0%
Depreciation and amortization	200,617	5.1%	191,274	5.4%
Lease and rental expense	50,367	1.3%	57,384	1.6%
Subtotal-operating expenses	3,433,935	87.6%	3,285,824	92.1%
Income from operations	487,966	12.4%	281,001	7.9%
Interest expense, net	4,305	0.1%	4,501	0.1%
Income before income taxes	483,661	12.3%	276,500	7.8%

On a same facility basis during 2014, as compared to 2013, net revenues at our acute care hospitals increased $355 million or 10%. Income before income taxes increased $207 million or 75% to $484 million or 12.3% of net revenues during 2014 as compared to $277 million or 7.8% of net revenues during 2013.

The increased income before income taxes experienced at our acute care facilities during 2014, as compared to 2013, was due in part to improved general economic conditions as well as a decrease in the number of uninsured patients treated at our hospitals. The decrease in the number of uninsured patients treated at our acute care hospitals was due primarily to the favorable impact of the Affordable Care Act which included the expansion of Medicaid in certain states in which we operate and the enrollment of patients in newly created commercial exchanges.

Inpatient admissions to these facilities increased 0.6% during 2014, as compared to 2013, while patient days increased 3.9%. Adjusted admissions increased 3.1% and adjusted patient days increased 6.5% during 2014, as compared to 2013. The average length of inpatient stay at these facilities was 4.7 days during 2014 and 4.5 days during 2013. The occupancy rate, based on the average

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available beds at these facilities, was 58% during 2014 and 56% during 2013. On a same facility basis, net revenue per adjusted admission at these facilities increased 6.6% during 2014, as compared to 2013, and net revenue per adjusted patient day increased 3.3% during 2014, as compared to 2013.

All Acute Care Hospital Services

The following table summarizes the results of operations for all our acute care operations during 2014 and 2013. These amounts include our acute care results on a same facility basis (as indicated above), the impact of provider tax assessments which increased net revenues and other operating expenses but had no impact on income before income taxes, as well as the impact of other items as mentioned below (dollar amounts in thousands).

	Year Ended December 31, 2014		Year Ended December 31, 2013	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$ 4,768,487		$ 4,618,607	
Less: Provision for doubtful accounts	590,384		1,015,733	
Net revenues	4,178,103	100.0%	3,602,874	100.0%
Operating charges:				
Salaries, wages and benefits	1,728,973	41.4%	1,635,428	45.4%
Other operating expenses	993,063	23.8%	753,729	20.9%
Supplies expense	709,776	17.0%	643,169	17.9%
Depreciation and amortization	253,769	6.1%	227,368	6.3%
Lease and rental expense	50,794	1.2%	57,512	1.6%
Electronic health records incentive income	(27,902)	-0.7%	(61,024)	-1.7%
Subtotal-operating expenses	3,708,473	88.8%	3,256,182	90.4%
Income from operations	469,630	11.2%	346,692	9.6%
Interest expense, net	4,302	0.1%	4,501	0.1%
Income before income taxes	465,328	11.1%	342,191	9.5%

During 2014, as compared to 2013, net revenues at our acute care hospitals increased $575 million or 16% to $4.18 billion due primarily to: (i) a $355 million, or 10%, increase same facility revenues, as discussed above, and; (ii) other combined net increase of $220 million consisting primarily of the net revenues generated during 2014 related to the acquisition of a commercial health insurer and a full year of net revenues generated during 2014 at Temecula Valley Hospital, a 140-bed acute care facility that was completed and opened during the fourth quarter of 2013.

Income before income taxes increased $123 million to $465 million or 11.1% of net revenues during 2014 as compared to $342 million or 9.5% of net revenues during 2013.

Included in these results are the following:

- the $207 million increase in income before income taxes experienced during 2014, as compared to 2013, at our acute care hospital services, on a same facility basis, as discussed above;
- a net decrease of $52 million net increase resulting from reductions to our professional and general liability self-insurance reserves attributable to our acute care hospitals recorded during 2014 ($11 million) and 2013 ($63 million);
- a net decrease of $27 million related to the incentive income ($28 million in 2014 and $61 million in 2013), net of related expenses ($37 million in 2014 and $43 million in 2013), recorded in connection with the implementation of EHR applications at our acute care hospitals, and;
- a net other combined decrease of $5 million consisting primarily of the decreased operating losses incurred at a Temecula Valley Hospital, offset by the operating losses incurred at a commercial health insurer acquired during 2014.

Behavioral Health Care Services

Year Ended December 31, 2015 as compared to the Year Ended December 31, 2014

Behavioral Health Care Facilities-Same Facility Basis

Our same facility basis results which include the operating results for facilities and businesses operated in both the current year and prior year period, neutralize the effect of items that are non-operational in nature including items such as, but not limited to, gains on sales of assets and businesses, impacts of settlements, legal judgments and lawsuits and other amounts that may be reflected in the current or prior year financial statements that relate to prior periods. Our same facility basis results reflected on the tables 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 Behavioral Health Care Facilities*. 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.

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 years ended December 31, 2015 and 2014 (dollar amounts in thousands):

	Year Ended December 31, 2015		Year Ended December 31, 2014	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$ 4,230,018		$ 4,036,585	
Less: Provision for doubtful accounts	107,362		108,917	
Net revenues	4,122,656	100.0%	3,927,668	100.0%
Operating charges:				
Salaries, wages and benefits	1,979,930	48.0%	1,904,763	48.5%
Other operating expenses	804,420	19.5%	744,870	19.0%
Supplies expense	186,489	4.5%	181,700	4.6%
Depreciation and amortization	115,232	2.8%	112,461	2.9%
Lease and rental expense	40,229	1.0%	41,090	1.0%
Subtotal-operating expenses	3,126,300	75.8%	2,984,884	76.0%
Income from operations	996,356	24.2%	942,784	24.0%
Interest expense, net	1,478	0.0%	1,917	0.0%
Income before income taxes	994,878	24.1%	940,867	24.0%

On a same facility basis during 2015, as compared to 2014, net revenues at our behavioral health care facilities increased $195 million or 5% to $4.12 billion during 2015 as compared to $3.93 billion during 2014. Income before income taxes increased $54 million or 6% to $995 million or 24.1% of net revenues during 2015 as compared to $941 million or 24.0% of net revenues during 2014.

Inpatient admissions to these facilities increased 3.2% during 2015, as compared to 2014, while patient days increased 1.6%. Adjusted admissions increased 2.9% and adjusted patient days increased 1.2% during 2015, as compared to 2014. The average length of inpatient stay at these facilities was 12.7 days during 2015 and 12.9 days during 2014. The occupancy rate, based on the average available beds at these facilities, was 76% during 2015 and 75% during 2014. On a same facility basis, net revenue per adjusted admission at these facilities increased 1.8% during 2015, as compared to 2014, and net revenue per adjusted patient day increased 3.4% during 2015, as compared to 2014.

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All Behavioral Health Care Facilities

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

	Year Ended December 31, 2015		Year Ended December 31, 2014	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$ 4,510,477		$ 4,121,186	
Less: Provision for doubtful accounts	110,142		108,970	
Net revenues	4,400,335	100.0%	4,012,216	100.0%
Operating charges:				
Salaries, wages and benefits	2,105,206	47.8%	1,917,927	47.8%
Other operating expenses	910,741	20.7%	808,894	20.2%
Supplies expense	192,387	4.4%	182,673	4.6%
Depreciation and amortization	124,205	2.8%	114,599	2.9%
Lease and rental expense	44,119	1.0%	42,138	1.1%
Subtotal-operating expenses	3,376,658	76.7%	3,066,231	76.4%
Income from operations	1,023,677	23.3%	945,985	23.6%
Interest expense, net	1,854	0.0%	1,917	0.0%
Income before income taxes	1,021,823	23.2%	944,068	23.5%

During 2015, as compared to 2014, net revenues at our behavioral health care facilities increased 10% or $388 million to $4.40 billion during 2015 as compared to $4.01 billion during 2014. The increase in net revenues was attributable to: (i) $195 million or 5% increase in same facility revenues, as discussed above, and; (ii) $193 million of other combined increases consisting primarily of the revenues generated at the 21 behavioral health care facilities acquired in the U.K. since September of 2014.

Income before income taxes increased $78 million or 8% to $1.02 billion or 23.2% of net revenues during 2015 as compared to $944 million or 23.5% of net revenues during 2014. The increase in income before income taxes at our behavioral health facilities was attributable to:

- a $54 million increase at our behavioral health facilities on a same facility basis, as discussed above;
- a combined net increase of $33 million related primarily to the income generated at the 21 behavioral health care facilities acquired in the U.K. since September of 2014, and;
- a $9 million net decrease resulting from the reduction to our professional and general liability self-insurance reserves applicable to our behavioral health facilities recorded during 2014.

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Year Ended December 31, 2014 as compared to the Year Ended December 31, 2013

Behavioral Health Care Facilities-Same Facility Basis

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 years ended December 31, 2014 and 2013 (dollar amounts in thousands):

	Year Ended December 31, 2014		Year Ended December 31, 2013	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$ 3,962,209		$ 3,764,435	
Less: Provision for doubtful accounts	107,498		111,308	
Net revenues	3,854,711	100.0%	3,653,127	100.0%
Operating charges:				
Salaries, wages and benefits	1,863,978	48.4%	1,785,006	48.9%
Other operating expenses	731,173	19.0%	669,587	18.3%
Supplies expense	178,810	4.6%	172,638	4.7%
Depreciation and amortization	109,479	2.8%	100,360	2.7%
Lease and rental expense	40,273	1.0%	38,182	1.0%
Subtotal-operating expenses	2,923,713	75.8%	2,765,773	75.7%
Income from operations	930,998	24.2%	887,354	24.3%
Interest expense, net	724	0.0%	2,079	0.1%
Income before income taxes	930,274	24.1%	885,275	24.2%

On a same facility basis during 2014, as compared to 2013, net revenues at our behavioral health care facilities increased $202 million or 6% to $3.85 billion during 2014 as compared to $3.65 billion during 2013. Income before income taxes increased $45 million or 5% to $930 million or 24.1% of net revenues during 2014 as compared to $885 million or 24.2% of net revenues during 2013.

Inpatient admissions and adjusted admissions to these facilities each increased 4.7% during 2014, as compared to 2013, while patient days and adjusted patient days each increased 1.7%. The average length of patient stay at these facilities was 12.7 days during 2014 and 13.1 days during 2013. The occupancy rate, based on the average available beds at these facilities, was 75% during each of 2014 and 2013. On a same facility basis, net revenue per adjusted admission at these facilities decreased 0.3% during 2014, as compared to 2013, and net revenue per adjusted patient day increased 2.7% during 2014, as compared to 2013.

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All Behavioral Health Care Facilities

The following table summarizes the results of operations for all our behavioral health care facilities during 2014 and 2013 which includes our behavioral health results on a same facility basis, the impact of the facilities acquired or opened within the previous twelve months, the impact of the other items mentioned below and the impact of provider tax assessments which increased net revenues and other operating expenses but had no impact on income before income taxes (dollar amounts in thousands):

	Year Ended December 31, 2014		Year Ended December 31, 2013	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$ 4,121,186		$ 3,836,783	
Less: Provision for doubtful accounts	108,970		111,270	
Net revenues	4,012,216	100.0%	3,725,513	100.0%
Operating charges:				
Salaries, wages and benefits	1,917,927	47.8%	1,799,589	48.3%
Other operating expenses	808,894	20.2%	712,483	19.1%
Supplies expense	182,673	4.6%	173,932	4.7%
Depreciation and amortization	114,599	2.9%	102,469	2.8%
Lease and rental expense	42,138	1.1%	39,092	1.0%
Subtotal-operating expenses	3,066,231	76.4%	2,827,565	75.9%
Income from operations	945,985	23.6%	897,948	24.1%
Interest expense, net	1,917	0.0%	2,079	0.1%
Income before income taxes	944,068	23.5%	895,869	24.0%

During 2014, as compared to 2013, net revenues at our behavioral health care facilities increased 8% or $287 million to $4.01 billion during 2014 as compared to $3.73 billion during 2013. The increase in net revenues was attributable to: (i) a $202 million or 6% increase in same facility revenues, as discussed above, and; (ii) $76 million of other combined net increases consisting primarily of the revenues generated at the facilities acquired during 2014 including the behavioral health facilities located in the U.K. and a 124-bed behavioral health care facility and outpatient treatment center located in Washington, D.C,.

Income before income taxes increased $48 million or 5% to $944 million or 23.5% of net revenues during 2014 as compared to $896 million or 24.0% of net revenues during 2013. The increase in income before income taxes at our behavioral health facilities was attributable to:

- a $45 million increase at our behavioral health facilities on a same facility basis, as discussed above;
- an $11 million increase related to the acquisition of the above-mentioned facilities located in the U.K. and Washington, D.C.;
- a $9 million net decrease resulting from reductions to our professional and general liability self-insurance reserves applicable to our behavioral health facilities recorded during 2014 ($9 million) and 2013 ($18 million), and;
- a $1 million other combined net increase.

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.

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

The following tables show the approximate percentages of net patient revenue during the past three years for: (i) our Acute Care and Behavioral Health Care Facilities Combined; (ii) our Acute Care Facilities, and; (iii) our Behavioral Health Care Facilities. Net patient revenue is defined as revenue from all sources after deducting contractual allowances and discounts from established billing rates, which we derived from various sources of payment for the years indicated.

	Percentage of Net Patient Revenues		
Acute Care and Behavioral Health Care Facilities Combined	**2015**	**2014**	**2013**
Third Party Payors:			
Medicare	21%	23%	24%
Medicaid	14%	15%	15%
Managed Care (HMO and PPOs)	52%	50%	49%
Other Sources	13%	12%	12%
Total	100%	100%	100%

	Percentage of Net Patient Revenues		
Acute Care Facilities	**2015**	**2014**	**2013**
Third Party Payors:			
Medicare	26%	27%	29%
Medicaid	7%	8%	8%
Managed Care (HMO and PPOs)	64%	61%	59%
Other Sources	3%	4%	4%
Total	100%	100%	100%

	Percentage of Net Patient Revenues		
Behavioral Health Care Facilities	**2015**	**2014**	**2013**
Third Party Payors:			
Medicare	16%	18%	19%
Medicaid	20%	22%	22%
Managed Care (HMO and PPOs)	40%	39%	40%
Other Sources	24%	21%	19%
Total	100%	100%	100%

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

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

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hospital may qualify for an "outlier" payment if a particular patient's treatment costs are extraordinarily high and exceed a specified threshold.

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

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

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

In August, 2013, CMS published its final IPPS 2014 payment rule which provided for a 2.5% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments and Health Care Reform mandated adjustments are considered, we estimate our overall increase from the final federal fiscal year 2014 rule (covering the period of October 1, 2013 through September 30, 2014) approximated 1.0%. This projected impact from the IPPS 2014 final rule includes both the impact of the ATRA of 2012 documentation and coding adjustment and the required changes to the DSH payments related to the traditional Medicare fee for service, however, it excludes the impact of the sequestration reductions related to the Budget Control Act of 2011, as discussed below. The final rule also expands CMS's policy under which it defines inpatient admissions to include the use of an objective time of care standard. Specifically, it would require Medicare's external review contractors to presume that hospital inpatient admissions are reasonable and necessary when beneficiaries receive a physician order for admission and receive medically necessary services for at least two midnights (the "Two Midnight" rule). Correspondingly, under the final rule, CMS presumes that hospital services spanning less than two midnights should have been provided on an outpatient basis and paid under Medicare Part B unless the medical record contains clear documentation supporting the physician's order and an expectation that the Medicare beneficiary would need medically necessary care for more than two midnights, or is receiving services which CMS designates as inpatient only. Our acute care hospitals have begun to comply with the Two Midnight rule and, although we are unable to determine the ultimate impact at this time, its application could have a material unfavorable impact on our future results of operations. Excluding the potential impact of the Two Midnight rule, the final IPPS 2014 payment rule did not have a material impact on our results of operations. In April, 2015, Congress voted to extend an enforcement moratorium on the Two Midnight rule through the end of fiscal year 2015. Although the prohibition of recovery auditor patient status reviews expired on October 1, 2015, CMS did not approve recovery auditors to conduct patient status reviews for admission dates through December 31, 2015.

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

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In August, 2011, the Budget Control Act of 2011 (the "2011 Act") was enacted into law. Included in this law are the imposition of annual spending limits for most federal agencies and programs aimed at reducing budget deficits by $917 billion between 2012 and 2021, according to a report released by the Congressional Budget Office. Among 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. The Bipartisan Budget Act of 2015, enacted on November 2, 2015, continued the 2% reductions to Medicare reimbursement imposed under the 2011 Act. For federal fiscal year 2015, the aggregate annual sequestration reduction to our Medicare net revenues was approximately $36 million with a uniform percentage reduction across all Medicare programs.

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

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

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

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

In October, 2015, CMS published its OPPS final rule for 2016. The hospital market basket increase is 2.4%. The Medicare statute requires a productivity adjustment reduction of 0.5% and 0.2% reduction to the 2016 OPPS market basket. Additionally, CMS also proposes a reduction of 2.0%, which the CMS claims is necessary to eliminate $1 billion in excess laboratory payments that CMS packaged into OPPS payment rates in 2014 resulting in a 2016 OPPS market basket update at -0.3%. When other statutorily required adjustments and hospital patient service mix are considered, we estimate that our overall Medicare OPPS update for 2016 will aggregate to a net decrease of -0.2% which includes a 7.0% increase to behavioral health division partial hospitalization rates. When the behavioral health division's partial hospitalization rate impact is excluded, we estimate that our Medicare 2016 OPPS payments will result in -1.6% decrease in payment levels for our acute care division, as compared to 2015.

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

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

We receive Medicaid revenues in excess of $90 million annually from each of Texas, Washington, D.C., California, Nevada, Illinois, Pennsylvania, Virginia, Massachusetts and Florida, making us particularly sensitive to reductions in Medicaid and other state based revenue programs as well as regulatory, economic, environmental and competitive changes in those states.

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

Texas and South Carolina Medicaid Disproportionate Share Hospital Payments:

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

Upon meeting certain conditions and serving a disproportionately high share of Texas' and South Carolina's low income patients, five of our facilities located in Texas and one facility located in South Carolina received additional reimbursement from each state's DSH fund. The South Carolina and Texas DSH programs were renewed for each state's 2016 DSH fiscal year (covering the period of October 1, 2015 through September 30, 2016). During the second quarter of 2015, the Texas Health and Human Services Commission ("THHSC") finalized DSH payments for federal fiscal year 2014 which resulted in a $6 million annualized reduction in our Texas Medicaid DSH payments retroactive to October, 2013. In connection with these DSH programs, included in our financial results was an aggregate of $36 million during 2015, $49 million during 2014 and $54 million during 2013. We expect reimbursements to our hospitals, pursuant to the 2016 fiscal year programs for Texas and South Carolina, to be at amounts similar to each state's 2015 fiscal year amounts.

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

Various State Medicaid Supplemental Payment Programs:

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

Under these programs, including the impact of Uncompensated Care and Upper Payment Limit programs, and the Texas Delivery System Reform Incentive program, we earned revenues (before Provider Taxes) of approximately $307 million during 2015, $295 million during 2014 and $213 million during 2013. These revenues were offset by Provider Taxes of $137 million during 2015, $140 million during 2014 and $84 million during 2013, which are recorded in other operating expenses on the Consolidated Statements of Income as included herein.

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Texas Uncompensated Care/Upper Payment Limit Payments:

Certain of our acute care hospitals located in various counties of Texas (Hidalgo, Maverick, Potter and Webb) participate in Medicaid supplemental payment Section 1115 Waiver indigent care programs. Section 1115 Waiver Uncompensated Care ("UC") payments replace the former Upper Payment Limit ("UPL") payments. These hospitals also have affiliation agreements with third-party hospitals to provide free hospital and physician care to qualifying indigent residents of these counties. Our hospitals receive both supplemental payments from the Medicaid program and indigent care payments from third-party, affiliated hospitals. The supplemental payments are contingent on the county or hospital district making an Inter-Governmental Transfer ("IGT") to the state Medicaid program while the indigent care payment is contingent on a transfer of funds from the applicable affiliated hospitals. However, the county or hospital district is prohibited from entering into an agreement to condition any IGT on the amount of any private hospital's indigent care obligation. During the second quarter of 2015, THHSC finalized the UC for federal fiscal year 2014 which resulted in an annualized $3 million increase in UC payments retroactive to October 1, 2013. We recorded net revenues/benefit from UC and affiliated hospital indigent care revenues of $61 million (net of Provider Taxes of $8 million) during 2015, $68 million (net of Provider Taxes of $17 million) during 2014 and $61 million (net of Provider Taxes of $10 million) during 2013. In April, 2015, THHSC published a final rule that would shift $136 million in funding from the private hospital UC pool to the large public hospital UC pool for the 2014 UC program year only. The impact from this final rule is incorporated into 2014 and 2015 UC amounts, as mentioned above. If the applicable hospital district or county makes IGTs consistent with 2015 levels, we believe we would be entitled to aggregate net revenues/benefit earned pursuant to these programs of approximately $55 million (net of Provider Taxes of $10 million) during 2016.

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

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

Texas Delivery System Reform Incentive Payments:

In addition, the Texas Medicaid Section 1115 Waiver includes a DSRIP pool to incentivize hospitals and other providers to transform their service delivery practices to improve quality, health status, patient experience, coordination, and cost-effectiveness. DSRIP pool payments are incentive payments to hospitals and other providers that develop programs or strategies to enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. In May, 2014, CMS formally approved specific DSRIP projects for certain of our hospitals for demonstration years 3 to 5 (our facilities did not materially participate in the DSRIP pool during demonstration years 1 or 2). DSRIP payments are contingent on the hospital meeting certain pre-determined milestones, metrics and clinical outcomes. Additionally, DSRIP payments are contingent on a governmental entity providing an IGT for the non-federal share component of the DSRIP payment. THHSC generally approves DSRIP reported metrics, milestones and clinical outcomes on a semi-annual basis in June and December. We recorded net DSRIP revenues/benefit of approximately $24 million (net of Provider Taxes of $15 million) during 2015 and $17 million (net of Provider Taxes of $8 million) during 2014. There were no DSRIP revenues/benefit recorded during 2013. Although we can provide no assurance that we will ultimately qualify for additional DSRIP revenues, subject to CMS's approval and other conditions as outlined above, we estimate that we may be entitled to additional DSRIP revenues/benefit of approximately $25 million (net of Provider Taxes of $16 million) during 2016.

Nevada SPA:

In Nevada, CMS approved a state plan amendment ("SPA") in August, 2014 that implemented a hospital supplemental payment program retroactive to January 1, 2014 and effective to June 30, 2015. In September, 2015, CMS also approved the successor

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supplemental payment program retroactive to July 1, 2015 to June 30, 2016. Included in our results of operations during 2015 and 2014 were approximately $10 million and $12 million, respectively, of net revenues earned in connection with this program. We estimate that our reimbursements pursuant to these programs will approximate $10 million during 2016.

Various Other State Medicaid Supplemental Payment Programs:

Including the impact of the programs in various states applicable to each year, and excluding the impact of various programs in Texas and the Nevada SPA, as discussed above, we earned an aggregate net revenues/benefit from Medicaid supplemental payments of approximately $86 million (net of Provider Taxes of $113 million) during 2015, $71 million (net of Provider Taxes of $115 million) during 2014 and $69 million (net of Provider Taxes of $74 million) during 2013. We estimate that our aggregate net revenues/benefit from Provider Tax programs will approximate $80 million (net of Provider Taxes of $126 million) during 2016. These amounts include the impact of the CMS approved California Provider Tax and related Medicaid supplemental payment programs, which did not have a material impact on our operating results. The aggregate net benefit is earned from multiple states and therefore no particular state's portion is individually material to our consolidated financial statements. However, Provider Taxes are governed by both federal and state laws and are subject to future legislative changes that, if reduced from current rates in several states, could have a material adverse impact on our consolidated future results of operations.

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

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

Pursuant to HITECH Act regulations, hospitals that do not qualify as a meaningful user of EHR by 2015 were subject to a reduced market basket update to the IPPS standardized amount in 2015 and each subsequent fiscal year. All of our acute care hospitals have met the applicable meaningful use criteria and therefore were not subject to a reduced market basked update to the IPPS standardized amount in federal fiscal year 2015. However, under the HITECH Act, hospitals must continue to meet the applicable meaningful use criteria in each fiscal year or they will be subject to a market basket update reduction in a subsequent fiscal year. No reduction is expected for federal fiscal year 2016. Failure of our acute care hospitals to continue to meet the applicable meaningful use criteria would have an adverse effect on our future net revenues and results of operations.

Our 2015 consolidated results of operations includes an unfavorable pre-tax impact of approximately $18 million consisting of approximately $16 million of EHR incentive income less approximately $37 million of depreciation and amortization expense, plus approximately $3 million of net expense attributable to noncontrolling interests. Our 2014 consolidated results of operations includes an unfavorable pre-tax impact of approximately $8 million consisting of approximately $28 million of EHR incentive income less approximately $37 million of depreciation and amortization expense, plus approximately $1 million of net expense attributable to noncontrolling interests. Our 2013 consolidated results of operations includes a favorable pre-tax impact of approximately $19 million consisting of approximately $61 million of EHR incentive income less approximately $10 million of salaries, wages, benefits and other operating expenses, approximately $33 million of depreciation and amortization expense, plus approximately $1 million of net expense attributable to noncontrolling interests.

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

Managed Care: A significant portion of our net patient revenues are generated from managed care companies, which include health maintenance organizations, preferred provider organizations and managed Medicare (referred to as Medicare Part C or

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Medicare Advantage) and Medicaid programs. In general, we expect the percentage of our business from managed care programs to continue to grow. The consequent growth in managed care networks and the resulting impact of these networks on the operating results of our facilities vary among the markets in which we operate. Typically, we receive lower payments per patient from managed care payors than we do from traditional indemnity insurers, however, during the past few years we have secured price increases from many of our commercial payors including managed care companies.

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

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

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

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

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

Implemented Medicare Reductions and Reforms:

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

Medicaid Revisions:

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

  $2.0 billion for FFY 2018

  $3.0 billion for FFY 2019

  $4.0 billion for FFY 2020

$5.0 billion for FFY 2021

$6.0 billion for FFY 2022

$7.0 billion for FFY 2023

$8.0 billion for FFY 2024

$8.0 billion for FFY 2025

Health Insurance Revisions:

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

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

Value-Based Purchasing:

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

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

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

Readmission Reduction Program:

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

HRRP, including which hospitals are subject to the HRRP, the methodology to calculate the hospital readmission payment adjustment factor, and what portion of the IPPS payment is used to calculate the readmission adjustment factor. In the fiscal year 2014 IPPS final rule, CMS finalized revisions to the three 30-day admission measures in the program—heart failure, myocardial infarction, and pneumonia—to exclude planned readmissions. Under the Affordable Care Act, beginning in fiscal year 2015, the maximum reduction in payments under the HRRP will increase from 2% to 3%. CMS will expand the program and add two readmission measures, one, acute exacerbation of chronic obstructive pulmonary disease (COPD) and, two, patients admitted for elective total hip

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arthroplasty (THA) and total knee arthroplasty (TKA). In the fiscal year 2015 IPPS final rule, CMS added readmissions for coronary artery bypass graft (CABG) surgical procedures beginning in fiscal year 2017. The impact of HRRP for federal fiscal year 2015 did not have a material adverse effect on our results of operations.

Accountable Care Organizations:

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

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

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

Other Operating Results

Combined net revenues and income/losses before income taxes from our surgical hospitals, ambulatory surgery centers and radiation oncology centers did not have a material impact on our consolidated results of operations during 2015, 2014 or 2013.

Interest Expense

Below is a schedule of our interest expense during 2015, 2014 and 2013 (amounts in thousands):

	2015	2014	2013
Revolving credit & demand notes (a.)	$ 3,355	$ 2,984	$ 3,463
$400 million, 7.125% Senior Notes due 2016	28,496	28,496	28,496
$250 million, 7.00% Senior Notes due 2018 (b.)	—	10,208	17,500
$300 million, 3.75% Senior Notes due 2019 (c.)	11,250	4,500	—
$300 million, 4.75% Senior Notes due 2022 (c.)	14,250	5,700	—
Term loan facility A/new (a.)	30,175	12,507	—
Term loan facility A/original (a.)	—	9,769	18,994
Term loan facility A2 (a.)	—	8,747	16,625
Term loan facility B/B1 (a.) (e.)	—	8,009	21,569
Accounts receivable securitization program (d.)	3,074	2,446	2,548
Subtotal-revolving credit, demand notes, senior notes, term loan facilities and accounts receivable securitization program	90,600	93,366	109,195
Interest rate swap expense, net	10,206	19,063	19,183
Amortization of financing fees	7,134	15,400	21,783
Other combined interest expense	6,137	6,346	6,645
Capitalized interest on major projects	(304)	—	(4,921)
Interest income	(279)	(537)	(5,754)
Interest expense, net	$ 113,494	$ 133,638	$ 146,131

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

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

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

(d.) In December, 2015, we amended our existing accounts receivable securitization program, which was scheduled to expire in October, 2016, to extend the term through December 21, 2018 and increase the borrowing limit to $400 million from $360 million.

(e.) In May, 2013 we completed a third amendment to our credit agreement dated November 15, 2010, as amended. The third amendment provided for a reduction in the interest rates payable in connection with certain borrowings outstanding at that time under the credit agreement. Specifically, we replaced our then outstanding $745.9 million senior secured term loan B with a new senior secured term loan B1 in the same amount on substantially the same terms as the term loan B, other than lower interest rates.

Interest expense decreased $20 million during 2015 to $113 million as compared to $134 million during 2014. The decrease was due primarily to: (i) a $3 million decrease in aggregate interest expense on our revolving credit, demand notes, senior notes, term loan facilities and accounts receivable securitization program due primarily to a decrease in our average outstanding borrowings as well as a decrease in our aggregate average cost of borrowings pursuant to these facilities, as discussed below; (ii) a $9 million decrease in interest rate swap expense, resulting primarily from the 2015 maturities of our previously outstanding interest rate swaps, and; (iii) an $8 million decrease in amortization and financing fees, resulting primarily from the write-off of certain deferred financing costs and original issue discounts in connection with various financing transactions that occurred during the third quarter of 2014, as discussed above.

Interest expense decreased $12 million during 2014 to $134 million as compared to $146 million during 2013. The decrease was due primarily to: (i) a $16 million decrease in aggregate interest expense on our revolving credit, demand notes, senior notes, term loan facilities and accounts receivable securitization program due primarily to a decrease in our average outstanding borrowings as well as a decrease in our aggregate average cost of borrowings pursuant to these facilities, as discussed below; (ii) a $6 million decrease in the amortization of financing fees, resulting primarily from the write-off of certain deferred financing costs and original issue discounts in connections with the financing transactions during the third quarter of 2014, as discussed above, offset by; (iii) $5 million of capitalized interest recorded on major projects during 2013, and; (iv) a $5 million decrease in interest income, primarily related to the interest income received from Illinois during 2013 related to delayed cash remittances to us.

The aggregate average outstanding borrowings under our revolving credit, demand notes, senior notes, term loan facilities and accounts receivable securitization program were approximately $3.1 billion during 2015, $3.2 billion during 2014 and $3.5 billion during 2013. The average effective interest rate on these facilities, excluding the amortization of deferred financing costs and original issue discounts and designated interest rate swap expense was 2.9% during each of 2015 and 2014 and 3.1% during 2013. The average effective interest rate on these facilities, including amortization of deferred financing costs and original issue discounts and designated interest rate swap expense was 3.4% during 2015, 3.9% during 2014 and 4.2% during 2013.

Costs Related to Early Extinguishment of Debt

In connection with various financing transactions completed during 2014, as discussed below in *Capital Resources-Credit Facilities and Outstanding Debt Securities,* our 2014 results of operations include a $36 million pre-tax charge incurred for the costs related to the extinguishment of debt. This charge consisted of the write-off of deferred charges ($20 million) and original issue discount on the extinguished debt ($5 million) as well as the make-whole premium paid ($11 million) on the early redemption of the $250 million, 7.00% senior unsecured notes. There were no costs related to early extinguishment of debt incurred during 2015 or 2013.

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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 each of the years ended December 31, 2015, 2014 and 2013 (dollar amounts in thousands):

	2015	2014	2013
Provision for income taxes	$ 395,203	$ 324,671	$ 315,309
Income before income taxes	1,145,901	929,667	869,332
Effective tax rate	34.5%	34.9%	36.3%

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

The effective tax rates, as calculated by dividing the provision for income taxes by the difference in income before income taxes, minus net income attributable to noncontrolling interests, were as follows for each of the years ended December 31, 2015, 2014 and 2013 (dollar amounts in thousands):

	2015	2014	2013
Provision for income taxes	$ 395,203	$ 324,671	$ 315,309
Income before income taxes	1,145,901	929,667	869,332
Less: Net income attributable to noncontrolling interests	(70,170)	(59,653)	(43,290)
Income before income taxes and after net income attributable to noncontrolling interests	1,075,731	870,014	826,042
Effective tax rate	36.7%	37.3%	38.2%

The impact of the discrete tax items did not have a material impact on our provision for income taxes during 2015, 2014 or 2013. The decrease in the effective tax rate during 2015, as compared to 2014, was due primarily to lower effective income tax rates applicable to the income generated during 2015 at the behavioral health care facilities located in the U.K. that were acquired since the third quarter of 2014. The decrease in the effective tax rate during 2014, as compared to 2013, was due primarily to: (i) a decrease in our blended effective state income tax rate during 2014; (ii) the income tax provision recorded during 2013 on the sale of Peak Behavioral Health Services which was divested in May, 2013 (the tax basis gain realized on the sale of Peak Behavioral Health Services exceeded the gain recorded pursuant to generally accepted accounting principles), and; (iii) a decrease to our federal income tax provision relating to 2013 that was recorded during 2014.

We consider the undistributed earnings of certain of our foreign subsidiaries as of December 31, 2015 and 2014, to be indefinitely reinvested and, accordingly, no U.S. income taxes have been provided thereon. As of December 31, 2015 and 2014, the amount of cash associated with indefinitely reinvested foreign earnings was approximately $49 million and $12 million, respectively.

Discontinued Operations

There were no material divestitures during 2015 or 2014.

In connection with the receipt of antitrust clearance from the Federal Trade Commission ("FTC") in connection with our acquisition of Ascend Health Corporation in October of 2012, we agreed to certain conditions, including the divestiture of Peak Behavioral Health Services ("Peak"), a 104-bed behavioral health care facility located in Santa Teresa, New Mexico. The divestiture of Peak was completed during the second quarter of 2013 for total cash proceeds of approximately $24 million resulting in a pre-tax gain of approximately $3 million which is included in our 2013 consolidated financial statements.

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The following table shows the results of operations for Peak, which was reflected as discontinued operations during our period of ownership during 2013 (amounts in thousands). Since the aggregate income from discontinued operations before income tax expense is not material to our consolidated financial statements, it is included as a reduction to other operating expenses.

	2013
Net revenues	$ 7,813
Income from discontinued operations, before income taxes	932
Gain on divestiture	3,080
Income from discontinued operations, before income tax expense	4,012
Income tax expense	(1,506)
Income from discontinued operations, net of income taxes	$ 2,506

Effects of Inflation and Seasonality

Seasonality —Our acute care services business is typically seasonal, with higher patient volumes and net patient service revenue in the first and fourth quarters of the year. This seasonality occurs because, generally, more people become ill during the winter months, which results in significant increases in the number of patients treated in our hospitals during those months.

Inflation —Inflation has not had a material impact on our results of operations over the last three years. However, since the healthcare industry is very labor intensive and salaries and benefits are subject to inflationary pressures, as are supply and other costs, we cannot predict the impact that future economic conditions may have on our ability to contain future expense increases. Our ability to pass on increased costs associated with providing healthcare to Medicare and Medicaid patients is limited due to various federal, state and local laws which have been enacted that, in certain cases, limit our ability to increase prices. We believe, however, that through adherence to cost containment policies, labor management and reasonable price increases, the effects of inflation on future operating margins should be manageable.

Liquidity

Year ended December 31, 2015 as compared to December 31, 2014:

Net cash provided by operating activities

Net cash provided by operating activities was $1.021 billion during 2015 as compared to $1.036 billion during 2014. The net decrease of $15 million was primarily attributable to the following:

- a favorable change of $162 million due to an increase in net income plus/minus depreciation and amortization expense, stock-based compensation expense, net gains on sales of assets and businesses, and costs related to extinguishment of debt;
- a $199 million unfavorable change in other working capital accounts due primarily to unfavorable changes in accrued compensation and accounts payable resulting from the timing of disbursements;
- a $68 million unfavorable change in accrued and deferred income taxes;
- a $60 million favorable change in accounts receivable;
- a favorable change of $22 million in accrued insurance expense, net of commercial premiums paid, due primarily to a $20 million reduction recorded during 2014 to our professional and general liability self-insurance reserves, based upon a reserve analysis, and;
- $8 million of other combined net favorable changes.

Days sales outstanding ("DSO"): Our DSO are calculated by dividing our net revenue by the number of days in the year. The result is divided into the accounts receivable balance the end of the year. Our DSO were 53 days at December 31, 2015, 57 days at December 31, 2014 and 55 days at December 31, 2013.

Net cash used in investing activities

Net cash used in investing activities was $913 million during 2015 and $833 million during 2014.

2015:

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The $913 million of net cash used in investing activities during 2015 consisted of $534 million spent related to the acquisition of businesses and property, $379 million spent on capital expenditures, $3 million spent to increase investments of insurance subsidiary and, net of $3 million received from the sale of assets and businesses consisting primarily of divestiture of a small operator of behavioral health care services.

2015 Acquisitions of Assets and Businesses:

During 2015 we spent $534 million to:

- acquire a 46-bed behavioral health care facility located in the U.K. (acquired during the first quarter);
- acquire Alpha Hospitals Holdings Limited consisting of four behavioral health care hospitals with 305 beds located in the U.K. (acquired during the third quarter);
- acquire Foundations Recovery Network, LLC consisting of 4 inpatient facilities (322 beds) as well as 8 outpatient centers (during the fourth quarter), and;
- various other businesses, a management contract and real property assets.

2015 Capital Expenditures:

During 2015 we spent $379 million to finance capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities, including additional capacity added to certain of our behavioral health facilities that have operated near full capacity, and the construction costs related to Henderson Hospital, a newly constructed 142-bed acute care facility scheduled to be completed and opened during the fourth quarter of 2016.

2014:

The $833 million of net cash used in investing activities during 2014 consisted of $431 million spent related to the acquisition of businesses and property, $391 million spent on capital expenditures, $13 million spent in connection with the purchase and implementation of an EHR application at our acute care facilities, $12 million spent to increase investments of insurance subsidiary, net of $15 million received from the sale of assets and businesses.

2014 Acquisitions of Assets and Businesses:

During 2014 we spent $431 million to:

- acquire the stock of Cygnet Health Care Limited comprised of 17 facilities located throughout the U.K. including 15 inpatient behavioral health hospitals and 2 nursing homes with a total of 723 beds (during the third quarter);
- acquire and fund the required capital reserves related to Prominence Health Plan, a commercial health insurer headquartered in Reno, Nevada (during the second quarter);
- acquire the Psychiatric Institute of Washington, a 124-bed behavioral health care facility and outpatient treatment center located in Washington, D.C. (during the second quarter);
- acquire the operations of Palo Verde Behavioral Health, a 48-bed behavioral health facility in Tucson, Arizona (during the first quarter);
- acquire the real property of The Bridgeway, a 103-bed behavioral health care facility located in North Little Rock, Arkansas, that was previously leased from Universal Health Realty Income Trust (during the fourth quarter);
- acquire the previously leased real property of Cygnet Hospital-Harrow, a 44-bed behavioral health care facility located in the U.K., the operations of which were acquired as part of our acquisition of Cygnet (during the fourth quarter), and;
- acquire physician practices.

2014 Capital Expenditures:

During 2014 we spent $391 million to finance capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities, including additional capacity added to certain of our behavioral health facilities that have operated near full capacity.

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2014 Divestiture of Assets and Businesses:

During 2014 we received $15 million in connection with the divestiture of a non-operating investment (during the first quarter) and the real property of a closed behavioral health facility (during the second quarter).

Net cash used in financing activities

Net cash used in financing activities was $77 million during 2015 and $187 million during 2014.

2015:

The $77 million of net cash used in financing activities during 2015 consisted of the following:

- generated $234 million of proceeds from additional borrowings consisting of: (i) $160 million of proceeds from new borrowings pursuant to our revolving credit facility; (ii) $70 million of proceeds from new borrowings pursuant to our accounts receivable securitization program, and; (iii) $4 million of proceeds from new borrowings pursuant to a short-term, on-demand line of credit;
- spent $68 million on net repayments of debt due primarily to repayments pursuant to our term loan A facility ($44 million) and various other combined debt facilities ($24 million);
- spent $210 million to repurchase shares of our Class B Common Stock in connection with: (i) open market purchases pursuant to our $400 million stock repurchase program ($152 million), and; (ii) income tax withholding obligations related to stock-based compensation programs ($58 million);
- generated $47 million of excess income tax benefits related to stock-based compensation;
- spent $40 million to pay quarterly cash dividends of $.10 per share;
- spent $62 million to pay profit distributions related to noncontrolling interests in majority owned businesses;
- generated $8 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans;
- generated $13 million from the from the sale/leaseback of two free-standing emergency departments, and;
- spent $1 million in financing costs

2014:

The $187 million of net cash used in financing activities during 2014 consisted of the following:

- generated $830 million of proceeds from additional borrowings pursuant to: (i) the issuance in August of 2014 of $300 million aggregate principal amount of 3.750% senior secured notes due 2019 and the issuance of $300 million aggregate principal amount of 4.750% senior secured notes due 2022; (ii) $140 million from new borrowings pursuant to our revolving credit facility, and; (iii) $90 million of proceeds from new borrowings pursuant to our accounts receivable securitization program;
- spent $879 million on net repayments of debt due primarily to repayments pursuant to our: (i) previously outstanding term loan B facility ($550 million); (ii) previously outstanding $250 million, 7% senior unsecured notes ($250 million); (iii) previously outstanding term loan term loan A and A2 facilities ($36 million); (iv) short-term, on-demand line of credit ($25 million); (v) new term loan A facility ($11 million), and; (vi) various other debt facilities ($7 million);
- spent $101 million to repurchase shares of our Class B Common Stock in connection with: (i) open market purchases pursuant to our $400 million stock repurchase program ($58 million), and; (ii) income tax withholding obligations related to stock-based compensation programs ($43 million);
- generated $34 million of excess income tax benefits related to stock-based compensation;
- spent $15 million in financing costs in connection with the various financing transactions as discussed below in *Credit Facilities and Outstanding Debt Securities*;
- spent $30 million to pay quarterly cash dividends of $.05 per share during each of the first and second quarters and $.10 per share during the third and fourth quarters;

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- spent $34 million to pay profit distributions related to noncontrolling interests in majority owned businesses, and;
- generated $7 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

Year ended December 31, 2014 as compared to December 31, 2013:

Net cash provided by operating activities

Net cash provided by operating activities was $1.04 billion during 2014 as compared to $884 million during 2013. The net increase of $152 million was primarily attributable to the following:

- a favorable change of $108 million due to an increase in net income plus/minus depreciation and amortization expense, stock-based compensation expense, net gains on sales of assets and businesses, and costs related to extinguishment of debt;
- a $56 million unfavorable change in accounts receivable;
- a $48 million favorable change in other working capital accounts due primarily to an increase in accrued compensation and accounts payable;
- a favorable change of $64 million in accrued insurance expense, net of commercial premiums paid, due primarily to an $81 million reduction recorded during 2013, as compared to $20 million during 2014, to our professional and general liability self-insurance reserves, based upon reserve analyses, and;
- $12 million of other combined net unfavorable changes.

Net cash used in investing activities

Net cash used in investing activities was $833 million during 2014 and $383 million during 2013. The factors contributing to the $833 million of net cash used in investing activities during 2014 are detailed above.

2013:

The $383 million of net cash used in investing activities during 2013 consisted of $358 million spent on capital expenditures, $13 million spent on the acquisition of property and businesses, $37 million received from the sale of assets and businesses and $50 million spent in connection with the purchase and implementation of an EHR application.

2013 Capital Expenditures:

During 2013, we spent $358 million to finance capital expenditures including the construction costs related to: (i) construction of Temecula Valley Hospital, a 140-bed acute care facility located in Temecula, California, that was completed and opened in October, 2013; (ii) the construction costs related to Austin Oaks Hospital, an 80-bed behavioral health facility located in Austin, Texas, that was completed and opened during the second quarter of 2013, and; (iii) capital expenditures related to equipment renovations and new projects at various existing facilities.

2013 Acquisitions of Assets and Businesses:

During 2013, we spent $13 million for the purchase of real property located in Pennsylvania, Nevada and Arizona.

2013 Divestiture of Assets and Businesses:

During 2013, we received $37 million in connection with the divestiture of Peak Behavioral Health Services and certain other assets and real property including three previously closed behavioral health care facilities.

Net cash used in financing activities

Net cash used in financing activities was $187 million during 2014 and $507 million during 2013. The factors contributing to the $187 million of net cash used in financing activities during 2014 are detailed above.

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2013:

The $507 million of net cash used in financing activities consisted of the following:

- spent $440 million on net repayments of debt due to repayments pursuant to our previously outstanding Term Loan A and A2 facilities ($72 million), previously outstanding Term Loan B ($196 million), revolving credit ($150 million), accounts receivable securitization ($9 million) and other debt facilities ($13 million);
- generated $16 million of proceeds from a short-term, on-demand facility and other debt;
- spent $61 million to pay profit distributions related to noncontrolling interests in majority owned businesses;
- spent $27 million to repurchase shares of our Class B Common Stock (in connection with income tax withholdings related to employee stock-based incentive compensation programs);
- spent $20 million to pay quarterly cash dividends of $.05 per share;
- generated $20 million of excess income tax benefits related to stock-based compensation, and;
- generated $6 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

2016 Expected Capital Expenditures:

During 2016, we expect to spend approximately $400 million to $425 million on capital expenditures which includes expenditures for capital equipment, renovations, new projects at existing hospitals and construction of new facilities (Henderson Hospital). Approximately $165 million of our 2016 expected capital expenditures relates to completion of projects that are in progress as of December 31, 2015. We believe that our capital expenditure program is adequate to expand, improve and equip our existing hospitals. We expect to finance all capital expenditures and acquisitions with internally generated funds and/or additional funds, as discussed below.

Capital Resources

Credit Facilities and Outstanding Debt Securities

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

- On August 7, 2014, we entered into a Fourth Amendment (the "Fourth Amendment") to our credit agreement dated as of November 15, 2010, as amended on March 15, 2011, September 21, 2012 and May 16, 2013, among UHS, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders ("Credit Agreement"). The Credit Agreement, as amended, which is scheduled to mature in August, 2019, consists of: (i) an $800 million revolving credit facility ($300 million of borrowings outstanding as of December 31, 2015), and; (ii) a $1.775 billion term loan A facility ($1.720 billion of borrowings outstanding as of December 31, 2015) which combined our previously outstanding term loan A and term loan A2 facilities which were scheduled to mature in 2016;
- Repaid $550 million of outstanding borrowings pursuant to our previously outstanding term loan B facility which was scheduled to mature in 2016;
- Increased the borrowing capacity on our existing accounts receivable securitization program ("Securitization") to $360 million from $275 million, effective August 1, 2014. In December, 2015, the Securitization was amended to increase the borrowing capacity to $400 million and extend the scheduled maturity date to December 21, 2018;
- Issued $300 million aggregate principal amount of 3.750% senior secured notes due in 2019 (see below for additional disclosure);
- Issued $300 million aggregate principal amount of 4.750% senior secured notes due in 2022 (see below for additional disclosure);
- Redeemed our previously outstanding $250 million, 7.00% senior unsecured notes due in 2018 on July 31, 2014 for an aggregate price equal to 104.56% of the principal amount.

In connection with these transactions, our 2014 results of operations included a $36 million pre-tax charge incurred for the costs related to the extinguishment of debt. This charge consisted of the write-off of deferred charges ($20 million) and original issue discount on the extinguished debt ($5 million) as well as the make-whole premium paid ($11 million) on the early redemption of the $250 million, 7.00% senior unsecured notes.

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Borrowings under the Credit Agreement bear interest at either (1) the ABR rate which is defined as the rate per annum equal to, at our election: the greatest of (a) the lender's prime rate, (b) the weighted average of the federal funds rate, plus 0.5% and (c) one month LIBOR rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.50% to 1.25% for revolving credit and term loan-A borrowings, or (2) the one, two, three or six month LIBOR rate (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.50% to 2.25% for revolving credit and term loan-A borrowings. As of December 31, 2015, the applicable margins were 0.50% for ABR-based loans and 1.50% for LIBOR-based loans under the revolving credit and term loan-A facilities.

As of December 31, 2015, we had $300 million of borrowings outstanding pursuant to the terms of our $800 million revolving credit facility and we had $461 million of available borrowing capacity, net of $5 million of outstanding borrowings pursuant to a short-term, on-demand credit facility and $34 million of outstanding letters of credit. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Credit Agreement is secured by certain assets of the Company (which generally excludes asset classes such as substantially all of the patient-related accounts receivable of our acute care hospitals, certain real estate assets and assets held in joint-ventures with third-parties) and our material subsidiaries and guaranteed by our material subsidiaries.

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

As discussed above, in December, 2015, our Securitization with a group of conduit lenders and liquidity banks was amended to increase the borrowing capacity to $400 million from $360 million and extend the scheduled maturity date to December 21, 2018. Substantially all of the patient-related accounts receivable of our acute care hospitals ("Receivables") serve as collateral for the outstanding borrowings. We have accounted for this Securitization as borrowings. We maintain effective control over the Receivables since, pursuant to the terms of the Securitization, the Receivables are sold from certain of our subsidiaries to special purpose entities that are wholly-owned by us. The Receivables, however, are owned by the special purpose entities, can be used only to satisfy the debts of the wholly-owned special purpose entities, and thus are not available to us except through our ownership interest in the special purpose entities. The wholly-owned special purpose entities use the Receivables to collateralize the loans obtained from the group of third-party conduit lenders and liquidity banks. The group of third-party conduit lenders and liquidity banks do not have recourse to us beyond the assets of the wholly-owned special purpose entities that securitize the loans. At December 31, 2015, we had $400 million of outstanding borrowings and no additional capacity pursuant to the terms of our accounts receivable securitization program.

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

On June 30, 2006, we issued $250 million of senior secured notes which have a 7.125% coupon rate and mature on June 30, 2016 (the "7.125% Notes"). Interest on the 7.125% Notes is payable semiannually in arrears on June 30th and December 30th of each year. In June, 2008, we issued an additional $150 million of 7.125% Notes which formed a single series with the original 7.125% Notes issued in June, 2006. Other than their date of issuance and initial price to the public, the terms of the 7.125% Notes issued in June, 2008 are identical to and trade interchangeably with, the 7.125% Notes which were originally issued in June, 2006. Since we have the ability and intent to refinance the 7.125% Notes on or before the scheduled maturity date (June 30, 2016) either through the issuance of new long-term notes, a new long-term debt facility, or utilizing funds borrowed pursuant to our revolving credit facility, the 7.125% Notes are classified as long-term on our Consolidated Balance Sheet as of December 31, 2015.

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

In connection with entering into the previous Credit Agreement on November 15, 2010, and in accordance with the Indenture dated January 20, 2000 governing the rights of our existing notes, we entered into a supplemental indenture pursuant to which our

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7.125% Notes (due in 2016) were equally and ratably secured with the lenders under the Credit Agreement with respect to the collateral for so long as the lenders under the Credit Agreement are so secured.

The average amounts outstanding during each of years 2015, 2014 and 2013 under the current and prior Credit Agreements, demand notes and accounts receivable securitization programs was $2.1 billion, $2.4 billion and $2.9 billion, respectively, with corresponding interest rates of 1.7%, 1.8% and 2.2%, respectively, including commitment and facility fees. The maximum amounts outstanding at any month-end were $2.3 billion in 2015, $2.7 billion in 2014 and $3.0 billion in 2013. The effective interest rate on our current and prior Credit Agreements, accounts receivable securitization programs, and demand notes, which includes the respective interest expense, commitment and facility fees, designated interest rate swaps expense and amortization of deferred financing costs and original issue discounts, was 2.4% in 2015, 3.1% in 2014 and 3.6% in 2013.

Our Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens and indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage and minimum interest coverage ratios. We are in compliance with all required covenants as of December 31, 2015.

At December 31, 2015, the carrying value and fair value of our debt were each approximately $3.5 billion. At December 31, 2014, the carrying value and fair value of our debt were each approximately $3.3 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 45% at December 31, 2015 and 47% at December 31, 2014.

We expect to finance all capital expenditures and acquisitions, pay dividends and potentially repurchase shares of our common stock utilizing internally generated and additional funds. Additional funds may be obtained through: (i) the issuance of equity; (ii) borrowings under our existing revolving credit facility or through refinancing the existing revolving credit agreement, and/or; (iii) the issuance of other long-term debt. We believe that our operating cash flows, cash and cash equivalents, available borrowing capacity under our $800 million revolving credit facility and $400 million accounts receivable securitization program, as well as access to the capital markets, provide us with sufficient capital resources to fund our operating, investing and financing requirements for the next twelve months. However, in the event we need to access the capital markets or other sources of financing, there can be no assurance that we will be able to obtain financing on acceptable terms or within an acceptable time. Our inability to obtain financing on terms acceptable to us could have a material unfavorable impact on our results of operations, financial condition and liquidity.

Contractual Obligations and Off-Balance Sheet Arrangements

As of December 31, 2015 we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds which totaled $120 million consisting of: (i) $96 million related to our self-insurance programs, and; (ii) $24 million of other debt and public utility guarantees.

Obligations under operating leases for real property, real property master leases and equipment amount to $331 million as of December 31, 2015. The real property master leases are leases for buildings on or near hospital property for which we guarantee a certain level of rental income. We sublease space in these buildings and any amounts received from these subleases are offset against the expense. In addition, we lease three hospital facilities from the Trust with terms expiring in 2016. These leases contain up to three 5-year renewal options. We also lease the real property of certain facilities as indicated in *Item 2. Properties,* as included herein.

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The following represents the scheduled maturities of our contractual obligations as of December 31, 2015:

	Payments Due by Period (Dollars in thousands)				
	Total	Less than 1 year	2-3 years	4-5 years	After 5 years
Long-term debt obligations (a)	$ 3,450,025	$ 62,722	$ 582,768	$ 2,488,615	$ 315,920
Estimated future interest payments on debt outstanding as of December 31, 2015 (b)	368,717	107,567	159,717	65,092	36,341
Construction commitments (c)	109,694	80,000	29,694	0	0
Purchase and other obligations (d)	170,540	44,320	83,270	42,950	0
Operating leases (e)	331,385	64,049	78,436	51,208	137,692
Estimated future payments for defined benefit pension plan, and other retirement plan (f)	242,026	11,622	15,023	14,916	200,465
Health and dental unpaid claims (g)	67,663	67,663	0	0	0
Total contractual cash obligations	$ 4,740,050	$ 437,943	$ 948,908	$ 2,662,781	$ 690,418

(a) Reflects borrowings outstanding as of December 31, 2015 as discussed in Note 4 to the Consolidated Financial Statements.

(b) Assumes that all debt outstanding as of December 31, 2015, including borrowings under our Credit Agreement, demand note and accounts receivable securitization program, remain outstanding until the final maturity of the debt agreements at the same interest rates (some of which are floating) which were in effect as of December 31, 2015. We have the right to repay borrowings upon short notice and without penalty, pursuant to the terms of the Credit Agreement, demand note and accounts receivable securitization program. Also includes the impact of various interest rate swap and cap agreements in effect as of December 31, 2015, as calculated to maturity dates utilizing the applicable floating interest rates in effect as of December 31, 2015.

(c) Estimated construction cost of a newly constructed acute care hospital located in Henderson, Nevada, (Henderson Hospital) that is scheduled to be completed and opened during the fourth quarter of 2016. We are required to build this hospital pursuant to an agreement with a third party. In addition, we had various other projects under construction as of December 31, 2015. Because we can terminate substantially all of the construction contracts related to the various other projects at any time without paying a termination fee, these costs are excluded from the above table except for the amount contractually committed to a third-party for Henderson Hospital. The aggregate estimated 2016 expenditures related to Henderson Hospital and the various other projects under construction as of December 31, 2015 is approximately $165 million.

(d) Consists of: (i) $70 million related to long-term contracts with third-parties consisting primarily of certain revenue cycle data processing services for our acute care facilities; (ii) $99 million related to the future expected costs to be paid to a third-party vendor in connection with the on-going operation of an electronic health records application for each of our acute care facilities, and; (iii) a $1 million liability for physician commitments expected to be paid in the future.

(e) Reflects our future minimum operating lease payment obligations related to our operating lease agreements outstanding as of December 31, 2015 as discussed in Note 7 to the Consolidated Financial Statements. Some of the lease agreements provide us with the option to renew the lease and our future lease obligations would change if we exercised these renewal options.

(f) Consists of $224 million of estimated future payments related to our non-contributory, defined benefit pension plan (estimated through 2089), as disclosed in *Note 8 to the Consolidated Financial Statements*, and $18 million of estimated future payments related to another retirement plan liability. Included in our other non-current liabilities as of December 31, 2015 was an $11 million liability recorded in connection with the non-contributory, defined benefit pension plan and included in other non-current liabilities as of December 31, 2015 was a $14 million liability recorded in connection with the other retirement plan.

(g) Consists of accrued and unpaid estimated claims expense incurred in connection with our commercial health insurers and self-insured employee benefit plans.

As of December 31, 2015, the total accrual for our professional and general liability claims was $204 million, of which $48 million is included in other current liabilities and $156 million is included in other non-current liabilities. We exclude the $204 million for professional and general liability claims from the contractual obligations table because there are no significant contractual obligations associated with these liabilities and because of the uncertainty of the dollar amounts to be ultimately paid as well as the timing of such payments. Please see *Self-Insured/Other Insurance Risks* above for additional disclosure related to our professional and general liability claims and reserves.

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

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also reflected as redeemable noncontrolling interests on our Consolidated Balance Sheet, the outside owner has a "put option" to put its entire ownership interest to us at any time. If exercised, the put option requires us to purchase the minority member's interest at fair market value. We exclude the approximate amount that we may be required to pay to repurchase the minority ownership interests from the contractual obligations table because of the uncertainty as to: (i) whether or not the put rights, if exercisable, will actually be exercised; (ii) the dollar amounts that would be paid if the put rights were exercised, and; (iii) the timing of such payments.

Additionally, the table above does not include $2 million of the total unrecognized tax benefits for uncertain tax positions as of December 31, 2015. Due to the high degree of uncertainty regarding the timing of potential cash flows, we cannot reasonably estimate the settlement periods for which the amounts may be utilized.

ITEM 7A. Quantitative and Qualitative Disclosures About Market Risk

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

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

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

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

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

During 2015, we entered into nine forward starting interest rate swaps whereby we pay a fixed rate on a total notional amount of $1.0 billion and receive one-month LIBOR. The average fixed rate payable on these swaps, which are scheduled to mature on April 15, 2019, is 1.31%. These interest rates swaps consist of:

- Four forward starting interest rate swaps, entered into during the second quarter of 2015, whereby we pay a fixed rate on a total notional amount of $500 million and receive one-month LIBOR. Each of the four swaps became effective on July 15, 2015 and are scheduled to mature on April 15, 2019. The average fixed rate payable on these swaps is 1.40%;
- Four forward starting interest rate swaps, entered into during the third quarter of 2015, whereby we pay a fixed rate on a total notional amount of $400 million and receive one-month LIBOR. One swap on a notional amount of $100 million became effective on July 15, 2015, two swaps on a total notional amount of $200 million became effective on September 15, 2015 and another swap on a notional amount of $100 million became effective on

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December 15, 2015. All of these swaps are scheduled to mature on April 15, 2019. The average fixed rate payable on these four swaps is 1.23%, and;

- One interest rate swap, entered into during the fourth quarter of 2015, which pays a fixed rate on a total notional amount of $100 million and receive one-month LIBOR. The swap became effective on December 15, 2015 and is scheduled to mature on April 15, 2019. The fixed rate payable on this swap is 1.21%.

We measure our interest rate swaps at fair value on a recurring basis. The fair value of our interest rate swaps is based on quotes from our counterparties. We consider those inputs to be "level 2" in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with derivative instruments and hedging activities. At December 31, 2015, the fair value of our interest rate swaps was a net liability of $1 million comprised of a $5 million asset which is included in other assets offset by a $6 million liability which is included in other current liabilities on the accompanying balance sheet. At December 31, 2014, the fair value of our interest rate swaps was a liability of $6 million, all of which is included in other current liabilities.

The table below presents information about our long-term financial instruments that are sensitive to changes in interest rates as of December 31, 2015. For debt obligations, the table presents principal cash flows and related weighted-average interest rates by contractual maturity dates.

Maturity Date, Fiscal Year Ending December 31

(dollars in thousands)

	2016	2017	2018	2019	2020	Thereafter	Total
Long-term debt:							
Fixed rate:							
Debt	$ 2,354	$ 2,505	$ 2,764	$ 301,988	$ 1,650	$ 315,920	$ 627,181
Average interest rates	4.40%	4.40%	4.40%	4.40%	5.00%	5.00%	4.60%
Variable rate:							
Debt	$ 60,368	$ 88,749	$488,750	$2,184,977			$2,822,844
Average interest rates	1.60%	1.80%	1.70%	1.80%			1.80%
Interest rate swaps:							
Notional amount				$1,000,000			$1,000,000
Average interest rates				1.31%			1.31%

As calculated based upon our variable rate debt outstanding as of December 31, 2015 that is subject to interest rate fluctuations, each 1% change in interest rates would impact our pre-tax income by approximately $18 million.

ITEM 8. *Financial Statements and Supplementary Data*

Our Consolidated Balance Sheets, Consolidated Statements of Income, Consolidated Statements of Changes in Equity and Consolidated Statements of Cash Flows, together with the reports of PricewaterhouseCoopers LLP, independent registered public accounting firm, are included elsewhere herein. Reference is made to the "Index to Financial Statements and Financial Statement Schedule."

ITEM 9. *Changes in and Disagreements with Accountants on Accounting and Financial Disclosure*

None.

ITEM 9A. *Controls and Procedures.*

As of December 31, 2015, under the supervision and with the participation of our management, including our Chief Executive Officer ("CEO") and Chief Financial Officer ("CFO"), we performed an evaluation of the effectiveness of our disclosure controls and procedures as defined in Rule 13a-15(e) or Rule 15d-15(e) of the Securities Exchange Act of 1934, as amended. 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 Securities Exchange Act of 1934, as amended, 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 fourth quarter of 2015 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

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Management's Report on Internal Control Over Financial Reporting

Management is responsible for establishing and maintaining an adequate system of internal control over our financial reporting. In order to evaluate the effectiveness of internal control over financial reporting, as required by Section 404 of the Sarbanes-Oxley Act, management has conducted an assessment, including testing, using the criteria on *Internal Control—Integrated Framework (2013)*, issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). Our system of internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation and fair presentation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles. Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness of internal control over financial reporting to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

We have excluded the acquisitions made during 2015, including the facilities acquired as part of our acquisition of Foundations Recovery Network, LLC and Alpha Hospitals Holdings Limited, from the assessment of internal control over financial reporting as of December 31, 2015 because they were acquired by us in purchase business combinations at various times during 2015. These facilities/businesses represented approximately 1% of our consolidated total assets and our consolidated net revenues as of, and for the year ended, December 31, 2015.

Based on its assessment, management has concluded that we maintained effective internal control over financial reporting as of December 31, 2015, based on criteria in *Internal Control—Integrated Framework (2013)*, issued by the COSO. The effectiveness of the Company's internal control over financial reporting as of December 31, 2015 has been audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm as stated in its report which appears herein.

ITEM 9B ***Other Information***

None.

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PART III

ITEM 10. *Directors, Executive Officers and Corporate Governance*

There is hereby incorporated by reference the information to appear under the captions "Election of Directors", "Section 16(a) Beneficial Ownership Reporting Compliance" and "Corporate Governance" in our Proxy Statement, to be filed with the Securities and Exchange Commission within 120 days after December 31, 2015. See also "Executive Officers of the Registrant" appearing in Item 1 hereof.

ITEM 11. *Executive Compensation*

There is hereby incorporated by reference the information to appear under the caption "Executive Compensation" in our Proxy Statement to be filed with the Securities and Exchange Commission within 120 days after December 31, 2015.

ITEM 12. *Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters*

There is hereby incorporated by reference the information to appear under the caption "Security Ownership of Certain Beneficial Owners and Management" and "Executive Compensation" in our Proxy Statement, to be filed with the Securities and Exchange Commission within 120 days after December 31, 2015.

ITEM 13. *Certain Relationships and Related Transactions, and Director Independence*

There is hereby incorporated by reference the information to appear under the captions "Certain Relationships and Related Transactions" and "Corporate Governance" in our Proxy Statement, to be filed with the Securities and Exchange Commission within 120 days after December 31, 2015.

ITEM 14. *Principal Accountant Fees and Services.*

There is hereby incorporated by reference the information to appear under the caption "Relationship with Independent Auditors" in our Proxy Statement, to be filed with the Securities and Exchange Commission within 120 days after December 31, 2015.

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PART IV

ITEM 15. *Exhibits and Financial Statement Schedules*

(a) Documents filed as part of this report:

(1) Financial Statements:

See "Index to Financial Statements and Financial Statement Schedule."

(2) Financial Statement Schedules:

See "Index to Financial Statements and Financial Statement Schedule."

(3) Exhibits:

3.1 Registrant's Restated Certificate of Incorporation, and Amendments thereto, previously filed as Exhibit 3.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 1997, are incorporated herein by reference.

3.2 Bylaws of Registrant, as amended, previously filed as Exhibit 3.2 to the Company's Annual Report on Form 10-K for the year ended December 31, 1987, is incorporated herein by reference.

3.3 Amendment to the Registrant's Restated Certificate of Incorporation previously filed as Exhibit 3.1 to the Company's Current Report on Form 8-K dated July 3, 2001 is incorporated herein by reference.

4.1 Form of Indenture dated January 20, 2000, between Universal Health Services, Inc. and J.P. Morgan Trust Company, National Association (as successor to Bank One Trust Company, N.A.), Trustee previously filed as Exhibit 4.1 to the Company's Registration Statement on Form S-3/A (File No. 333-85781), dated February 1, 2000, is incorporated herein by reference.

4.2 Supplemental Indenture between Universal Health Services, Inc. and J.P. Morgan Trust Company, National Association, dated as of June 20, 2006, previously filed as Exhibit 4.2 to the Company's Registration Statement on Form S-3 (File No. 333-135277) dated June 23, 2006, is incorporated herein by reference.

4.3 Form of Debt Security, previously filed as Exhibit 4.1 to the Company's Registration Statement on Form S-3 (File No. 333-135277) dated June 23, 2006, is incorporated herein by reference.

4.4 Form of 7.125% Notes due 2016, previously filed as Exhibit 4.1 to the Company's Current Report on Form 8-K dated June 30, 2006, is incorporated herein by reference.

4.5 Officer's Certificate relating to the 7.125% Notes due 2016, previously filed as Exhibit 4.1 to the Company's Current Report on Form 8-K dated June 30, 2006, is incorporated herein by reference.

4.6 Form of Note, previously filed as Exhibit 4.1 to the Company's Current Report on Form 8-K dated May 30, 2008, is incorporated herein by reference.

4.7 Officers' Certificate, previously filed as Exhibit 4.2 to the Company's Current Report on Form 8-K dated May 30, 2008, is incorporated herein by reference.

4.8 Indenture, dated as of August 7, 2014, among Universal Health Services, Inc., its subsidiaries specified therein, MUFG Union Bank, N.A., as Trustee, JPMorgan Chase Bank, N.A., as Collateral Agent (including forms of the 3.750% Senior Secured Notes due 2019 and the 4.750% Senior Secured Notes due 2022), previously filed as Exhibit 4.1 to the Company's Current Report on Form 8-K dated August 12, 2014, is incorporated herein by reference.

4.9 Second Supplement Indenture, dated as of November 15, 2010, to the Indenture, dated January 20, 2000, between Universal Health Services, Inc. and the Bank of New York Mellon Trust company, N.A., as Trustee, previously filed as Exhibit 4.2 to the Company's Current Report on Form 8-K dated November 17, 2010, is incorporated herein by reference.

4.10 Third Supplemental Indenture, dated as of August 7, 2014, to Indenture, dated as of January 20, 2000, between Universal Health Services, Inc. and The Bank of New York Mellon Trust Company, N.A., as Trustee, previously filed as Exhibit 10.3 to the Company's Current Report on Form 8-K dated August 12, 2014, is incorporated herein by reference.

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10.1* Employment Agreement, dated as of July 24, 2013, by and between Universal Health Services, Inc. and Alan B. Miller, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated July 26, 2013, is incorporated herein by reference.

10.2 Advisory Agreement, dated as of December 24, 1986, between Universal Health Realty Income Trust and UHS of Delaware, Inc., previously filed as Exhibit 10.2 to the Company's Current Report on Form 8-K dated December 24, 1986, is incorporated herein by reference.

10.3 Agreement, dated December 4, 2015, to renew Advisory Agreement, dated as of December 24, 1986, between Universal Health Realty Income Trust and UHS of Delaware, Inc.

10.4 Form of Leases, including Form of Master Lease Document for Leases, between certain subsidiaries of the Company and Universal Health Realty Income Trust, filed as Exhibit 10.3 to Amendment No. 3 of the Registration Statement on Form S-11 and Form S-2 of Registrant and Universal Health Realty Income Trust (Registration No. 33-7872), is incorporated herein by reference.

10.5 Corporate Guaranty of Obligations of Subsidiaries Pursuant to Leases and Contract of Acquisition, dated December 24, 1986, issued by the Company in favor of Universal Health Realty Income Trust, previously filed as Exhibit 10.5 to the Company's Current Report on Form 8-K dated December 24, 1986, is incorporated herein by reference.

10.6* Universal Health Services, Inc. Executive Retirement Income Plan dated January 1, 1993, previously filed as Exhibit 10.7 to the Company's Annual Report on Form 10-K for the year ended December 31, 2002, is incorporated herein by reference.

10.7 Asset Purchase Agreement dated as of February 6, 1996, among Amarillo Hospital District, UHS of Amarillo, Inc. and Universal Health Services, Inc., previously filed as Exhibit 10.28 to the Company's Annual Report on Form 10-K for the year ended December 31, 1995, is incorporated herein by reference.

10.8 Agreement of Limited Partnership of District Hospital Partners, L.P. (a District of Columbia limited partnership) by and among UHS of D.C., Inc. and The George Washington University, previously filed as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarters ended March 30, 1997, and June 30, 1997, is incorporated herein by reference.

10.9 Contribution Agreement between The George Washington University (a congressionally chartered institution in the District of Columbia) and District Hospital Partners, L.P. (a District of Columbia limited partnership), previously filed as Exhibit 10.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 1997, is incorporated herein by reference.

10.10 Valley/Desert Contribution Agreement dated January 30, 1998, by and among Valley Hospital Medical Center, Inc. and NC-DSH, Inc. previously filed as Exhibit 10.30 to the Company's Annual Report on Form 10-K for the year ended December 31, 1997, is incorporated herein by reference.

10.11 Summerlin Contribution Agreement dated January 30, 1998, by and among Summerlin Hospital Medical Center, L.P. and NC-DSH, Inc., previously filed as Exhibit 10.31 to the Company's Annual Report on Form 10-K for the year ended December 31, 1997, is incorporated herein by reference.

10.12* Amended and Restated Universal Health Services, Inc. Supplemental Deferred Compensation Plan dated as of January 1, 2002, previously filed as Exhibit 10.29 to the Company's Annual Report on Form 10-K for the year ended December 31, 2002, is incorporated herein by reference.

10.13* Universal Health Services, Inc. Employee Stock Purchase Plan, previously filed as Exhibit 4.1 to the Company's Registration Statement on Form S-8 (File No. 333-122188), dated January 21, 2005 is incorporated herein by reference.

10.14* Universal Health Services, Inc. Third Amended and Restated 2005 Stock Incentive Plan, previously filed as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q filed on August 7, 2015, is incorporated herein by reference.

10.15* Form of Stock Option Agreement, previously filed as Exhibit 10.4 to the Company's Current Report on Form 8-K, dated June 8, 2005, is incorporated herein by reference.

10.16* Form of Stock Option Agreement for Non-Employee Directors, previously filed as Exhibit 10.2 to the Company's Current Report on Form 8-K, dated October 3, 2005, is incorporated herein by reference.

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10.17 Amendment No. 1 to the Master Lease Document, between certain subsidiaries of Universal Health Services, Inc. and Universal Health Realty Income Trust, dated April 24, 2006, previously filed as Exhibit 10.29 to the Company's Annual Report on Form 10-K for the year ended December 31, 2006, is incorporated herein by reference.

10.18* Amended and Restated Universal Health Services, Inc. 2010 Employees' Restricted Stock Purchase Plan, previously filed as Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q filed on August 7, 2015, is incorporated herein by reference

10.19* Universal Health Services, Inc. 2010 Executive Incentive Plan, previously filed as Exhibit 10.3 to the Company's Quarterly Report on Form 10-Q filed on August 7, 2015, is incorporated herein by reference.

10.20 Omnibus Amendment to Receivables Sale Agreements, dated as of October 27, 2010, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated November 2, 2010, is incorporated herein by reference.

10.21 Amended and Restated Credit and Security Agreement, dated as of October 27, 2010, previously filed as Exhibit 10.2 to the Company's Current Report on Form 8-K dated November 2, 2010, is incorporated herein by reference.

10.22 Second Amendment to Amended and Restated Credit and Security Agreement, dated as of October 25, 2013, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated October 30, 2013, is incorporated herein by reference.

10.23 Third Amendment to Amended and Restated Credit and Security Agreement, dated as of August 1, 2014, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated August 4, 2014, is incorporated herein by reference.

10.24 Fourth Amendment to Amended and Restated Credit and Security Agreement, dated as of December 22, 2015, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated December 22, 2015, is incorporated herein by reference

Assignment and Assumption Agreement, dated as of October 27, 2010, previously filed as Exhibit 10.3 to the Company's Current Report on Form 8-K dated November 2, 2010, is incorporated herein by reference.

10.25 Credit Agreement, dated as of November 15, 2010, by and among Universal Health Services, Inc., JPMorgan Chase Bank, N.A. and the various financial institutions as are or may become parties thereto, as Lenders, SunTrust Bank, The Royal Bank of Scotland, Plc, Bank of Tokyo-Mitsubishi UFJ Trust Company and Credit Agricole Corporate and Investment Bank, as co-documentation agents, Deutsche Bank Securities Inc. and Bank of America N.A. as co-syndication agents, and JPMorgan Chase Bank, N.A., as administrative agent for the Lenders and as collateral agent for the secured parties, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated November 17, 2010, is incorporated herein by reference.

10.26 First Amendment, dated as of March 15, 2011, to the Credit Agreement, dated as of November 15, 2010, by and among Universal Health Services, Inc., JPMorgan Chase Bank, N.A. and the various financial institutions as are or may become parties thereto, as Lenders, certain banks as co-documentation agents, and as co-syndication agents, and JPMorgan Chase Bank, N.A., as administrative agent for the Lenders and as collateral agent for the secured parties, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated March 15, 2011, is incorporated herein by reference.

10.27 Credit Agreement, dated as of November 15, 2010 and amended and restated as of September 21, 2012, by and among Universal Health Services, Inc. (the borrower), the several lenders from time to time parties thereto, Credit Agricole Corporate and Investment Bank, Mizuho Corporate Bank LTD., Royal Bank of Canada and The Royal Bank of Scotland PLC (as co-documentation agents), Bank of Tokoyo-Mitsubishi UFJ Trust Company, Bank of America N.A. and Suntrust Bank (as co-syndication agents), and JPMorgan Chase Bank, N.A. (as administrative agent), previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated September 26, 2012, is incorporated herein by reference.

10.28 Second Amendment, dated as of September 21, 2012, to the Credit Agreement, dated as of November 15, 2010 (as amended from time to time), among Universal Health Services, Inc., a Delaware corporation, the several banks and other financial institutions from time to time parties thereto, JPMorgan Chase Bank, N.A., as administrative agent and the other agents party thereto, previously filed as Exhibit 10.2 to the Company's Current Report on Form 8-K dated September 26, 2012, is incorporated herein by reference.

10.29 Third Amendment, dated as of May 16, 2013, to the Credit Agreement, dated as of November 15, 2010, as amended from time to time, among Universal Health Services, Inc., a Delaware corporation, the several banks and other financial institutions from time to time parties thereto, JPMorgan Chase Bank, N.A., as administrative agent and the other agents party thereto, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated May 17, 2013, is incorporated herein by reference.

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10.30 Fourth Amendment, dated as of August 7, 2014, to the Credit Agreement, dated as of November 15, 2010, as previously amended from time to time, by and among Universal Health Services, Inc., the several banks and other financial institutions from time to time parties thereto, JPMorgan Chase Bank, N.A., as administrative agent and the other agents party thereto, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated August 12, 2014, is incorporated herein by reference.

10.31 Credit Agreement, dated as of November 15, 2010 and amended and restated as of August 7, 2014, by and among Universal Health Services, Inc., the several banks and other financial institutions from time to time parties thereto, JPMorgan Chase Bank, N.A., as administrative agent and the other agents party thereto, previously filed as Exhibit 10.2 to the Company's Current Report on Form 8-K dated August 12, 2014, is incorporated herein by reference.

10.32* Form of Supplemental Life Insurance Plan and Agreement Part A: Alan B. Miller 1998 Dual Life Insurance Trust (effective December 9, 2010, by and between Universal Health Services, Inc., a Delaware corporation (the "Company"), and Anthony Pantaleoni as Trustee), previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated December 10, 2010, is incorporated herein by reference.

10.33* Form of Supplemental Life Insurance Plan and Agreement Part B: Alan B. Miller 2002 Trust (effective December 9, 2010, by and between Universal Health Services, Inc., a Delaware corporation (the "Company"), and Anthony Pantaleoni as Trustee), previously filed as Exhibit 10.2 to the Company's Current Report on Form 8-K dated December 10, 2010, is incorporated herein by reference.

10.34* Universal Health Services, Inc. Termination, Assignment and Release Agreement (effective December 9, 2010, by and between Universal Health Services, Inc., a Delaware corporation (the "Company"), Anthony Pantaleoni as Trustee of the Alan B. Miller 1998 Dual Life Insurance Trust, and Alan B. Miller, Executive), previously filed as Exhibit 10.3 to the Company's Current Report on Form 8-K dated December 10, 2010, is incorporated herein by reference.

10.35* Universal Health Services, Inc. Termination, Assignment and Release Agreement (effective December 9, 2010, by and between Universal Health Services, Inc., a Delaware corporation (the "Company"), Anthony Pantaleoni as Trustee of the Alan B. Miller 2002 Trust, and Alan B. Miller, Executive), previously filed as Exhibit 10.4 to the Company's Current Report on Form 8-K dated December 10, 2010, is incorporated herein by reference.

10.36 Collateral Agreement, dated as of August 7, 2014, among Universal Health Services, Inc., the subsidiary guarantors party thereto, MUFG Union Bank, N.A., as 2014 Trustee, The Bank of New York Mellon Trust Company, N.A., as 2006 Trustee, and JPMorgan Chase Bank, N.A., as collateral agent, previously filed as Exhibit 10.4 to the Company's Current Report on Form 8-K dated August 12, 2014, is incorporated herein by reference.

11 Statement regarding computation of per share earnings is set forth in Note 1 of the Notes to the Consolidated Financial Statements.

21 Subsidiaries of Registrant.

23.1 Consent of Independent Registered Public Accounting Firm-PricewaterhouseCoopers LLP.

31.1 Certification from the Company's Chief Executive Officer Pursuant to Rule 13a-14(a)/15(d)-14(a) of the Securities Exchange Act of 1934.

31.2 Certification from the Company's Chief Financial Officer Pursuant to Rule 13a-14(a)/15(d)-14(a) of the Securities Exchange Act of 1934.

32.1 Certification from 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 from the Company's Chief Financial Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

101.INS XBRL Instance Document

101.SCH XBRL Taxonomy Extension Schema Document

101.CAL XBRL Taxonomy Extension Calculation Linkbase Document

101.DEF XBRL Taxonomy Extension Definition Linkbase Document

101.LAB XBRL Taxonomy Extension Label Linkbase Document

101.PRE XBRL Taxonomy Extension Presentation Linkbase Document

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* Management contract or compensatory plan or arrangement.

Exhibits, other than those incorporated by reference, have been included in copies of this Annual Report filed with the Securities and Exchange Commission. Stockholders of the Company will be provided with copies of those exhibits upon written request to the Company.

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SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) 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.

By: /s/ ALAN B. MILLER
Alan B. Miller
Chairman of the Board
and Chief Executive Officer

February 25, 2016

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

Signatures	Title	Date
/s/ ALAN B. MILLER **Alan B. Miller**	Chairman of the Board and Chief Executive Officer (Principal Executive Officer)	February 25, 2016
/s/ MARC D. MILLER **Marc D. Miller**	Director and President	February 25, 2016
/s/ LAWRENCE S. GIBBS **Lawrence S. Gibbs**	Director	February 25, 2016
/s/ JOHN H. HERRELL **John H. Herrell**	Director	February 25, 2016
/s/ ROBERT H. HOTZ **Robert H. Hotz**	Director	February 25, 2016
/s/ EILEEN C. MCDONNELL **Eileen C. McDonnell**	Director	February 25, 2016
/s/ ANTHONY PANTALEONI **Anthony Pantaleoni**	Director	February 25, 2016
/s/ STEVE FILTON **Steve Filton**	Senior Vice President, Chief Financial Officer and Secretary (Principal Financial and Accounting Officer)	February 25, 2016

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of Universal Health Services, Inc.:

In our opinion, the consolidated financial statements listed in the accompanying index present fairly, in all material respects, the financial position of Universal Health Services, Inc. and its subsidiaries at December 31, 2015 and 2014, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2015 in conformity with accounting principles generally accepted in the United States of America. In addition, in our opinion, the financial statement schedule listed in the accompanying index presents fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2015, based on criteria established in *Internal Control—Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these financial statements, financial statement schedule, and for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in Item 9A as *Management's Report on Internal Control over Financial Reporting*. Our responsibility is to express opinions on these financial statements, on the financial statement schedule, and on the Company's internal control over financial reporting based on our integrated audits. We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed 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. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

As described in *Management's Report on Internal Control over Financial Reporting*, management has excluded Foundations Recovery Network, LLC and Alpha Hospitals Holdings Limited from its assessment of internal control over financial reporting as of December 31, 2015 because the entities were acquired by the Company in purchase business combinations during 2015. We have also excluded Foundations Recovery Network, LLC and Alpha Hospitals Holdings Limited from our audit of internal control over financial reporting. Foundations Recovery Network, LLC and Alpha Hospitals Holdings Limited are wholly-owned subsidiaries whose total assets and total net revenues represent 1% of the related consolidated financial statement amounts as of and for the year ended December 31, 2015.

/s/ PricewaterhouseCoopers LLP

Philadelphia, Pennsylvania
February 25, 2016

SUPPLEMENTAL #1

June 29, 2016

12:31 pm

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

	Year Ended December 31,		
	2015	2014	2013
	(in thousands, except per share data)		
Net revenues before provision for doubtful accounts	$ 9,784,724	$ 8,904,071	$ 8,495,089
Less: Provision for doubtful accounts	741,273	698,983	1,127,216
Net revenues	9,043,451	8,205,088	7,367,873
Operating charges:			
Salaries, wages and benefits	4,212,387	3,845,461	3,604,620
Other operating expenses	2,119,805	1,922,743	1,552,795
Supplies expense	974,088	895,693	821,089
Depreciation and amortization	398,618	375,624	337,172
Lease and rental expense	94,973	93,993	97,758
Electronic health records incentive income	(15,815)	(27,902)	(61,024)
Costs related to extinguishment of debt	0	36,171	0
	7,784,056	7,141,783	6,352,410
Income from operations	1,259,395	1,063,305	1,015,463
Interest expense, net	113,494	133,638	146,131
Income before income taxes	1,145,901	929,667	869,332
Provision for income taxes	395,203	324,671	315,309
Net income	750,698	604,996	554,023
Less: Net income attributable to noncontrolling interests	70,170	59,653	43,290
Net income attributable to UHS	$ 680,528	$ 545,343	$ 510,733
Basic earnings per share attributable to UHS	$ 6.89	$ 5.52	$ 5.21
Diluted earnings per share attributable to UHS	$ 6.76	$ 5.42	$ 5.14
Weighted average number of common shares—basic	98,797	98,826	98,033
Add: Other share equivalents	1,897	1,718	1,328
Weighted average number of common shares and equivalents—diluted	100,694	100,544	99,361

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

SUPPLEMENTAL #1
June 29, 2016
12:31 pm

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

	Year Ended December 31,		
	2015	2014	2013
Net income	$ 750,698	$ 604,996	$ 554,023
Other comprehensive income (loss):			
Unrealized derivative gains (losses) on cash flow hedges	4,970	17,668	16,963
Amortization of terminated hedge	(336)	(336)	(336)
Minimum pension liability	2,177	(14,270)	14,657
Foreign currency translation adjustment	(1,728)	(2,431)	0
Other comprehensive income (loss) before tax	5,083	631	31,284
Income tax (benefit) expense related to items of other comprehensive income	2,980	1,053	11,940
Total other comprehensive income (loss), net of tax	2,103	(422)	19,344
Comprehensive income	752,801	604,574	573,367
Less: Comprehensive income attributable to noncontrolling interests	70,170	59,653	43,290
Comprehensive income attributable to UHS	$ 682,631	$ 544,921	$ 530,077

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

SUPPLEMENTAL #1

June 29, 2016
12:31 pm

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS

	December 31, 2015	2014
	(Dollar amounts in thousands)	
Assets		
Current assets:		
Cash and cash equivalents	$ 61,228	$ 32,069
Accounts receivable, net	1,302,429	1,282,735
Supplies	116,037	108,115
Deferred income taxes	135,120	114,565
Other current assets	103,490	77,654
Total current assets	1,718,304	1,615,138
Property and Equipment		
Land	451,717	435,632
Buildings and improvements	4,181,576	3,948,501
Equipment	1,659,485	1,648,718
Property under capital lease	45,665	40,782
	6,338,443	6,073,633
Accumulated depreciation	(2,694,591)	(2,532,341)
	3,643,852	3,541,292
Construction-in-progress	192,126	138,397
	3,835,978	3,679,689
Other assets:		
Goodwill	3,596,114	3,291,213
Deferred charges	35,357	40,319
Other	448,360	348,084
	4,079,831	3,679,616
	$ 9,634,113	$ 8,974,443
Liabilities and Stockholders' Equity		
Current liabilities:		
Current maturities of long-term debt	$ 62,722	$ 68,319
Accounts payable	366,238	336,447
Accrued liabilities		
Compensation and related benefits	245,117	323,425
Interest	13,284	13,977
Taxes other than income	60,255	112,119
Other	348,803	327,094
Current federal and state income taxes	3,987	1,446
Total current liabilities	1,100,406	1,182,827
Other noncurrent liabilities	278,834	268,555
Long-term debt	3,387,303	3,210,215
Deferred income taxes	315,900	282,214
Commitments and contingencies (Note 8)		
Redeemable noncontrolling interest	242,509	239,552
Equity:		
Class A Common Stock, voting, $.01 par value; authorized 12,000,000 shares: issued and outstanding 6,595,308 shares in 2015 and 6,595,708 shares in 2014	66	66
Class B Common Stock, limited voting, $.01 par value; authorized 150,000,000 shares: issued and outstanding 91,013,487 shares in 2015 and 91,427,258 shares in 2014	910	914
Class C Common Stock, voting, $.01 par value; authorized 1,200,000 shares: issued and outstanding 663,940 shares in 2015 and 664,000 shares in 2014	7	7
Class D Common Stock, limited voting, $.01 par value; authorized 5,000,000 shares: issued and outstanding 23,742 shares in 2015 and 29,121 shares in 2014	0	0
Cumulative dividends	(294,728)	(255,196)
Retained earnings	4,566,521	4,015,387
Accumulated other comprehensive loss	(23,129)	(25,232)
Universal Health Services, Inc. common stockholders' equity	4,249,647	3,735,946
Noncontrolling interest	59,514	55,134
Total Equity	4,309,161	3,791,080
	$ 9,634,113	$ 8,974,443

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY
For the Years Ended December 31, 2015, 2014 and 2013
(in thousands)

	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, 2013	$ 234,303	$ 66	$ 903	$ 7	$ 0	$ (205,910)	$2,962,433	$ (44,154)	$ 2,713,345	$ 52,604	$2,765,949
Common Stock											
Issued/(converted) including tax benefits from exercise of stock options	—	—	11	—	—	—	26,869	—	26,880	—	26,880
Repurchased	—	—	(4)	—	—	—	(27,197)	—	(27,201)	—	(27,201)
Restricted share-based compensation expense	—	—	—	—	—	—	664	—	664	—	664
Dividends paid	—	—	—	—	—	(19,621)	—	—	(19,621)	—	(19,621)
Stock option expense	—	—	—	—	—	—	25,835	—	25,835	—	25,835
Distributions to noncontrolling interests	(48,290)	—	—	—	—	—	—	—	—	(13,039)	(13,039)
Other	—	—	—	—	—	—	—	—	—	(511)	(511)
Comprehensive income:											
Net income	32,094	—	—	—	—	—	510,733	—	510,733	11,196	521,929
Amortization of terminated hedge (net of income tax effect of $120)	—	—	—	—	—	—	—	(216)	(216)	—	(216)
Unrealized derivative gains on cash flow hedges (net of income tax effect of $6,390)	—	—	—	—	—	—	—	10,573	10,573	—	10,573
Minimum pension liability (net of income tax effect of $5,670)	—	—	—	—	—	—	—	8,987	8,987	—	8,987
Subtotal - comprehensive income	32,094	—	—	—	—	—	510,733	19,344	530,077	11,196	541,273
Balance, December 31, 2013	$ 218,107	$ 66	$ 910	$ 7	$ 0	$ (225,531)	$3,499,337	$ (24,810)	$ 3,249,979	$ 50,250	$3,300,229

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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY—(Continued)
For the Years Ended December 31, 2015, 2014 and 2013
(in thousands)

	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
Common Stock											
Issued/(converted) including tax benefits from exercise of stock options	—	—	14	—	—	—	41,787	—	41,801	—	41,801
Repurchased	—	—	(10)	—	—	—	(100,739)	—	(100,749)	—	(100,749)
Restricted share-based compensation expense	—	—	—	—	—	—	491	—	491	—	491
Dividends paid	—	—	—	—	—	(29,665)	—	—	(29,665)	—	(29,665)
Stock option expense	—	—	—	—	—	—	29,168	—	29,168	—	29,168
Distributions to noncontrolling interests	(26,016)	—	—	—	—	—	—	—	—	(7,666)	(7,666)
Other	—	—	—	—	—	—	—	—	—	358	358
Comprehensive income:											
Net income	47,461	—	—	—	—	—	545,343	—	545,343	12,192	557,535
Foreign currency translation adjustments	—	—	—	—	—	—	—	(2,431)	(2,431)	—	(2,431)
Amortization of terminated hedge (net of income tax effect of $120)	—	—	—	—	—	—	—	(216)	(216)	—	(216)
Unrealized derivative gains on cash flow hedges (net of income tax effect of $6,529)	—	—	—	—	—	—	—	11,139	11,139	—	11,139
Minimum pension liability (net of income tax effect of $5,356)	—	—	—	—	—	—	—	(8,914)	(8,914)	—	(8,914)
Subtotal - comprehensive income	47,461	—	—	—	—	—	545,343	(422)	544,921	12,192	557,113
Balance, December 31, 2014	$ 239,552	$ 66	$ 914	$ 7	$ 0	$ (255,196)	$4,015,387	$ (25,232)	$ 3,735,946	$ 55,134	$3,791,080

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June 29, 2016
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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY—(Continued)
For the Years Ended December 31, 2015, 2014 and 2013
(in thousands)

	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
Common Stock											
Issued/(converted) including tax benefits from exercise of stock options	—	—	14	—	—	—	56,473	—	56,487	—	56,487
Repurchased	—	—	(18)	—	—	—	(224,242)	—	(224,260)	—	(224,260)
Restricted share-based compensation expense	—	—	—	—	—	—	393	—	393	—	393
Dividends paid	—	—	—	—	—	(39,532)	—	—	(39,532)	—	(39,532)
Stock option expense	—	—	—	—	—	—	37,982	—	37,982	—	37,982
Distributions to noncontrolling interests	(51,106)	—	—	—	—	—	—	—	—	(11,114)	(11,114)
Other	—	—	—	—	—	—	—	—	—	(613)	(613)
Comprehensive income:											
Net income	54,063	—	—	—	—	—	680,528	—	680,528	16,107	696,635
Foreign currency translation adjustments	—	—	—	—	—	—	—	(1,728)	(1,728)	—	(1,728)
Amortization of terminated hedge (net of income tax effect of $120)	—	—	—	—	—	—	—	(216)	(216)	—	(216)
Unrealized derivative gains on cash flow hedges (net of income tax effect of $2,283)	—	—	—	—	—	—	—	2,687	2,687	—	2,687
Minimum pension liability (net of income tax effect of $817)	—	—	—	—	—	—	—	1,360	1,360	—	1,360
Subtotal - comprehensive income	54,063	—	—	—	—	—	680,528	2,103	682,631	16,107	698,738
Balance, December 31, 2015	$ 242,509	$ 66	$ 910	$ 7	$ 0	$ (294,728)	$4,566,521	$ (23,129)	$ 4,249,647	$ 59,514	$4,309,161

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

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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2015	2014	2013
	(Amounts in thousands)		
Cash Flows from Operating Activities:			
Net income	$ 750,698	$ 604,996	$ 554,023
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation & amortization	398,618	375,624	337,356
Gains on sales of assets and businesses, net of losses	(3,615)	(7,837)	(3,114)
Stock-based compensation expense	39,971	31,092	27,783
Costs related to extinguishment of debt	0	19,730	0
Changes in assets & liabilities, net of effects from acquisitions and dispositions:			
Accounts receivable	(45,814)	(105,708)	(49,708)
Accrued interest	(693)	4,400	(1,197)
Accrued and deferred income taxes	(34,394)	33,920	34,861
Other working capital accounts	(125,556)	73,912	26,234
Other assets and deferred charges	6,631	13,667	8,984
Other	23,295	2,449	23,485
Accrued insurance expense, net of commercial premiums paid	90,895	59,276	(3,821)
Payments made in settlement of self-insurance claims	(79,138)	(69,645)	(70,645)
Net cash provided by operating activities	1,020,898	1,035,876	884,241
Cash Flows from Investing Activities:			
Property and equipment additions, net of disposals	(379,321)	(391,150)	(358,493)
Acquisition of property and businesses	(533,655)	(431,386)	(12,636)
Proceeds received from sales of assets and businesses	3,391	15,178	37,482
Costs incurred for purchase and implementation of electronic health records application	0	(13,488)	(49,811)
Increase in insurance subsidiary investments	(3,300)	(12,000)	0
Net cash used in investing activities	(912,885)	(832,846)	(383,458)
Cash Flows from Financing Activities:			
Reduction of long-term debt	(68,166)	(879,129)	(440,224)
Additional borrowings	234,400	830,000	15,761
Financing costs	(515)	(14,976)	(231)
Repurchase of common shares	(209,782)	(100,749)	(27,201)
Dividends paid	(39,532)	(29,665)	(19,621)
Issuance of common stock	8,441	6,863	5,708
Excess income tax benefits related to stock based compensation	47,364	33,912	20,121
Profit distributions to noncontrolling interests	(62,220)	(33,680)	(61,329)
Proceeds received from sale/leaseback of real property	12,765	0	0
Net cash used in financing activities	(77,245)	(187,424)	(507,016)
Effect of exchange rate changes on cash and cash equivalents	(1,609)	(775)	0
Increase (decrease) in cash and cash equivalents	29,159	14,831	(6,233)
Cash and cash equivalents, beginning of period	32,069	17,238	23,471
Cash and cash equivalents, end of period	$ 61,228	$ 32,069	$ 17,238
Supplemental Disclosures of Cash Flow Information:			
Interest paid, including early redemption premium and original issue discount write-off in 2014	$ 107,054	$ 130,279	$ 131,259
Income taxes paid, net of refunds	$ 380,658	$ 258,612	$ 259,896
Noncash purchases of property and equipment	$ 49,086	$ 35,469	$ 36,212

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

SUPPLEMENTAL #1
June 29, 2016
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1) BUSINESS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Services provided by our hospitals, all of which are operated by subsidiaries of ours 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, through our subsidiaries, 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.

The more significant accounting policies follow:

A) Principles of Consolidation: The consolidated financial statements include the accounts of our majority-owned subsidiaries and partnerships controlled by us or our subsidiaries as the managing general partner. All significant intercompany accounts and transactions have been eliminated.

B) Revenue Recognition: We record revenues and related receivables for health care services at the time the services are provided. Medicare and Medicaid revenues represented 35% of our net patient revenues during 2015, 38% during 2014 and 39% during 2013. Revenues from managed care entities, including health maintenance organizations and managed Medicare and Medicaid programs accounted for 52% of our net patient revenues during 2015, 50% during 2014 and 49% during 2013.

We report net patient service revenue at the estimated net realizable amounts from patients and third-party payors and others for services rendered. We have agreements with third-party payors that provide for payments to us at amounts different from our established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments. Estimates of contractual allowances under managed care plans are based upon the payment terms specified in the related contractual agreements. We closely monitor our historical collection rates, as well as changes in applicable laws, rules and regulations and contract terms, to assure that provisions are made using the most accurate information available. However, due to the complexities involved in these estimations, actual payments from payors may be different from the amounts we estimate and record.

We estimate our Medicare and Medicaid revenues using the latest available financial information, patient utilization data, government provided data and in accordance with applicable Medicare and Medicaid payment rules and regulations. The laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation and as a result, there is at least a reasonable possibility that recorded estimates will change by material amounts in the near term. Certain types of payments by the Medicare program and state Medicaid programs (e.g. Medicare Disproportionate Share Hospital, Medicare Allowable Bad Debts and Inpatient Psychiatric Services) are subject to retroactive adjustment in future periods as a result of administrative review and audit and our estimates may vary from the final settlements. Such amounts are included in accounts receivable, net, on our Consolidated Balance Sheets. The vast majority of the net revenues generated at our behavioral health facilities located in the United Kingdom are derived from government based payors. The funding of both federal Medicare and state Medicaid programs, and the government based payor programs in the United Kingdom, are subject to legislative and regulatory changes. As such, we cannot provide any assurance that future legislation and regulations, if enacted, will not have a material impact on our future government based reimbursements. Adjustments related to the final settlement of these retrospectively determined amounts did not materially impact our results in 2015, 2014 and 2013. We provide care to patients who meet certain financial or economic criteria without charge or at amounts substantially less than our established rates. Because we do not pursue collection of amounts determined to qualify as charity care, they are not reported in net revenues or in accounts receivable, net. See additional disclosure below in *Charity Care, Uninsured Discounts and Provision for Doubtful Accounts* for our estimated uncompensated care provided and estimated cost of providing uncompensated care.

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

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assistance including our charity care policy. If the patient is deemed unwilling to pay, the account is written-off as bad debt and transferred to an outside collection agency for additional collection effort.

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

A portion of the accounts receivable at our acute care facilities are comprised of Medicaid accounts that are pending approval from third-party payers but we also have smaller amounts due from other miscellaneous payers such as county indigent programs in certain states. Our patient registration process includes an interview of the patient or the patient's responsible party at the time of registration. At that time, an insurance eligibility determination is made and an insurance plan code is assigned. There are various pre-established insurance profiles in our patient accounting system which determine the expected insurance reimbursement for each patient based on the insurance plan code assigned and the services rendered. Certain patients may be classified as Medicaid pending at registration based upon a screening evaluation if we are unable to definitively determine if they are currently Medicaid eligible. When a patient is registered as Medicaid eligible or Medicaid pending, our patient accounting system records net revenues for services provided to that patient based upon the established Medicaid reimbursement rates, subject to the ultimate disposition of the patient's Medicaid eligibility. When the patient's ultimate eligibility is determined, reclassifications may occur which impacts the reported amounts in future periods for the provision for doubtful accounts and other accounts such as Medicaid pending. Although the patient's ultimate eligibility determination may result in amounts being reclassified among these accounts from period to period, these reclassifications did not have a material impact on our results of operations in 2015, 2014 or 2013 since our facilities make estimates at each financial reporting period to reserve for amounts that are deemed to be uncollectible.

We also provide discounts to uninsured patients (included in "uninsured discounts" amounts below) who do not qualify for Medicaid or charity care. Because we do not pursue collection of amounts classified as uninsured discounts, they are not reported in our net revenues or in our net accounts receivable. In implementing the discount policy, we first attempt to qualify uninsured patients for governmental programs, charity care or any other discount program. If an uninsured patient does not qualify for these programs, the uninsured discount is applied. Effective January 1, 2014, in response to market conditions and other considerations, we modified our uninsured discount policy and increased the discount to 60% of gross charges from 30% previously. Since we expect to collect only a small portion of amounts due from our uninsured patients, the increase in the uninsured discount as of January 1, 2014 had no material impact on our 2015 and 2014 net revenues, net income attributable to UHS or net accounts receivable, as compared to 2013. However, this change resulted in an increase in uninsured discounts and a decrease in the provision for doubtful accounts.

On a consolidated basis, we monitor our total self-pay receivables to ensure that the total allowance for doubtful accounts provides adequate coverage based on historical collection experience. Our accounts receivable are recorded net of allowance for doubtful accounts of $399 million and $325 million at December 31, 2015 and 2014, respectively.

Uncompensated care (charity care and uninsured discounts):

The following table shows the amounts recorded at our acute care hospitals for charity care and uninsured discounts, based on charges at established rates, for the years ended December 31, 2015, 2014 and 2013:

	(dollar amounts in thousands)					
	2015		2014		2013	
	Amount	%	Amount	%	Amount	%
Charity care	$ 506,571	42%	$ 515,435	45%	$ 593,474	59%
Uninsured discounts	696,463	58%	620,587	55%	405,296	41%
Total uncompensated care	$1,203,034	100%	$1,136,022	100%	$ 998,770	100%

The provision for doubtful accounts at our acute care hospitals was approximately $631 million during 2015, $590 million during 2014 and $1.02 billion during 2013. The decrease in the provision for doubtful accounts during 2014, as compared to 2013, was primarily due to the increase in the uninsured discount (effective January 1, 2014, as discussed above in *Charity Care, Uninsured discounts and Provision for Doubtful Accounts)*, and reclassifications among provision for doubtful accounts and other accounts such as Medicaid pending based upon our patients' ultimate eligibility determination, as discussed above.

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The estimated cost of providing uncompensated care:

The estimated cost 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. An increase in the level of uninsured patients to our facilities and the resulting adverse trends in the provision for doubtful accounts and uncompensated care provided could have a material unfavorable impact on our future operating results.

	(amounts in thousands)		
	2015	2014	2013
Estimated cost of providing charity care	$ 77,557	$ 78,475	$ 95,675
Estimated cost of providing uninsured discounts related care	106,630	94,484	65,338
Estimated cost of providing uncompensated care	$ 184,187	$ 172,959	$ 161,013

Our accounts receivable as of December 31, 2015 and 2014 include amounts due from Illinois of approximately $28 million and $44 million, respectively. Collection of the outstanding receivables continues to be delayed due to state budgetary and funding pressures. Approximately $12 million as of December 31, 2015 and $23 million as of December 31, 2014, of the receivables due from Illinois were outstanding in excess of 60 days, as of each respective date. In addition, our accounts receivable as of December 31, 2015 and 2014 includes approximately $80 million and $102 million due from Texas in connection with Medicaid supplemental payment programs. The $80 million due from Texas as of December 31, 2015 consists of $47 million related to uncompensated care program revenues, $9 million related to disproportionate share hospital program revenues and $24 million related to Delivery Service Reform Incentive Payment program ("DSRIP") revenues. The above-mentioned Texas DSRIP receivables outstanding as of December 31, 2015 were collected in January, 2016. Although the accounts receivable due from Illinois and Texas could remain outstanding for the foreseeable future, since we expect to eventually collect all amounts due to us, no related reserves have been established in our consolidated financial statements. However, we can provide no assurance that we will eventually collect all amounts due to us from Illinois and/or Texas. Failure to ultimately collect all outstanding amounts due from these states would have an adverse impact on our future consolidated results of operations and cash flows.

D) Concentration of Revenues: Our five majority owned acute care hospitals in the Las Vegas, Nevada market contributed, on a combined basis, 13% in 2015, and 14% in both 2014 and 2013 of our consolidated net revenues.

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

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

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

F) Cash and Cash Equivalents: We consider all highly liquid investments purchased with maturities of three months or less to be cash equivalents.

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G) Property and Equipment: Property and equipment are stated at cost. Expenditures for renewals and improvements are charged to the property accounts. Replacements, maintenance and repairs which do not improve or extend the life of the respective asset are expensed as incurred. We remove the cost and the related accumulated depreciation from the accounts for assets sold or retired and the resulting gains or losses are included in the results of operations. Construction-in-progress includes both construction projects and equipment not yet placed into service.

We capitalize interest expense on major construction projects while in progress. We capitalized interest on major construction projects and the development and implementation of electronic health records applications amounting to $304,000 during 2015, $0 during 2014 and $4.9 million during 2013.

Depreciation is provided on the straight-line method over the estimated useful lives of buildings and improvements (twenty to forty years) and equipment (three to fifteen years). Depreciation expense (excluding discontinued operations) was $337.5 million during 2015, $314.5 million during 2014 and $285.6 million during 2013.

H) Long-Lived Assets: We review our long-lived assets, including intangible assets, for impairment whenever events or circumstances indicate that the carrying value of these assets may not be recoverable. The assessment of possible impairment is based on our ability to recover the carrying value of our asset based on our estimate of its undiscounted future cash flow. If the analysis indicates that the carrying value is not recoverable from future cash flows, the asset is written down to its estimated fair value and an impairment loss is recognized. Fair values are determined based on estimated future cash flows using appropriate discount rates.

I) Goodwill and Intangible Assets: Goodwill and indefinite-lived intangible assets are reviewed for impairment at the reporting unit level on an annual basis or sooner if the indicators of impairment arise. Our judgments regarding the existence of impairment indicators are based on market conditions and operational performance of each reporting unit. During the quarter ended September 30, 2015, we changed our annual goodwill and indefinite-lived intangibles testing date from September 1st to October 1st. Management believes that this voluntary change in accounting method is preferable as it aligns the annual impairment testing date with our annual budgeting process. In connection with this change, we first performed an impairment test as of September 1, 2015, which indicated no impairment of goodwill or indefinite-lived intangible assets. We performed an additional impairment test as of October 1, 2015 which also indicated no impairment of goodwill or indefinite-lived intangible assets. There were also no impairments during 2014 or 2013. The 2015 change in annual testing date does not delay, accelerate or avoid an impairment charge. Future changes in the estimates used to conduct the impairment review, including profitability and market value projections, could indicate impairment in future periods potentially resulting in a write-off of a portion or all of our goodwill or indefinite-lived intangible assets.

Changes in the carrying amount of goodwill for the two years ended December 31, 2015 were as follows (in thousands):

	Acute Care Services	Behavioral Health Services	Total Consolidated
Balance, January 1, 2014	$ 383,011	$ 2,666,005	$ 3,049,016
Goodwill acquired during the period	4,088	246,124	250,212
Adjustments to goodwill (a)	0	(8,015)	(8,015)
Balance, December 31, 2014	387,099	2,904,114	3,291,213
Goodwill acquired during the period	2,480	316,427	318,907
Goodwill divested during the period	0	(1,497)	(1,497)
Adjustments to goodwill (a)	(72)	(12,437)	(12,509)
Balance, December 31, 2015	$ 389,507	$ 3,206,607	$ 3,596,114

(a) The decrease in the Behavioral Health Services' goodwill consists primarily of foreign currency translation adjustments.

J) Other Assets: Other assets consist primarily of amounts related to: (i) intangible assets acquired in connection with our acquisitions of Foundations Recovery Network, LLC during 2015, Ascend Health Corporation during 2012 and Psychiatric Solutions, Inc. during 2010; (ii) prepaid fees for various software and other applications used by our hospitals; (iii) costs incurred in connection with the purchase and implementation of an electronic health records application for each of our acute care facilities; (iv) required capital reserves related to our commercial insurer; (v) deposits; (vi) investments in various businesses, including Universal Health Realty Income Trust and Premier, Inc.; (vii) the invested assets related to a deferred compensation plan that is held by an independent trustee in a rabbi-trust and that has a related payable included in other noncurrent liabilities; (viii) the estimated future payments related to physician-related contractual commitments, as discussed below, and; (ix) other miscellaneous assets. As of December 31, 2015, net intangible assets were $219 million and consisted of the following: Tradename ($124 million), Medicare licenses ($57 million), Certificates of need ($12 million), and contract relationships and other ($25 million, net of $25 million of accumulated amortization). As of December 31, 2014, net intangible assets were $98 million and consistent of the following: Medicare licenses

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($57 million), Certificates of need ($12 million), and contract relationships ($29 million, net of $19 million of accumulated amortization).

K) Physician Guarantees and Commitments: As of December 31, 2015 and 2014, our accrued liabilities-other, and our other assets included $1 million and $2 million, respectively, of estimated future payments related to physician-related contractual commitments. The $1 million of potential future financial obligations outstanding as of December 31, 2015 are potential 2016 obligations.

L) Self-Insured/Other Insurance Risks: We provide for self-insured risks, primarily general and professional liability claims and workers' compensation claims. Our estimated liability for self-insured professional and general liability claims is based on a number of factors including, among other things, the number of asserted claims and reported incidents, estimates of losses for these claims based on recent and historical settlement amounts, estimate of incurred but not reported claims based on historical experience, and estimates of amounts recoverable under our commercial insurance policies. All relevant information, including our own historical experience is used in estimating the expected amount of claims. While we continuously monitor these factors, our ultimate liability for professional and general liability claims could change materially from our current estimates due to inherent uncertainties involved in making this estimate. Our estimated self-insured reserves are reviewed and changed, if necessary, at each reporting date and changes are recognized currently as additional expense or as a reduction of expense. See Note 8 for discussion of adjustments to our prior year reserves for claims related to our self-insured general and professional liability and workers' compensation liability.

In addition, we also: (i) own commercial health insurers headquartered in Nevada and Puerto Rico, and; (ii) maintain self-insured employee benefits programs for employee healthcare and dental claims. The ultimate costs related to these programs/operations include expenses for claims incurred and paid in addition to an accrual for the estimated expenses incurred in connection with claims incurred but not yet reported. Given our significant insurance-related exposure, there can be no assurance that a sharp increase in the number and/or severity of claims asserted against us will not have a material adverse effect on our future results of operations.

M) Income Taxes: Deferred tax assets and liabilities are recognized for the amount of taxes payable or deductible in future years as a result of differences between the tax bases of assets and liabilities and their reported amounts in the financial statements. We believe that future income will enable us to realize our deferred tax assets net of recorded valuation allowances relating to state net operating loss carry-forwards.

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. See Note 6— *Income Taxes,* for additional disclosure.

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

O) Redeemable Noncontrolling Interests and Noncontrolling Interest: Outside owners hold noncontrolling, minority ownership interests of: (i) approximately 28% in six acute care facilities (including a facility currently under construction) located in Las Vegas, Nevada; (ii) 20% in an acute care facility located in Washington, D.C.; (iii) approximately 11% in an acute care facility located in Laredo, Texas, and; (iv) 20% in a behavioral health care facility located in Philadelphia, Pennsylvania. The redeemable noncontrolling interest balances of $243 million as of December 31, 2015 and $240 million as of December 31, 2014, and the noncontrolling interest balances of $60 million as of December 31, 2015 and $55 million as of December 31, 2014, consist primarily of the third-party ownership interests in these hospitals.

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

P) Accumulated Other Comprehensive Income: The accumulated other comprehensive income ("AOCI") component of stockholders' equity includes: net unrealized gains and losses on effective cash flow hedges, foreign currency translation adjustments

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and the net minimum pension liability of a non-contributory defined benefit pension plan which covers employees at one of our subsidiaries. See Note 10, "Pension Plan" for additional disclosure regarding the defined benefit pension plan.

The amounts recognized in AOCI for the two years ended December 31, 2015 were as follows (in thousands):

	Net Unrealized Gains (Losses) on Effective Cash Flow Hedges	Foreign Currency Translation Adjustment	Minimum Pension Liability	Total AOCI
Balance, January 1, 2014, net of income tax	$ (14,170)	$ 0	$ (10,640)	$ (24,810)
2014 activity:				
Pretax amount	17,332	(2,431)	(14,270)	631
Income tax effect	(6,409)	0	5,356	(1,053)
Change, net of income tax	10,923	(2,431)	(8,914)	(422)
Balance, January 1, 2015, net of income tax	(3,247)	(2,431)	(19,554)	(25,232)
2015 activity:				
Pretax amount	4,634	(1,728)	2,177	5,083
Income tax effect	(2,163)	0	(817)	(2,980)
Change, net of income tax	2,471	(1,728)	1,360	2,103
Balance, December 31, 2015, net of income tax	$ (776)	$ (4,159)	$ (18,194)	$ (23,129)

Q) Accounting for Derivative Financial Investments and Hedging Activities and Foreign Currency Forward Exchange Contracts: We manage our ratio of fixed to floating rate debt with the objective of achieving a mix that management believes is appropriate. To manage this risk in a cost-effective manner, we, from time to time, enter into interest rate swap agreements in which we agree to exchange various combinations of fixed and/or variable interest rates based on agreed upon notional amounts.

We account for our derivative and hedging activities using the Financial Accounting Standard Board's ("FASB") guidance which requires all derivative instruments, including certain derivative instruments embedded in other contracts, to be carried at fair value on the balance sheet. For derivative transactions designated as hedges, we formally document all relationships between the hedging instrument and the related hedged item, as well as its risk-management objective and strategy for undertaking each hedge transaction.

Derivative instruments designated in a hedge relationship to mitigate exposure to variability in expected future cash flows, or other types of forecasted transactions, are considered cash flow hedges. Cash flow hedges are accounted for by recording the fair value of the derivative instrument on the balance sheet as either an asset or liability, with a corresponding amount recorded in accumulated other comprehensive income ("AOCI") within stockholders' equity. Amounts are reclassified from AOCI to the income statement in the period or periods the hedged transaction affects earnings.

We use interest rate derivatives in our cash flow hedge transactions. Such derivatives are designed to be highly effective in offsetting changes in the cash flows related to the hedged liability. For derivative instruments designated as cash flow hedges, the ineffective portion of the change in expected cash flows of the hedged item are recognized currently in the income statement.

Derivative instruments designated in a hedge relationship to mitigate exposure to changes in the fair value of an asset, liability, or firm commitment attributable to a particular risk, such as interest rate risk, are considered fair value hedges. Fair value hedges are accounted for by recording the changes in the fair value of both the derivative instrument and the hedged item in the income statement.

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

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. The cash flows from these contracts are reported as operating activities in the Consolidated Statements of Cash Flows. For the years ended December 31, 2015 and 2014, we recorded net favorable cash inflows of $22.9 million and $15.6 million, respectively, associated with these forward exchange contracts.

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R) Stock-Based Compensation: At December 31, 2015, we have a number of stock-based employee compensation plans. Pursuant to the FASB's guidance, we expense the grant-date fair value of stock options and other equity-based compensation pursuant to the straight-line method over the stated vesting period of the award using the Black-Scholes option pricing model.

The expense associated with share-based compensation arrangements is a non-cash charge. In the Consolidated Statements of Cash Flows, share-based compensation expense is an adjustment to reconcile net income to cash provided by operating activities. The applicable FASB guidance requires that cash flows resulting from tax deductions in excess of compensation cost recognized be classified as financing cash flows.

S) Earnings per Share: Basic earnings per share are based on the weighted average number of common shares outstanding during the year. Diluted earnings per share are based on the weighted average number of common shares outstanding during the year 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:

	Twelve Months Ended December 31,		
	2015	2014	2013
Basic and diluted:			
Net Income	$ 750,698	$ 604,996	$ 554,023
Less: Net income attributable to noncontrolling interest	(70,170)	(59,653)	(43,290)
Less: Net income attributable to unvested restricted share grants	(281)	(236)	(294)
Net income attributable to UHS—basic and diluted	$ 680,247	$ 545,107	$ 510,439
Basic earnings per share attributable to UHS:			
Weighted average number of common shares—basic	98,797	98,826	98,033
Total basic earnings per share	$ 6.89	$ 5.52	$ 5.21
Diluted earnings per share attributable to UHS:			
Weighted average number of common shares	98,797	98,826	98,033
Net effect of dilutive stock options and grants based on the treasury stock method	1,897	1,718	1,328
Weighted average number of common shares and equivalents—diluted	100,694	100,544	99,361
Total diluted earnings per share	$ 6.76	$ 5.42	$ 5.14

The "Net effect of dilutive stock options and grants based on the treasury stock method", for all years presented above, excludes certain outstanding stock options applicable to each year since the effect would have been anti-dilutive. The excluded weighted-average stock options totaled 765,000 during 2015, 2,250 during 2014, and 4,000 during 2013.

T) Fair Value of Financial Instruments: The fair values of our registered debt and investments are based on quoted market prices. The fair values of other long-term debt, including capital lease obligations, are estimated by discounting cash flows using period-end interest rates and market conditions for instruments with similar maturities and credit quality. The carrying amounts reported in the balance sheet for cash, accounts receivable, accounts payable, and short-term borrowings approximates their fair values due to the short-term nature of these instruments. Accordingly, these items have been excluded from the fair value disclosures included elsewhere in these notes to consolidated financial statements.

U) Use of Estimates: The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires us to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

V) Mergers and Acquisitions: The acquisition method of accounting for business combinations requires that the assets acquired and liabilities assumed be recorded at the date of acquisition at their respective fair values with limited exceptions. Fair value is defined as the exchange price that would be received for 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. Any excess of the purchase price (consideration transferred) over the estimated fair values of net assets acquired is recorded as goodwill. Transaction costs and costs to restructure the acquired company are expensed as incurred. The fair value of intangible assets, including Medicare Licenses, Certificates of Need, Tradenames and certain contracts, is based on significant judgments made by our management, and accordingly, for significant items we typically obtain assistance from third party valuation specialists.

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W) GPO Agreement/Minority Ownership Interest: During 2013, we entered into a new group purchasing organization agreement ("GPO") with Premier, Inc. ("Premier), a healthcare performance improvement alliance, and acquired a minority interest in the GPO 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, which were recorded as deferred income and included in liabilities on our consolidated balance sheet as of December 31, 2015 and 2014. The deferred income is being recognized, on a pro rata basis, as a reduction to our supplies expense over the expected life of the GPO agreement. Also in connection with this GPO agreement, we received shares of restricted stock in Premier which vest ratably over a seven-year period (2014 through 2020), contingent upon our continued participation and minority ownership interest in the GPO. We are recognizing the fair value of this restricted stock, as a reduction to our supplies expense, in our consolidated statements of income on a pro rata basis over the vesting period.

X) Provider Taxes: We incur health-care related taxes ("Provider Taxes") imposed by states in the form of a licensing fee, assessment or other mandatory payment which are related to: (i) healthcare items or services; (ii) the provision of, or the authority to provide, the health care items or services, or; (iii) the payment for the health care items or services. Such Provider Taxes are subject to various federal regulations that limit the scope and amount of the taxes that can be levied by states in order to secure federal matching funds as part of their respective state Medicaid programs. We derive a related Medicaid reimbursement benefit from assessed Provider Taxes in the form of Medicaid claims based payment increases and/or lump sum Medicaid supplemental payments. Under these programs, including the impact of Uncompensated Care and Upper Payment Limit programs, and the Texas Delivery System Reform Incentive program, we earned revenues (before Provider Taxes) of approximately $307 million during 2015, $295 million during 2014, and $213 million during 2013. These revenues were offset by Provider Taxes of approximately $137 million during 2015, $140 million during 2014, and $84 million during 2013, which are recorded in other operating expenses on the Consolidated Statements of Income as included herein. Prior to 2015, these Provider Taxes were recorded as a reduction to our net revenues. Accordingly, the Consolidated Statements of Income for 2014 and 2013 have been revised to reflect the current year presentation, resulting in an increase in net revenue and an increase in other operating expenses of $140 million during 2014 and $84 million during 2013. The aggregate net benefit from these programs was $170 million during 2015, $155 million during 2014, and $130 million during 2013. The aggregate net benefit pursuant to these programs is earned from multiple states and therefore no particular state's portion is individually material to our consolidated financial statements. In addition, under various disproportionate share hospital payment programs and the Nevada state plan amendment program, we earned revenues of $46 million in 2015, $59 million in 2014, and $54 million in 2013.

Y) Recent Accounting Standards:

In November, 2015, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2015-17, "Income Taxes (Topic 740): Balance Sheet Classification of Deferred Taxes", which eliminates the guidance in Topic 740, Income Taxes, that required an entity to separate deferred tax liabilities and assets between current and noncurrent amounts in a classified balance sheet. The amendments require that all deferred tax liabilities and assets of the same tax jurisdiction or a tax filing group, as well as any related valuation allowance, be offset and presented as a single noncurrent amount in a classified balance sheet. The amendments are effective for public business entities for annual fiscal years beginning after December 15, 2016. We do not expect the adoption of these amendments to have a material impact on our condensed consolidated financial statements.

In September 2015, the FASB issued ASU No. 2015-16, "Simplifying the Accounting for Measurement-Period Adjustments," which changes the reporting requirement for retrospective adjustments to provisional amounts in the measurement period. The amendments in this update require an entity to present separately on the face of the income statement or disclose in the notes, the portion of the amount recorded in current-period earnings by line item that would have been recorded in previous reporting periods if the adjustment to the provisional amounts had been recognized as of the acquisition date. The revised guidance is effective for annual fiscal periods beginning after December 15, 2015. We do not expect the adoption of this revised guidance to have a material impact on our condensed consolidated financial statements.

In May 2014, the FASB issued ASU 2014-09, "Revenue from Contracts with Customers", which provides guidance for revenue recognition. The standard's core principle is that a company will recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods or services. This ASU also requires additional disclosures. ASU 2014-09 is effective for annual reporting periods beginning after December 15, 2016; however, in July 2015, the FASB approved a one-year deferral of this standard, with a new effective date for fiscal years beginning after December 15, 2017. We are currently in the process of evaluating the impact of adoption of this ASU on our consolidated financial statements.

In August 2014, FASB issued ASU No. 2014-15, "Preparation of Financial Statements—Going Concern (Subtopic 205-40), Disclosure of Uncertainties about an Entity's Ability to Continue as a Going Concern" (ASU 2014-15). Continuation of a reporting entity as a going concern is presumed as the basis for preparing financial statements unless and until the entity's liquidation becomes imminent. Preparation of financial statements under this presumption is commonly referred to as the going concern basis of accounting. If and when an entity's liquidation becomes imminent, financial statements should be prepared under the liquidation basis of accounting in accordance with Subtopic 205-30, "Presentation of Financial Statements—Liquidation Basis of Accounting". Even

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when an entity's liquidation is not imminent, there may be conditions or events that raise substantial doubt about the entity's ability to continue as a going concern. In those situations, financial statements should continue to be prepared under the going concern basis of accounting, but the new criteria in ASU 2014-15 should be followed to determine whether to disclose information about the relevant conditions and events. The amendments in ASU 2014-15 are effective for the annual period ending after December 15, 2016, and for annual periods and interim periods thereafter. Early application is permitted. We will evaluate the going concern considerations in this ASU.

In April and August 2015, the FASB issued ASU No. 2015-03 and ASU No. 2015-15, "Interest- Imputation of Interest," respectively, to simplify the presentation of debt issuance costs. The standard requires debt issuance costs be presented in the balance sheet as a direct deduction from the carrying value of the debt liability. The FASB clarified that debt issuance costs related to line-of-credit arrangements can be presented as an asset and amortized over the term of the arrangement. The guidance is effective for annual fiscal periods beginning after December 15, 2015. We do not expect the adoption of this guidance to have a material impact on our condensed consolidated financial statements.

Z) Foreign Currency Translation: Assets and liabilities of our U.K. subsidiaries are denominated in pound sterling and translated into U.S. dollars at: (i) the rates of exchange at the balance sheet date, and; (ii) average rates of exchange prevailing during the year for revenues and expenses. The currency translation adjustments are reported as a component of accumulated other comprehensive income.

2) ACQUISITIONS AND DIVESTITURES

Year ended December 31, 2015:

2015 Acquisitions of Assets and Businesses:

During 2015 we spent $534 million to:

- acquire a 46-bed behavioral health care facility located in the U.K. (acquired during the first quarter);
- acquire Alpha Hospitals Holdings Limited consisting of four behavioral health care hospitals with 305 beds located in the U.K. (acquired during the third quarter);
- acquire Foundations Recovery Network, LLC consisting of 4 inpatient facilities (322 beds) as well as 8 outpatient centers (during the fourth quarter), and;
- various other businesses, a management contract and real property assets.

The aggregate net purchase price of the facilities was allocated to assets and liabilities based on their preliminary estimated fair values as follows:

	Amount (000s)
Working capital, net	$ (7,000)
Property & equipment	116,000
Goodwill	319,000
Other assets	128,000
Income tax assets, net of deferred tax liabilities	(22,000)
Cash paid in 2015 for acquisitions	$ 534,000

Goodwill of the facilities acquired is computed, pursuant to the residual method, by deducting the fair value of the acquired assets and liabilities from the total purchase price. The factors that contribute to the recognition of goodwill, which may also influence the purchase price, include the following for each of the acquired facilities: (i) the historical cash flows and income levels; (ii) the reputations in their respective markets; (iii) the nature of the respective operations, and; (iv) the future cash flows and income growth projections. The vast majority of the goodwill resulting from these transactions is not deductible for federal income tax purposes (see Note 6. Income Taxes).

Other assets includes an indefinite lived tradename for $124 million recorded in connection with the Foundations acquisition.

Included in our consolidated net revenues for the year ended December 31, 2015 was an aggregate of approximately $30 million representing the net revenues generated at the newly acquired facilities from their respective dates of acquisition through December

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31, 2015. The aggregate effect of the earnings generated by these facilities since the dates of acquisition, less the cost on the borrowings utilized to finance the acquisition, was not material to our 2015 net income attributable to UHS and net income attributable to UHS per diluted share.

Assuming the acquisitions occurred on January 1, 2015, our 2015 unaudited pro forma net revenues would have been approximately $9.17 billion and our unaudited pro forma net income attributable to UHS would have been approximately $690 million, or $6.85 per diluted share. Assuming the above-mentioned acquisitions occurred on January 1, 2014, our 2014 unaudited pro forma net revenues would have been approximately $8.35 billion and our unaudited pro forma net income attributable to UHS would have been approximately $545 million and $5.42 per diluted share.

2015 Divestiture of Assets and Businesses:

During 2015 we received $3 million in connection with the divestiture of a small operator of behavioral health care services.

Year ended December 31, 2014:

2014 Acquisitions of Assets and Businesses:

During 2014 we spent $431 million to:

- acquire the stock of Cygnet Health Care Limited ("Cygnet") which consists of 17 facilities located throughout the United Kingdom including 15 inpatient behavioral health hospitals and 2 nursing homes with a total of 723 beds (during the third quarter);
- acquire and fund the required capital reserves related to Prominence Health Plan, a commercial health insurer headquartered in Reno, Nevada (during the second quarter);
- acquire the Psychiatric Institute of Washington, a 124-bed behavioral health care facility and outpatient treatment center located in Washington, D.C. (during the second quarter);
- acquire the operations of Palo Verde Behavioral Health, a 48-bed behavioral health facility in Tucson, Arizona (during the first quarter);
- acquire the real property of The Bridgeway, a 103-bed behavioral health care facility located in North Little Rock, Arkansas, that was previously leased from Universal Health Realty Income Trust (during the fourth quarter);
- acquire the previously leased real property of Cygnet Hospital-Harrow, a 44-bed behavioral health care facility located in the U.K., the operations of which were acquired as part of our acquisition of Cygnet (during the fourth quarter), and;
- acquire physician practices.

The aggregate net purchase price of the facilities was allocated to assets and liabilities based on their preliminary estimated fair values as follows:

	Amount (000s)
Working capital, net	$ (41,000)
Property & equipment	174,000
Goodwill	250,000
Other assets	59,000
Income tax assets, net of deferred tax liabilities	4,000
Debt	(16,000)
Other	1,000
Cash paid in 2014 for acquisitions	$ 431,000

Goodwill of the facilities acquired is computed, pursuant to the residual method, by deducting the fair value of the acquired assets and liabilities from the total purchase price. The factors that contribute to the recognition of goodwill, which may also influence the purchase price, include the following for each of the acquired facilities: (i) the historical cash flows and income levels; (ii) the reputations in their respective markets; (iii) the nature of the respective operations, and; (iv) the future cash flows and income growth projections. The vast majority of the goodwill resulting from these transactions is not deductible for federal income tax purposes (see Note 6. Income Taxes).

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Included in our consolidated net revenues for the year ended December 31, 2014 was an aggregate of approximately $175 million representing the net revenues generated at the Cygnet facilities, the commercial health insurer located in Reno, Nevada and the 124-bed behavioral health care facility and outpatient treatment center located in Washington, D.C. from the respective dates of acquisition through December 31, 2014. The aggregate effect of the earnings generated by these facilities since the dates of acquisition, less the cost on the borrowings utilized to finance the acquisition, was not material to our 2014 net income attributable to UHS and net income attributable to UHS per diluted share.

Assuming the acquisitions occurred on January 1, 2014, our 2014 unaudited pro forma net revenues would have been approximately $8.28 billion and our unaudited pro forma net income attributable to UHS would have been approximately $558 million, or $5.55 per diluted share. Assuming the above-mentioned acquisitions occurred on January 1, 2013, our 2013 unaudited pro forma net revenues would have been approximately $7.62 billion and our unaudited pro forma net income attributable to UHS would have been approximately $522 million and $5.25 per diluted share.

2014 Divestiture of Assets and Businesses:

During 2014 we received $15 million in connection with the divestiture of a non-operating investment (during the first quarter) and the real property of a closed behavioral health facility (during the second quarter).

Year ended December 31, 2013:

2013 Acquisitions of Assets and Businesses:

During 2013, we spent an aggregate of $13 million for the purchase of real property located in Pennsylvania, Nevada and Arizona. The aggregate net purchase price of these properties was allocated to property and equipment on our consolidated balance sheet.

2013 Divestiture of Assets and Businesses:

During 2013, we received an aggregate of $37 million in connection with the divestiture of Peak Behavioral Health Services (sold during the second quarter of 2013) and certain other assets and real property including three previously closed behavioral health care facilities. As discussed below in *Discontinued Operations*, we agreed to sell Peak Behavioral Health Services as part of our agreement with the Federal Trade Commission in connection with our acquisition of Ascend Health Corporation ("Ascend") in October of 2012. The aggregate pre-tax gain on these divestitures was approximately $3 million and in included in our 2013 consolidated results of operations.

Discontinued Operations

There were no material divestitures during 2015 or 2014.

In connection with the receipt of antitrust clearance from the Federal Trade Commission ("FTC") in connection with our acquisition of Ascend Health Corporation in October of 2012, we agreed to certain conditions, including the divestiture of Peak Behavioral Health Services ("Peak"), a 104-bed behavioral health care facility located in Santa Teresa, New Mexico. The divestiture of Peak was completed during the second quarter of 2013 for total cash proceeds of approximately $24 million resulting in a pre-tax gain of approximately $3 million which is included in our 2013 consolidated financial statements.

The following table shows the results of operations for Peak, which was reflected as discontinued operations during our period of ownership during 2013 (amounts in thousands). Since the aggregate income from discontinued operations before income tax expense is not material to our consolidated financial statements, it is included as a reduction to other operating expenses.

	2013
Net revenues	$ 7,813
Income (loss) from discontinued operations, before income Taxes	932
Gain on divestiture	3,080
Income from discontinued operations, before income tax Expense	4,012
Income tax expense	(1,506)
Income from discontinued operations, net of income taxes	$ 2,506

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3) FINANCIAL INSTRUMENTS

Fair Value Hedges:

During 2015, 2014 and 2013, we had no fair value hedges outstanding.

Cash Flow Hedges:

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

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

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

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

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

During 2015, we entered into nine forward starting interest rate swaps whereby we pay a fixed rate on a total notional amount of $1.0 billion and receive one-month LIBOR. The average fixed rate payable on these swaps, which are scheduled to mature on April 15, 2019, is 1.31%. These interest rates swaps consist of:

- Four forward starting interest rate swaps, entered into during the second quarter of 2015, whereby we pay a fixed rate on a total notional amount of $500 million and receive one-month LIBOR. Each of the four swaps became effective on July 15, 2015 and are scheduled to mature on April 15, 2019. The average fixed rate payable on these swaps is 1.40%;
- Four forward starting interest rate swaps, entered into during the third quarter of 2015, whereby we pay a fixed rate on a total notional amount of $400 million and receive one-month LIBOR. One swap on a notional amount of $100 million became effective on July 15, 2015, two swaps on a total notional amount of $200 million became effective on September 15, 2015 and another swap on a notional amount of $100 million became effective on December 15, 2015. All of these swaps are scheduled to mature on April 15, 2019. The average fixed rate payable on these four swaps is 1.23%, and;
- One interest rate swap, entered into during the fourth quarter of 2015, whereby we pay a fixed rate on a total notional amount of $100 million and receive one-month LIBOR. The swap became effective on December 15, 2015 and is scheduled to mature on April 15, 2019. The fixed rate payable on this swap is 1.21%.

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We measure our interest rate swaps at fair value on a recurring basis. The fair value of our interest rate swaps is based on quotes from our counterparties. We consider those inputs to be "level 2" in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with derivative instruments and hedging activities. At December 31, 2015, the fair value of our interest rate swaps was a net liability of $1 million comprised of a $5 million asset which is included in other assets offset by a $6 million liability which is included in other current liabilities on the accompanying balance sheet. At December 31, 2014, the fair value of our interest rate swaps was a liability of $6 million, all of which is included in other current liabilities.

4) LONG-TERM DEBT

A summary of long-term debt follows:

	December 31,	
	2015	2014
	(amounts in thousands)	
Long-term debt:		
Notes payable and Mortgages payable (including obligations under capitalized leases of $24,900 in 2015 and $21,600 in 2014) and term loans with varying maturities through 2027; weighted average interest rates of 6.8% in 2015 and 6.4% in 2014 (see Note 7 regarding capitalized leases)	$ 27,513	$ 41,257
Revolving credit and on-demand credit facility	304,900	140,500
Term Loan A, net of unamortized discount of $1,593 in 2015 and $2,035 in 2014	1,717,940	1,761,872
Revenue bonds, interest at floating rates of 0.05% at December 31, 2014	—	5,300
Accounts receivable securitization program	400,000	330,000
3.75% Senior Secured Notes due 2019, net of unamortized discount of $155 in 2015 and $198 in 2014	299,845	299,802
4.75% Senior Secured Notes due 2022, net of unamortized discount of $177 in 2015 and $204 in 2014	299,823	299,796
7.125% Senior Secured Notes due 2016, including unamortized net premium of $4 in 2015 and $7 in 2014	400,004	400,007
Total debt	3,450,025	3,278,534
Less-Amounts due within one year	(62,722)	(68,319)
Long-term debt	$ 3,387,303	$ 3,210,215

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

- On August 7, 2014, we entered into a Fourth Amendment (the "Fourth Amendment") to our credit agreement dated as of November 15, 2010, as amended on March 15, 2011, September 21, 2012 and May 16, 2013, among UHS, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders ("Credit Agreement"). The Credit Agreement, as amended, which is scheduled to mature in August, 2019, consists of: (i) an $800 million revolving credit facility ($300 million of borrowings outstanding as of December 31, 2015), and; (ii) a $1.775 billion term loan A facility ($1.720 billion of borrowings outstanding as of December 31, 2015) which combined our previously outstanding term loan A and term loan A2 facilities which were scheduled to mature in 2016;
- Repaid $550 million of outstanding borrowings pursuant to our previously outstanding term loan B facility which was scheduled to mature in 2016;
- Increased the borrowing capacity on our existing accounts receivable securitization program ("Securitization") to $360 million from $275 million, effective August 1, 2014. In December, 2015, the Securitization was amended to increase the borrowing capacity to $400 million and extend the scheduled maturity date to December 21, 2018;
- Issued $300 million aggregate principal amount of 3.750% senior secured notes due in 2019 (see below for additional disclosure);
- Issued $300 million aggregate principal amount of 4.750% senior secured notes due in 2022 (see below for additional disclosure);
- Redeemed our previously outstanding $250 million, 7.00% senior unsecured notes due in 2018 on July 31, 2014 for an aggregate price equal to 104.56% of the principal amount.

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In connection with these transactions, our 2014 results of operations included a $36 million pre-tax charge incurred for the costs related to the extinguishment of debt. This charge consisted of the write-off of deferred charges ($20 million) and original issue discount on the extinguished debt ($5 million) as well as the make-whole premium paid ($11 million) for the early redemption of the $250 million, 7.00% senior unsecured notes.

Borrowings under the Credit Agreement bear interest at either (1) the ABR rate which is defined as the rate per annum equal to, at our election: the greatest of (a) the lender's prime rate, (b) the weighted average of the federal funds rate, plus 0.5% and (c) one month LIBOR rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.50% to 1.25% for revolving credit and term loan-A borrowings, or (2) the one, two, three or six month LIBOR rate (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.50% to 2.25% for revolving credit and term loan-A borrowings. As of December 31, 2015, the applicable margins were 0.50% for ABR-based loans and 1.50% for LIBOR-based loans under the revolving credit and term loan-A facilities.

As of December 31, 2015, we had $300 million of borrowings outstanding pursuant to the terms of our $800 million revolving credit facility and we had $461 million of available borrowing capacity, net of $5 million of outstanding borrowings pursuant to a short-term, on-demand credit facility and $34 million of outstanding letters of credit. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Credit Agreement is secured by certain assets of the Company (which generally excludes asset classes such as substantially all of the patient-related accounts receivable of our acute care hospitals, certain real estate assets and assets held in joint-ventures with third-parties) and our material subsidiaries and guaranteed by our material subsidiaries.

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

As discussed above, in December, 2015, our Securitization with a group of conduit lenders and liquidity banks was amended to increase the borrowing capacity to $400 million from $360 million and extend the scheduled maturity date to December 21, 2018. Substantially all of the patient-related accounts receivable of our acute care hospitals ("Receivables") serve as collateral for the outstanding borrowings. We have accounted for this Securitization as borrowings. We maintain effective control over the Receivables since, pursuant to the terms of the Securitization, the Receivables are sold from certain of our subsidiaries to special purpose entities that are wholly-owned by us. The Receivables, however, are owned by the special purpose entities, can be used only to satisfy the debts of the wholly-owned special purpose entities, and thus are not available to us except through our ownership interest in the special purpose entities. The wholly-owned special purpose entities use the Receivables to collateralize the loans obtained from the group of third-party conduit lenders and liquidity banks. The group of third-party conduit lenders and liquidity banks do not have recourse to us beyond the assets of the wholly-owned special purpose entities that securitize the loans. At December 31, 2015, we had $400 million of outstanding borrowings and no additional capacity pursuant to the terms of our accounts receivable securitization program.

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

On June 30, 2006, we issued $250 million of senior secured notes which have a 7.125% coupon rate and mature on June 30, 2016 (the "7.125% Notes"). Interest on the 7.125% Notes is payable semiannually in arrears on June 30th and December 30th of each year. In June, 2008, we issued an additional $150 million of 7.125% Notes which formed a single series with the original 7.125% Notes issued in June, 2006. Other than their date of issuance and initial price to the public, the terms of the 7.125% Notes issued in June, 2008 are identical to and trade interchangeably with, the 7.125% Notes which were originally issued in June, 2006. Since we have the ability and intent to refinance the 7.125% Notes on or before the scheduled maturity date (June 30, 2016) either through the issuance of new long-term notes, a new long-term debt facility, or utilizing funds borrowed pursuant to our revolving credit facility, the 7.125% Notes are classified as long-term on our Consolidated Balance Sheet as of December 31, 2015.

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

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registered in April, 2011. Interest on the Unsecured Note was payable semiannually in arrears on April 1st and October 1st of each year.

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

The average amounts outstanding during each of years 2015, 2014 and 2013 under the current and prior Credit Agreements, demand notes and accounts receivable securitization programs was $2.1 billion, $2.4 billion and $2.9 billion, respectively, with corresponding interest rates of 1.7%, 1.8% and 2.2%, respectively, including commitment and facility fees. The maximum amounts outstanding at any month-end were $2.3 billion in 2015, $2.7 billion in 2014 and $3.0 billion in 2013. The effective interest rate on our current and prior Credit Agreements, accounts receivable securitization programs, and demand notes, which includes the respective interest expense, commitment and facility fees, designated interest rate swaps expense and amortization of deferred financing costs and original issue discounts, was 2.4% in 2015, 3.1% in 2014 and 3.6% in 2013.

Our Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens and indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage and minimum interest coverage ratios. We are in compliance with all required covenants as of December 31, 2015.

At December 31, 2015, the carrying value and fair value of our debt were each approximately $3.5 billion. At December 31, 2014, the carrying value and fair value of our debt were each approximately $3.3 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.

The aggregate scheduled maturities of our total debt outstanding as of December 31, 2015 are as follows:

	(000s)
2016	$ 62,722
2017	91,254
2018	491,514
2019	2,486,965
2020	1,650
Later	315,920
Total	$ 3,450,025

5) COMMON STOCK

Dividends

Cash dividends of $0.40 per share ($39.5 million in the aggregate) were declared and paid during 2015, $0.30 per share ($29.7 million in the aggregate) were declared and paid during 2014, and $.20 per share ($19.6 million in the aggregate) were declared and paid during 2013. All classes of our common stock have similar economic rights.

Stock Repurchase Programs

In July, 2014, our Board of Directors authorized a stock repurchase program whereby, from time to time as conditions allow, we may spend up to $400 million to purchase shares of our Class B Common Stock on the open market at prevailing market prices or in negotiated private transactions. There is no expiration date for our stock repurchase programs.

The following schedule provides information related to our stock repurchase program for each of the three years ended December 31, 2015. During 2015, 1,326,207 shares ($166.2 million) were repurchased pursuant to the terms of our stock repurchase program and 493,296 shares ($58.0 million in the aggregate) were repurchased in connection with the income tax withholding obligations resulting from the exercise of stock options and the vesting of restricted stock grants. During 2014, 548,192 shares ($58.0 million in the aggregate) were repurchased pursuant to the terms of our stock repurchase program and 480,972 shares ($42.7 million in the aggregate) were repurchased in connection with income tax withholding obligations resulting from the exercise of stock options

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and the vesting of restricted stock grants. No shares were repurchased during 2013 pursuant to publicly announced stock repurchase programs and 427,170 shares ($27.2 million in the aggregate) were repurchased in connection with income tax withholding obligations resulting from the exercise of stock options and the vesting of restricted stock grants.

	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 pad per share for shares purchased as part of publicly announced program	Aggregate purchase price paid (in thousands)	Aggregate purchase price paid for shares purchased as part of publicly announced program	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)
Balance as of January 1, 2013									767,704	N/A
2013	—	427,170	—	N/A	—	N/A	$ 27,201	N/A	767,704	N/A
2014	400,000	1,029,164	767,704	N/A	548,192	$ 105.71	$100,749	$ 57,950	N/A	$342,050
2015	$ —	1,819,503	—	N/A	1,326,207	$ 125.34	$224,260	$166,222	N/A	$175,828
Total for three year period ended December 31, 2015	$400,000	3,275,837	767,704	N/A	1,874,399	$ 119.60	$352,210	$224,172		

Stock-based Compensation Plans

At December 31, 2015, we have a number of stock-based employee compensation plans. Pursuant to the FASB's guidance, we expense the grant-date fair value of stock options and other equity-based compensation pursuant to the straight-line method over the stated vesting period of the award using the Black-Scholes option-pricing model.

Pre-tax compensation costs of $38.0 million during 2015, $29.2 million during 2014 and $25.8 million during 2013 were recognized related to outstanding stock options. In addition, pre-tax compensation costs of $2.0 million during 2015, $1.9 million during 2014 and $2.0 million during 2013 were recognized related to amortization of restricted stock and discounts provided in connection with shares purchased pursuant to our 2005 Employee Stock Purchase Plan. As of December 31, 2015, there was approximately $67.7 million of unrecognized compensation cost related to unvested stock options and restricted stock which is expected to be recognized over the remaining average vesting period of 2.7 years.

The expense associated with stock-based compensation arrangements is a non-cash charge. In the 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 $40.0 million in 2015, $31.1 million in 2014 and $27.8 million in 2013. In accordance with ASC 718, excess income tax benefits related to stock-based compensation are classified as cash inflows from financing activities on the Consolidated Statement of Cash Flows. During 2015, 2014 and 2013 we generated $47.4 million, $33.9 million and $20.1 million, respectively, of excess income tax benefits related to stock based compensation which are reflected as cash inflows from financing activities in our Consolidated Statements of Cash Flows, as included herein.

In 2005, we adopted the 2005 Stock Incentive Plan which was amended in 2008, 2010 and 2015 (the "Stock Incentive Plan"). An aggregate of 29.5 million shares of Class B Common Stock has been reserved under the Stock Incentive Plan. During 2015, 2014 and 2013, stock options, net of cancellations, of approximately 2.9 million, 2.8 million and 2.6 million, respectively, were granted. The per option weighted-average grant-date fair value of options granted during 2015, 2014 and 2013 was $21.37, $17.23 and $13.33, respectively. Stock options to purchase Class B Common Stock have been granted to our officers, key employees and members of our Board of Directors. All stock options were granted with an exercise price equal to the fair market value on the date of the grant. Options are exercisable ratably over a four-year period beginning one year after the date of the grant. All outstanding options expire five years after the date of the grant. As of December 31, 2015, approximately 6.9 million shares of Class B Common Stock remain available for issuance pursuant to the Stock Incentive Plan.

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The fair value of each option grant was estimated on the date of grant using the Black-Scholes option-pricing model. The following weighted average assumptions were derived from averaging the number of options granted during the most recent five-year period. The weighted-average assumptions reflected below were based upon twenty-five option grants for the five-year period ending December 31, 2015, twenty-one option grants for the five-year period ending December 31, 2014 and eighteen option grants for the five-year period ended December 31, 2013.

Year Ended December 31,	2015	2014	2013
Volatility	33%	35%	36%
Interest rate	1%	1%	1%
Expected life (years)	3.4	3.4	3.6
Forfeiture rate	10%	10%	11%
Dividend yield	0.4%	0.4%	0.5%

The risk-free rate is based on the U.S. Treasury zero coupon four year yield in effect at the time of grant. The expected life of the stock options granted was estimated using the historical behavior of employees. Expected volatility was based on historical volatility for a period equal to the stock option's expected life. Expected dividend yield is based on our dividend yield at the time of grant.

The table below summarizes our stock option activity during each of the last three years:

Outstanding Options	Number of Shares	Average Option Price	Range (High-Low)
Balance, January 1, 2013	7,436,238	$ 36.31	$54.79-$16.22
Granted	2,889,750	$ 53.51	$79.79-$53.38
Exercised	(2,288,666)	$ 32.27	$54.79-$16.22
Cancelled	(416,364)	$ 43.93	$53.38-$16.22
Balance, January 1, 2014	7,620,958	$ 43.63	$79.79-$30.32
Granted	2,845,500	$ 78.65	$102.21-$78.17
Exercised	(2,277,469)	$ 38.50	$73.65-$30.32
Cancelled	(291,538)	$ 55.63	$78.17-$36.95
Balance, January 1, 2015	7,897,451	$ 57.29	$102.21-$36.95
Granted	3,039,350	$ 117.70	$142.43-$108.29
Exercised	(2,256,454)	$ 48.97	$102.21-$36.95
Cancelled	(280,164)	$ 83.63	$134.70-$36.95
Balance, December 31, 2015	8,400,183	$ 80.50	$142.43-$36.95
Outstanding options vested and exercisable as of December 31, 2015	1,671,216	$ 52.19	$102.21-$36.95

The following table provides information about unvested options for the year December 31, 2015:

	Shares	Weighted Average Grant Date Fair Value
Unvested options as of January 1, 2015	6,485,029	$ 14.36
Granted	3,039,350	$ 21.37
Vested	(2,515,248)	$ 13.38
Cancelled	(280,164)	$ 17.36
Unvested options as of December 31, 2015	6,728,967	$ 17.77

The following table provides information regarding all options outstanding at December 31, 2015:

	Options Outstanding	Options Exercisable
Number of options outstanding	8,400,183	1,671,216
Weighted average exercise price	$ 80.50	$ 52.19
Aggregate intrinsic value as of December 31, 2015	$328,564,543	$112,466,544
Weighted average remaining contractual life	3.0	1.9

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The total in-the-money value of all stock options exercised during the years ended December 31, 2015, 2014 and 2013 were $154.1 million, $112.5 million and $70.9 million, respectively.

The weighted average remaining contractual life for options outstanding and weighted average exercise price per share for exercisable options at December 31, 2015 were as follows:

Exercise Price	Options Outstanding Shares	Weighted Average Exercise Price Per Share	Weighted Average Remaining Contractual Life (in Years)	Exercisable Options Shares	Weighted Average Exercise Price Per Share	Expected to Vest Options (a) Shares	Weighted Average Exercise Price Per Share
$36.95 – $46.97	1,298,145	$ 37.13	1.0	717,517	$ 37.25	574,626	$ 36.97
$53.38 – $73.65	1,805,950	53.49	2.0	571,450	53.45	1,098,889	53.50
$78.17 – $96.98	2,321,238	78.31	3.2	380,249	78.25	1,295,612	78.34
$102.21 – $142.43	2,974,850	117.54	4.2	2,000	102.21	1,980,776	117.52
Total	8,400,183	$ 80.50	3.0	1,671,216	$ 52.19	4,949,903	$ 88.86

(a) Assumes a weighted average forfeiture rate of 9.95%.

In addition to the Stock Incentive Plan, we have the following stock incentive and purchase plans: (i) the 2010 Employees' Restricted Stock Purchase Plan, as amended in 2015, ("2010 Plan") which allows eligible participants to purchase shares of Class B Common Stock at par value, subject to certain restrictions, and; (ii) a 2005 Employee Stock Purchase Plan which allows eligible employees to purchase shares of Class B Common Stock at a ten percent discount. There were 17,789, 26,189 and 10,000 and shares of restricted stock granted pursuant to the 2010 Plan during 2015, 2014 and 2013, respectively, with various ratable vesting periods ranging up to five years from the date of grant. There were 68,213, 75,303 and 90,587 and shares issued pursuant to the Employee Stock Purchase Plan during 2015, 2014 and 2013, respectively.

We have reserved 2.8 million shares of Class B Common Stock for issuance under these various plans (excluding terminated plans and including a reserve reduction during 2015) and have issued approximately 1.3 million shares, net of cancellations, pursuant to the terms of these plans (excluding terminated plans) as of December 31, 2015. As of December 31, 2015, approximately 1.5 million shares of Class B Common Stock remain available for issuance pursuant to these various plans.

At December 31, 2015, 24,056,061 shares of Class B Common Stock were reserved for issuance upon conversion of shares of Class A, C and D Common Stock outstanding, for issuance upon exercise of options to purchase Class B Common Stock and for issuance of stock under other incentive plans. Class A, C and D Common Stock are convertible on a share for share basis into Class B Common Stock.

6) INCOME TAXES

Components of income tax expense/(benefit) are as follows (amounts in thousands):

	Year Ended December 31,		
	2015	2014	2013
Current			
Federal	$ 363,734	$ 248,172	$ 256,545
Foreign	3,151	4,167	1,655
State	38,987	23,224	28,490
	405,872	275,563	286,690
Deferred			
Federal	(15,912)	41,583	25,341
Foreign	5,545	—	—
State	(302)	7,525	3,278
	(10,669)	49,108	28,619
Total	$ 395,203	$ 324,671	$ 315,309

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Deferred taxes are required to be classified based on the financial statement classification of the related assets and liabilities which give rise to temporary differences. Deferred taxes result from temporary differences between the financial statement carrying amounts and the tax bases of assets and liabilities. The components of deferred taxes are as follows (dollar amounts in thousands):

	Year Ended December 31,	
	2015	2014
Deferred income tax assets:		
Self-insurance reserves	$ 88,401	$ 84,915
Compensation accruals	66,399	55,788
State and foreign net operating loss carryforwards and other state and foreign deferred tax assets	62,541	60,521
Other currently non-deductible accrued liabilities	17,213	16,739
Net pension liability—OCI only	10,929	11,746
Doubtful accounts and other reserves	29,616	18,428
Other combined items—OCI only	457	2,615
	275,556	250,752
Less: Valuation Allowance	(52,567)	(52,764)
Net deferred income tax assets:	222,989	197,988
Deferred income tax liabilities:		
Depreciable and amortizable assets	(400,809)	(362,674)
Other deferred tax liabilities	(2,960)	(2,963)
Net deferred income tax liabilities	$ (180,780)	$ (167,649)

Increases in deferred tax assets relating to foreign net operating loss carryforwards reflect the impact of deferred taxes recorded in conjunction with the acquisition of 5 additional behavioral health care facilities located in the U.K. during 2015. Increases in deferred tax liabilities relating to depreciable and separately identifiable intangible assets primarily reflect the impact of deferred taxes recorded in conjunction with the acquisition of Foundations Recovery Network, LLC ("Foundations").

The effective tax rates, as calculated by dividing the provision for income taxes by income before income taxes, were as follows for each of the years ended December 31, 2015, 2014 and 2013 (dollar amounts in thousands):

	2015	2014	2013
Provision for income taxes	$ 395,203	$ 324,671	$ 315,309
Income before income taxes	1,145,901	929,667	869,332
Effective tax rate	34.5%	34.9%	36.3%

Impacting the effective tax rates during 2015, 2014 and 2013 were favorable discrete tax items of approximately $1 million recorded during each year to adjust the estimated liabilities for uncertain tax positions.

The foreign provision for income taxes is based on foreign pre-tax earnings of $41 million in 2015, $15 million in 2014 and $6 million in 2013. Our consolidated financial statements provide for any related tax liability on undistributed earnings that we do not intend to be indefinitely reinvested outside the U.S. Certain of our undistributed international earnings intended to be indefinitely reinvested in operations outside the U.S. have a statutory rate of 20.25%. As of December 31, 2015, U.S. income taxes have not been provided on a cumulative total of $53 million of such earnings. The amount of unrecognizable deferred tax liability related to these temporary differences is estimated to be approximately $8 million.

A reconciliation between the federal statutory rate and the effective tax rate is as follows:

	Year Ended December 31,		
	2015	2014	2013
Federal statutory rate	35.0%	35.0%	35.0%
State taxes, net of federal income tax benefit	2.3%	2.3%	2.5%
Divestiture gain	0.0%	0.0%	0.3%
Other items	-0.6%	0.0%	0.4%
Impact of income attributable to noncontrolling interests	-2.2%	-2.4%	-1.9%
Effective tax rate	34.5%	34.9%	36.3%

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Included in "Other current assets" on our Consolidated Balance Sheet are prepaid federal, foreign, and state income taxes amounting to approximately $42 million and $17 million as of December 31, 2015 and 2014, respectively.

The net deferred tax assets and liabilities are comprised as follows (amounts in thousands):

	Year Ended December 31,	
	2015	2014
Current deferred taxes		
Assets	$ 135,120	$ 115,870
Liabilities	—	(1,305)
Total deferred taxes-current	135,120	114,565
Noncurrent deferred taxes		
Assets	92,383	85,792
Liabilities	(408,283)	(368,006)
Total deferred taxes-noncurrent	(315,900)	(282,214)
Total deferred tax liabilities	$ (180,780)	$ (167,649)

The assets and liabilities classified as current relate primarily to the allowance for uncollectible patient accounts, compensation-related accruals and the current portion of the temporary differences related to self- insurance reserves. At December 31, 2015, state net operating loss carryforwards (expiring in years 2016 through 2035), and credit carryforwards available to offset future taxable income approximated $1.08 billion representing approximately $53 million in deferred state tax benefit (net of the federal benefit). At December 31, 2015, there were foreign net operating loss carryforwards of approximately $20 million expiring through 2023 representing approximately $5 million in deferred foreign tax benefit.

A valuation allowance is required when it is more likely than not that some portion of the deferred tax assets will not be realized. Based on available evidence, it is more likely than not that certain of our state tax benefits will not be realized. Therefore, valuation allowances of approximately $51 million and $50 million have been reflected as of December 31, 2015 and 2014, respectively. During 2015, the valuation allowance on these state tax benefits increased by $1 million due to additional net operating losses incurred. In addition, valuation allowances of approximately $2 million and $3 million have been reflected as of December 31, 2015 and 2014 related to foreign net operating losses. There were no significant increases in valuation allowances as a result of the acquisition of Foundations.

We adopted the provisions of Accounting for Uncertainty in Income Taxes effective January 1, 2007. During 2015 and 2014, the estimated liabilities for uncertain tax positions (including accrued interest and penalties) were increased less than $1 million due to tax positions taken in the current and prior years. During 2015, the estimated liabilities for uncertain tax positions (including accrued interest and penalties) were reduced due to the lapse of the statute of limitations resulting in a net income tax benefit of approximately $1 million. The balance at each of December 31, 2015 and 2014, if subsequently recognized, that would favorably affect the effective tax rate and the provision for income taxes is approximately $1 million and $2 million, respectively.

We recognize accrued interest and penalties associated with uncertain tax positions as part of the tax provision. As of December 31, 2015 and 2014, we have accrued interest and penalties of less than $1 million as of each date. The U.S. federal statute of limitations remains open for the 2012 and subsequent years. Foreign and U.S. state and local jurisdictions have statutes of limitations generally ranging for 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 unrecognized 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.

The tabular reconciliation of unrecognized tax benefits for the years ended December 31, 2015, 2014 and 2013 is as follows (amounts in thousands).

	As of December 31,		
	2015	2014	2013
Balance at January 1,	$ 2,402	$ 3,369	$ 6,824
Additions based on tax positions related to the current year	50	50	50
Additions for tax positions of prior years	111	195	283
Reductions for tax positions of prior years	(524)	(1,212)	(1,260)
Settlements	(57)	—	(2,528)
Balance at December 31,	$ 1,982	$ 2,402	$ 3,369

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7) LEASE COMMITMENTS

Three of our hospital facilities are held under operating leases with Universal Health Realty Income Trust with terms expiring in 2016 (see Note 9 for additional disclosure). We also lease the real property of certain facilities (see Item 2. Properties for additional disclosure).

A summary of property under capital lease follows (amounts in thousands):

	As of December 31,	
	2015	2014
Land, buildings and equipment	$ 45,665	$ 40,782
Less: accumulated amortization	(27,169)	(27,556)
	$ 18,496	$ 13,226

Future minimum rental payments under lease commitments with a term of more than one year as of December 31, 2015, are as follows (amounts in thousands):

Year	Capital Leases	Operating Leases
	(000s)	
2016	$ 3,849	$ 64,049
2017	3,929	42,989
2018	4,061	35,447
2019	3,996	29,721
2020	3,339	21,487
Later years	22,055	137,692
Total minimum rental	$ 41,229	$ 331,385
Less: Amount representing interest	(16,316)	
Present value of minimum rental commitments	24,913	
Less: Current portion of capital lease obligations	(1,557)	
Long-term portion of capital lease obligations	$ 23,356	

During 2015 and 2014, we assumed capital lease obligations of approximately $7 million and $16 million, respectively, in connection with the leases on certain real estate assets. We incurred no capital lease obligations during 2013. In the ordinary course of business, our facilities routinely lease equipment pursuant to new lease arrangements that will likely result in future lease and rental expense in excess of amounts indicated above.

8) COMMITMENTS AND CONTINGENCIES

Professional and General Liability, Workers' Compensation Liability and Property Insurance

Professional and General Liability and Workers Compensation Liability:

Effective November, 2010, excluding certain subsidiaries acquired since 2010 as discussed below, the vast majority of our subsidiaries are self-insured for professional and general liability exposure up to $10 million and $3 million per occurrence, respectively. Our subsidiaries were provided with several excess policies through commercial insurance carriers which provide for coverage in excess of the applicable per occurrence self-insured retention (either $3 million or $10 million) up to $250 million per occurrence and in the aggregate for claims incurred in 2015 and 2014 and up to $200 million per occurrence and in the aggregate for claims incurred from 2011 through 2013. We remain liable for 10% of the claims paid pursuant to the commercially insured coverage in excess of $10 million up to $60 million per occurrence and in the aggregate.

Since our acquisition of Psychiatric Solutions, Inc. ("PSI") in November, 2010, the former PSI subsidiaries are self-insured for professional and general liability exposure up to $3 million per occurrence. The nine behavioral health facilities acquired from Ascend Health Corporation ("Ascend") in October, 2012 have general and professional liability policies through commercial insurance carriers which provide for up to $12 million of aggregate coverage, subject to a $100,000 per occurrence deductible. The 21 behavioral health care facilities located in the U.K. have policies through a commercial insurance carrier located in the U. K. that provides for £10 million of professional liability coverage and £25 million of general liability coverage. The facilities acquired from PSI, Ascend and the facilities located in the U.K., like our other facilities, are also provided excess coverage through commercial insurance carriers for coverage in excess of the underlying commercial policy limitations, as mentioned above.

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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 December 31, 2015, the total accrual for our professional and general liability claims was $204 million, of which $48 million is included in current liabilities. As of December 31, 2014, the total accrual for our professional and general liability claims was $193 million, of which $51 million is included in current liabilities.

Below is a schedule showing the changes in our general and professional liability and workers' compensation reserves during the three years ended December 31, 2015 (amount in thousands):

	General and Professional Liability	Workers' Compensation	Total
Balance at January 1, 2013	$ 278,599	$ 65,954	$ 344,553
Plus: Accrued insurance expense, net of commercial premiums paid (a)	(35,182)	31,361	(3,821)
Less: Payments made in settlement of self-insured claims	(37,127)	(33,517)	(70,644)
Balance at January 1, 2014	206,290	63,798	270,088
Plus: Accrued insurance expense, net of commercial premiums paid (a)	22,601	36,675	59,276
Less: Payments made in settlement of self-insured claims	(35,987)	(33,659)	(69,646)
Balance at January 1, 2015	192,904	66,814	259,718
Plus: Accrued insurance expense, net of commercial premiums paid	58,460	32,435	90,895
Less: Payments made in settlement of self-insured claims	(47,391)	(31,746)	(79,137)
Balance at December 31, 2015	$ 203,973	$ 67,503	$ 271,476

(a) General and professional liability amounts are net of adjustments recorded during 2014 and 2013, as discussed below.

The adjustments recorded during 2015 to our prior year reserves for professional and general liability claims did not have a material impact on our 2015 consolidated results of operations. We recorded reductions to our professional and general liability self-insurance reserves (relating to prior years) amounting to $20 million during 2014, and $81 million during 2013. The favorable change recorded during 2014 resulted from favorable changes in our estimated future claims payments pursuant to a reserve analysis. The favorable change in our estimated future claims payments recorded during 2013, relating to years prior to 2013, were due primarily to: (i) an increased weighting given to company-specific metrics (to 100% from 75%), and decreased general industry metrics (to 0% from 25%), related to projected incidents per exposure, historical claims experience and loss development factors; (ii) historical data which measured the realized favorable impact of medical malpractice tort reform experienced in several states in which we operate, and; (iii) a decrease in claims related to certain higher risk specialties (such as obstetrical) due to a continuation of the company-wide patient safety initiative undertaken during the last several years. As the number of our facilities and our patient volumes have increased, thereby providing for a statistically significant data group, and taking into consideration our long-history of company-specific risk management programs and claims experience, our reserve analyses have included a greater emphasis on our historical professional and general liability experience which has developed favorably as compared to general industry trends.

As of December 31, 2015, the total accrual for our workers' compensation liability claims was $68 million, of which $34 million is included in current liabilities. As of December 31, 2014, the total accrual for our workers' compensation liability claims was $67 million, of which $32 million is included in current liabilities. The adjustments recorded during the last three years to our prior year reserves for workers' compensation claims did not have a material impact on our consolidated results of operations for the years ended December 31, 2015, 2014 or 2013.

Although we are unable to predict whether or not our future financial statements will include adjustments to our prior year reserves for self-insured general and professional and workers' compensation claims, given the relatively unpredictable nature of the 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.

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Property Insurance:

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

Legal Proceedings

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

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

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

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

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

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

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

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

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

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

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

In December, 2015, we were notified by the DOJ Civil Division that the civil investigation also includes Arbour Hospital, Arbour-Fuller Hospital, Pembroke Hospital and Westwood Lodge located in Massachusetts. To date, these facilities have not received any requests for documentation or other information.

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

In December, 2015, we were advised that the DOJ opened an investigation involving the El Paso Behavioral Health System in El Paso, Texas. The DOJ is investigating potential Stark law violations relating to arrangements between the facility and physician(s) at the facility. These agreements were entered into before we acquired the facility as a part of our acquisition of Ascend Health Corporation in October, 2012. To our knowledge, this matter is not a part of the omnibus investigation referenced above. At present, we are uncertain as to potential liability and/or financial exposure, if any, which may be associated with this matter.

In January, 2016, we were notified that the Department of Justice opened an investigation of the South Texas Health System of a potential False Claim Act case regarding compensation paid to cardiologists pursuant to employment agreements entered into in 2005. At present, we are uncertain as to potential liability and/or financial exposure, if any, which may be associated with this matter.

Regulatory Matters:

On July 23, 2015, Timberlawn Mental Health System ("Timberlawn") received notification from CMS of its intent to terminate Timberlawn's Medicare provider agreement effective August 7, 2015. This notification resulted from surveys conducted which alleged that Timberlawn was out of compliance with conditions of participation required for participation in the Medicare/Medicaid program. We filed a request for expedited administrative appeal with the U.S. Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, seeking review and reversal of the termination action. In conjunction with the administrative appeal, we filed litigation in the U.S District Court for the Northern District of Texas seeking a temporary restraining order and preliminary injunction to have the termination stayed pending the conclusion of the administrative appeal. The trial court denied Timberlawn's request for a temporary restraining order and dismissed the case. Timberlawn's provider agreement was terminated effective August 14, 2015. In September, 2015 Timberlawn reached an agreement with CMS relative to its reapplication to the Medicare/Medicaid program. In exchange, Timberlawn agreed to dismiss its administrative appeal as well as not to pursue an appeal of the decision of the trial court. During this time, Timberlawn has remained open. In December, 2015, Timberlawn received notice from the Texas Department of State Health Services of its intent to revoke Timberlawn's license and impose an administrative penalty. We have appealed and are contesting the proposed revocation and fine. In January, 2016, Timberlawn submitted its application for re-enrollment into the Medicare/Medicaid program. Although the operating results of Timberlawn did not have a material impact on our consolidated results of operations or financial condition for the years ended December 31, 2015 or 2014, the termination of Timberlawn's provider agreement has had a material adverse effect on the facility's results of operations and financial condition.

During the second quarter of 2015, Texoma Medical Center ("Texoma"), which includes TMC Behavioral Health Center, entered into a Systems Improvement Agreement ("SIA") with CMS. The SIA abated a termination action from CMS following surveys which identified alleged failures to comply with conditions of participation primarily involving Texoma's behavioral health operations. The terms of the SIA required Texoma to engage independent consultants/experts approved by CMS to analyze and

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develop implementation plans at Texoma to meet Medicare conditions of participation. At the conclusion of the SIA, CMS will conduct a full certification survey to determine if Texoma is in substantial compliance with the Medicare conditions of participation. The term of agreement is set to conclude October 2, 2016 unless the terms of the agreement are further extended. During the term of the SIA, Texoma remains eligible to receive reimbursements from Medicare and Medicaid for services rendered to Medicare and Medicaid beneficiaries.

Other Matters:

In late September, 2015, many hospitals in Pennsylvania, including seven of our behavioral health care hospitals located in the state, received letters from the Pennsylvania Department of Public Welfare ("DPW") demanding repayment of allegedly excess Medicaid Disproportionate Share Hospital payments ("DSH") for the federal fiscal year 2011 ("FFY2011") amounting to approximately $4 million in the aggregate. We have filed administrative appeals for all of our facilities contesting the recoupment efforts since we believe DPW's calculation methodology is inaccurate and conflicts with applicable federal and state laws and regulations. DPW has agreed to postpone the recoupment of the state's share of the DSH payments until all hospital appeals are resolved. DPW also extended the deadline to recoup the federal share (2011 federal share is 55%) until April 30, 2016. However, if DPW is ultimately successful in its demand related to FFY2011, it could take similar action with regards to FFY2012 through FFY2014. Due to a change in the Pennsylvania Medicaid State Plan and implementation of a CMS-approved Medicaid Section 1115 Waiver, we do not believe the methodology applied by DPW to FFY2011 is applicable to reimbursements received for Medicaid services provided after January 1, 2015 by our behavioral health care facilities located in Pennsylvania. We can provide no assurance that we will ultimately be successful in our legal and administrative appeals related to DPW'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.

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

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

Department of Justice Investigation of Friends Hospital:

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

Department of Justice Investigation of Riveredge Hospital:

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

General:

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

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Criminal Division of the DOJ, announced that all qui tam cases will be shared with their Division to determine if a parallel criminal investigation should be opened. The 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 Affordable Care Act has added additional obligations on healthcare providers to report and refund overpayments by government healthcare programs and authorizes the suspension of Medicare and Medicaid payments "pending an investigation of a credible allegation of fraud." We monitor our business and have developed an ethics and compliance program with respect to these complex laws, rules and regulations. Although we believe our policies, procedures and practices comply with government regulations, there is no assurance that we will not be faced with the sanctions referenced above which include fines, penalties and/or substantial damages, repayment obligations, payment suspensions, licensure revocation, and expulsion from government healthcare programs. Even if we were to ultimately prevail in any action brought against us or our facilities or in responding to any inquiry, such action or inquiry could have a material adverse effect on us.

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

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

In addition to our long-term debt obligations as discussed in Note 4. Long-Term Debt and our operating lease obligations as discussed in Note 7. Lease Commitments, we have various other contractual commitments outstanding as of December 31, 2015 as follows: (i) other combined estimated future purchase obligations of $171 million related to a long-term contract with third-parties consisting primarily of certain revenue cycle data processing services for our acute care facilities ($70 million), expected future costs to be paid to a third-party vendor in connection with the purchase, implementation and on-going operation of an electronic health records application for each of our acute care facilities ($100 million) and estimated minimum liabilities for physician commitments expected to be paid in the future ($1 million); (ii) estimated construction commitment of $110 million made to a third-party for construction of a new acute care hospital located in Henderson, Nevada; (iii) combined estimated future payments of $242 million related to our non-contributory, defined benefit pension plan ($224 million consisting of estimated payments through 2089) and other retirement plan liabilities ($18 million), and; (iv) accrued and unpaid estimated claims expense incurred in connection with our commercial health insurers and self-insured employee benefit plans ($68 million).

9) RELATIONSHIP WITH UNIVERSAL HEALTH REALTY INCOME TRUST AND OTHER RELATED PARTY TRANSACTIONS

Relationship with Universal Health Realty Income Trust:

At December 31, 2015, we held approximately 5.9% 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. In December, 2015, the advisory agreement was renewed by the Trust for 2016 pursuant to the same terms in place during each of the last three years. During 2015, 2014 and 2013, the advisory fee was computed at 0.70% of the Trust's average invested real estate assets. In addition, certain of our officers and directors are also officers and/or directors of the Trust. Management believes that it has the ability to exercise significant influence over the Trust, therefore we account for our investment in the Trust using the equity method of accounting. We earned an advisory fee from the Trust, which is included in net

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revenues in the accompanying consolidated statements of income, of approximately $2.8 million during 2015, $2.5 million during 2014 and $2.4 million during 2013.

Our pre-tax share of income from the Trust was $1.4. million during 2015, $3.2 million during 2014 and $842,000 during 2013, and is included in net revenues in the accompanying consolidated statements of income for each year. Included in our share of the Trust's income was approximately$500,000 in 2015, and $2.3 million in 2014, related to our share gains on various transactions recorded by the Trust.

The carrying value of our investment in the Trust was $8.7 million and $9.3 million at December 31, 2015 and 2014, respectively, and is included in other assets in the accompanying consolidated balance sheets. The market value of our investment in the Trust was $39.4 million at December 31, 2015 and $37.9 million at December 31, 2014, based on the closing price of the Trust's stock on the respective dates.

Total rent expense under the operating leases on the three hospital facilities with the Trust during 2015 was $15.6 million. Total rent expense under the operating leases on the four hospital facilities with the Trust during 2014 and 2013 (as discussed below) was $16.8 million and $16.4 million, respectively. In addition, certain of our subsidiaries are tenants in several medical office buildings owned by the Trust or by limited liability companies in which the Trust holds 100% of the ownership interest.

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

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

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

The table below details the renewal options and terms for each of our three hospital facilities leased from the Trust:

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

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

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

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Other Related Party Transactions:

In December, 2010, our Board of Directors approved the Company's entering into supplemental life insurance plans and agreements on the lives of our chief executive officer ("CEO") and his wife. As a result of these agreements, based on actuarial tables and other assumptions, during the life expectancies of the insureds, we would pay approximately $25 million in premiums, and certain trusts owned by our chief executive officer, would pay approximately $8 million in premiums. Based on the projected premiums mentioned above, and assuming the policies remain in effect until the death of the insureds, we will be entitled to receive death benefit proceeds of no less than $33 million representing the $25 million of aggregate premiums paid by us as well as the $8 million of aggregate premiums paid by the trusts. In connection with these policies, we paid approximately $1.3 million in premium payments , during each of 2015, 2014 and 2013. These agreements did not have a material effect on our consolidated financial statements or results of operations during 2015, 2014 or 2013.

In August, 2015, Marc D. Miller, our President 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 vest ratably over a seven-year period (2014 through 2020), contingent upon our continued participation and minority ownership interest in the GPO. See Note 1 to the Consolidated Financial Statements-*Business and Summary of Significant Accounting Policies, W) GPO Agreement/Minority Ownership Interest* for additional disclosure related to this agreement.

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

10) PENSION PLAN

We maintain contributory and non-contributory retirement plans for eligible employees. Our contributions to the contributory plan amounted to $40.7 million, $35.7 million and $29.9 million in 2015, 2014 and 2013, respectively. The non-contributory plan is a defined benefit pension plan which covers employees of one of our subsidiaries. The benefits are based on years of service and the employee's highest compensation for any five years of employment. Our funding policy is to contribute annually at least the minimum amount that should be funded in accordance with the provisions of ERISA.

The following table shows the reconciliation of the defined benefit pension plan as of December 31, 2015 and 2014:

	2015	2014
	(000s)	
Change in plan assets:		
Fair value of plan assets at beginning of year	$ 116,697	$ 106,469
Actual return (loss) on plan assets	(3,223)	16,470
Benefits paid	(6,086)	(5,605)
Administrative expenses	(549)	(637)
Fair value of plan assets at end of year	$ 106,839	$ 116,697
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 127,342	$ 103,558
Service cost	1,051	966
Interest cost	4,912	4,986
Benefits paid	(6,086)	(5,605)
Actuarial (gain) loss	(9,039)	23,437
Benefit obligation at end of year	$ 118,180	$ 127,342
Amounts recognized in the Consolidated Balance Sheet:		
Other non-current liabilities	11,341	10,645
Total amounts recognized at end of year	$ 11,341	$ 10,645

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	2015	2014	2013
Components of net periodic cost (benefit)			
Service cost	$ 1,051	$ 966	$ 1,060
Interest cost	4,912	4,985	4,528
Expected return on plan assets	(6,254)	(7,772)	(7,601)
Recognized actuarial loss	3,164	1,107	3,305
Net periodic cost	$ 2,873	$ (714)	$ 1,292

	2015	2014
Measurement Dates		
Benefit obligations	12/31/2015	12/31/2014
Fair value of plan assets	12/31/2015	12/31/2014

	2015	2014
Weighted average assumptions as of December 31		
Discount rate	4.34%	3.95%
Rate of compensation increase	4.00%	4.00%

	2015	2014	2013
Weighted-average assumptions for net periodic benefit cost calculations			
Discount rate	3.95%	4.95%	4.05%
Expected long-term rate of return on plan assets	5.50%	7.50%	7.50%
Rate of compensation increase	4.00%	4.00%	4.00%

The accumulated benefit obligation was $117.7 million and $126.4 million as of December 31, 2015 and 2014, respectively. As of December 31, 2015, the accumulated benefit obligation exceeded the fair value of plan assets by $10.9 million. As of December 31, 2014, the accumulated benefit obligation exceeded the fair value of plan assets by $9.7 million.

We estimate that there will be a $3.1 million net loss amortized from accumulated other comprehensive income during 2016.

The market values of our pension plan assets at December 31, 2015 and December 31, 2014 by asset category are as follows:

December 31, 2015	Total	Level 1	Level 2	Level 3
Equities:				
U.S. Large Cap	$ 8,520	$ —	$ 8,520	$ —
U.S. Mid Cap	2,613	—	2,613	—
U.S. Small Cap	2,649	—	2,649	—
International Developed	6,406	—	6,406	—
Emerging Markets	4,114	—	4,114	—
Fixed income:				
Core Fixed Income	23,782	—	23,782	—
Long Duration Fixed Income	55,931	—	55,931	—
Real Estate:				
REIT Fund	2,212	—	2,212	—
Cash/Currency:				
Cash Equivalents	612	—	612	—
Total market value	$ 106,839	$ —	$ 106,839	$ —

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December 31, 2014	Total	Level 1	Level 2	Level 3
Equities:				
U.S. Large Cap	$ 9,212	$ —	$ 9,212	$ —
U.S. Mid Cap	2,852	—	2,852	—
U.S. Small Cap	2,626	—	2,626	—
International Developed	6,181	—	6,181	—
Emerging Markets	4,139	—	4,139	—
Fixed income:				
Core Fixed Income	27,062	—	27,062	—
Long Duration Fixed Income	61,718	—	61,718	—
Real Estate:				
REIT Fund	2,395	—	2,395	—
Cash/Currency:				
Cash Equivalents	512	—	512	—
Total market value	$ 116,697	$ —	$ 116,697	$ —

To develop the expected long-term rate of return on plan assets assumption, we considered the historical returns and the future expectations for returns for each asset class, as well as the target asset allocation of the pension portfolio.

The following table shows expected benefit payments for the years ended December 31, 2015 through 2025 for our defined pension plan. There will be benefit payments under this plan beyond 2025.

Estimated Future Benefit Payments (000s)	
2016	$ 6,086
2017	6,343
2018	6,563
2019	6,753
2020	6,900
2021-2025	35,657
Total	$ 68,302

	2015	2014
Plan Assets		
Asset Category		
Equity securities	23%	21%
Fixed income securities	75%	76%
Other	2%	3%
Total	100%	100%

Investment Policy, Guidelines and Objectives have been established for the defined benefit pension plan. The investment policy is in keeping with the fiduciary requirements under existing federal laws and managed in accordance with the Prudent Investor Rule. Total portfolio risk is regularly evaluated and compared to that of the plan's policy target allocation and judged on a relative basis over a market cycle. The following asset allocation policy and ranges have been established in accordance with the overall risk and return objectives of the portfolio:

	As of 12/31/2015	Permitted Range
Total Equity	23%	10-30%
Total Fixed Income	75%	70-90%
Other	2%	0-10%

In accordance with the investment policy, the portfolio will invest in high quality, large and small capitalization companies traded on national exchanges, and investment grade securities. The investment managers will not write or buy options for speculative purposes; securities may not be margined or sold short. The manager may employ futures or options for the purpose of hedging exposure, and will not purchase unregistered sectors, private placements, partnerships or commodities.

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11) SEGMENT REPORTING

Our reportable operating segments consist of acute care hospital services and behavioral health care services. The "Other" segment column below includes centralized services including information services, purchasing, reimbursement, accounting, taxation, legal, advertising, design and construction and patient accounting as well as the operating results for our other operating entities including outpatient surgery and radiation centers. The chief operating decision making group for our acute care hospital services and behavioral health care services is comprised of our Chief Executive Officer, the President 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 this Annual Report on Form 10-K for the year ended December 31, 2015. 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, with the non-directly allocated overhead expenses allocated based upon each segment's respective percentage of total facility-based operating expenses.

2015	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Dollar amounts in thousands)			
Gross inpatient revenues	$16,847,944	$ 7,456,397	$ —	$24,304,341
Gross outpatient revenues	$ 9,604,952	$ 839,884	$ 15,794	$10,460,630
Total net revenues	$ 4,632,564	$ 4,400,335	$ 10,552	$ 9,043,451
Income (loss) before allocation of corporate overhead and income taxes	$ 519,630	$ 1,021,823	$ (395,552)	$ 1,145,901
Allocation of corporate overhead	$ (197,699)	$ (117,203)	$ 314,902	$ 0
Income (loss) after allocation of corporate overhead and before income taxes	$ 321,931	$ 904,620	$ (80,650)	$ 1,145,901
Total assets	$ 3,413,879	$ 5,867,088	$ 353,146	$ 9,634,113

2014	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Dollar amounts in thousands)			
Gross inpatient revenues	$14,943,102	$ 6,689,753	—	$21,632,855
Gross outpatient revenues	$ 8,147,031	$ 784,309	$ 34,238	$ 8,965,578
Total net revenues	$ 4,178,103	$ 4,012,216	$ 14,769	$ 8,205,088
Income (loss) before allocation of corporate overhead and income taxes	$ 465,328	$ 944,068	$ (479,729)	$ 929,667
Allocation of corporate overhead	$ (178,781)	$ (98,811)	$ 277,592	$ 0
Income (loss) after allocation of corporate overhead and before income taxes	$ 286,547	$ 845,257	$ (202,137)	$ 929,667
Total assets	$ 3,362,870	$ 5,286,960	$ 324,613	$ 8,974,443

2013	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Dollar amounts in thousands)			
Gross inpatient revenues	$13,469,269	$ 6,294,046	—	$19,763,315
Gross outpatient revenues	$ 6,828,307	$ 744,510	$ 40,460	$ 7,613,277
Total net revenues	$ 3,602,874	$ 3,725,513	$ 39,486	$ 7,367,873
Income (loss) before allocation of corporate overhead and income taxes	$ 342,191	$ 895,869	$ (368,728)	$ 869,332
Allocation of corporate overhead	$ (184,444)	$ (89,447)	$ 273,891	$ 0
Income (loss) after allocation of corporate overhead and before income taxes	$ 157,747	$ 806,422	$ (94,837)	$ 869,332
Total assets	$ 3,125,626	$ 4,966,182	$ 219,915	$ 8,311,723

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12) QUARTERLY RESULTS (unaudited)

The following tables summarize the quarterly financial data for the two years ended December 31, 2015 and 2014:

2015	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Total
	(amounts in thousands, except per share amounts)				
Net revenues	$ 2,225,353	$ 2,275,204	$ 2,227,655	$ 2,315,239	$ 9,043,451
Net income	$ 194,323	$ 201,404	$ 163,654	$ 191,317	$ 750,698
Less: Net income attributable to noncontrolling interests	$ 20,024	$ 19,211	$ 13,367	$ 17,568	$ 70,170
Net income attributable to UHS	$ 174,299	$ 182,193	$ 150,287	$ 173,749	$ 680,528
Earnings per share attributable to UHS-Basic:					
Total basic earnings per share	$ 1.76	$ 1.84	$ 1.52	$ 1.76	$ 6.89
Earnings per share attributable to UHS-Diluted:					
Total diluted earnings per share	$ 1.73	$ 1.80	$ 1.48	$ 1.74	$ 6.76

The 2015 quarterly financial data presented above includes the following:

First Quarter:

- an unfavorable $8.3 million pre-tax impact ($5.3 million, or $.05 per diluted share, net of taxes) recorded in connection with the implementation of EHR applications;

Second Quarter:

- an unfavorable $6.9 million pre-tax impact ($4.4 million, or $.05 per diluted share, net of taxes) recorded in connection with the implementation of EHR applications.

Third Quarter:

- an unfavorable $8.0 million pre-tax impact ($5.0 million, or $.05 per diluted share, net of taxes) recorded in connection with the implementation of EHR applications;

Fourth Quarter:

- a favorable $4.9 million pre-tax impact ($3.1 million, or $.03 per diluted share, net of taxes) recorded in connection with the implementation of EHR applications;

2014	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Total
	(amounts in thousands, except per share amounts)				
Net revenues	$ 1,938,314	$ 2,051,766	$ 2,038,717	$ 2,176,291	$ 8,205,088
Net income	$ 151,852	$ 166,614	$ 96,038	$ 190,492	$ 604,996
Less: Net income attributable to noncontrolling interests	$ 13,774	$ 14,943	$ 13,241	$ 17,695	$ 59,653
Net income attributable to UHS	$ 138,078	$ 151,671	$ 82,797	$ 172,797	$ 545,343
Earnings per share attributable to UHS-Basic:					
Total basic earnings per share	$ 1.40	$ 1.53	$ 0.84	$ 1.75	$ 5.52
Earnings per share attributable to UHS-Diluted:					
Total diluted earnings per share	$ 1.38	$ 1.51	$ 0.82	$ 1.71	$ 5.42

The 2014 quarterly financial data presented above includes the following:

First Quarter:

- an unfavorable $8.9 million pre-tax impact ($4.9 million, or $.05 per diluted share, net of taxes) recorded in connection with the implementation of EHR applications;
- a favorable $10.1 million pre-tax impact ($6.3 million, or $0.07 per diluted share, net of taxes) resulting from the gain realized on the sale of a non-operating investment.

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Second Quarter:

- an unfavorable $7.1 million pre-tax impact ($3.9 million, or $.04 per diluted share, net of taxes) recorded in connection with the implementation of EHR applications.

Third Quarter:

- an unfavorable $7.9 million pre-tax impact ($4.5 million, or $.04 per diluted share, net of taxes) recorded in connection with the implementation of EHR applications;
- an unfavorable $36.2 million pre-tax impact ($22.7 million, or $0.23 per diluted share, net of taxes) recorded in connection with the costs related to extinguishment of debt resulting primarily from the early redemption of our previously outstanding $250 million, 7.00% senior unsecured notes that were scheduled to mature in 2018 and the repayment of $550 million of borrowings pursuant to the terms of our previously outstanding Term Loan B facility which was scheduled to mature in 2016;
- an unfavorable $44.0 million pre-tax impact ($27.6 million, or $0.27 per diluted share, net of taxes) incurred in connection with the previously disclosed $65 million settlement of the Garden City matter. This matter was a shareholder class action lawsuit filed in 2009 against PSI and certain of its former officers alleging their violations of federal securities laws and we assumed the defense and liability of this matter as a result of our acquisition of PSI in 2010. This charge is net of approximately $17 million of commercial insurance recoveries that we were entitled to and a previously recorded estimated reserve;

Fourth Quarter:

- a favorable $13.8 million pre-tax impact ($8.6 million, or $.08 per diluted share, net of taxes) recorded in connection with the implementation of EHR applications;
- A favorable $19.7 million pre-tax impact reduction ($11.7 million, or $.12 per diluted share, net of taxes) to our professional and general liability self-insurance reserves relating to years prior to 2014, as discussed in *Self-Insured/Other Insurance Risks.*

13) SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION

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

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

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

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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF INCOME
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2015
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net revenues before provision for doubtful accounts	$ 0	$ 6,798,664	$ 3,018,364	$ (32,304)	$ 9,784,724
Less: Provision for doubtful accounts	0	481,294	259,979	0	741,273
Net revenues	0	6,317,370	2,758,385	(32,304)	9,043,451
Operating charges:					
Salaries, wages and benefits	0	3,014,296	1,198,091	0	4,212,387
Other operating expenses	0	1,459,607	690,341	(30,143)	2,119,805
Supplies expense	0	583,644	390,444	0	974,088
Depreciation and amortization	0	280,985	117,633	0	398,618
Lease and rental expense	0	58,394	38,740	(2,161)	94,973
Electronic health records incentive income	0	(12,232)	(3,583)	0	(15,815)
	0	5,384,694	2,431,666	(32,304)	7,784,056
Income from operations	0	932,676	326,719	0	1,259,395
Interest expense	107,665	4,695	1,134	0	113,494
Interest (income) expense, affiliate	0	86,494	(86,494)	0	0
Equity in net income of consolidated affiliates	(746,984)	(215,119)	0	962,103	0
Income before income taxes	639,319	1,056,606	412,079	(962,103)	1,145,901
Provision for income taxes	(41,209)	354,611	81,801	0	395,203
Net income	680,528	701,995	330,278	(962,103)	750,698
Less: Income attributable to noncontrolling interests	0	0	70,170	0	70,170
Net income attributable to UHS	$ 680,528	$ 701,995	$ 260,108	$ (962,103)	$ 680,528

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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF INCOME
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2014
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net revenues before provision for doubtful accounts	$ 0	$ 6,225,997	$ 2,707,294	$ (29,220)	$ 8,904,071
Less: Provision for doubtful accounts	0	471,181	227,802	0	698,983
Net revenues	0	5,754,816	2,479,492	(29,220)	8,205,088
Operating charges:					
Salaries, wages and benefits	0	2,757,738	1,087,723	0	3,845,461
Other operating expenses	0	1,342,745	607,098	(27,100)	1,922,743
Supplies expense	0	546,578	349,115	0	895,693
Depreciation and amortization	0	269,490	106,134	0	375,624
Lease and rental expense	0	58,619	37,494	(2,120)	93,993
Electronic health records incentive income	0	(19,480)	(8,422)	0	(27,902)
Costs related to extinguishment of debt	36,171	0	0	0	36,171
	36,171	4,955,690	2,179,142	(29,220)	7,141,783
Income from operations	(36,171)	799,126	300,350	0	1,063,305
Interest expense	127,528	4,516	1,594	0	133,638
Interest (income) expense, affiliate	0	88,246	(88,246)	0	0
Equity in net income of consolidated affiliates	(646,386)	(184,385)	0	830,771	0
Income before income taxes	482,687	890,749	387,002	(830,771)	929,667
Provision for income taxes	(62,656)	305,320	82,007	0	324,671
Net income	545,343	585,429	304,995	(830,771)	604,996
Less: Income attributable to noncontrolling interests	0	0	59,653	0	59,653
Net income attributable to UHS	$ 545,343	$ 585,429	$ 245,342	$ (830,771)	$ 545,343

SUPPLEMENTAL #1
June 29, 2016
12:31 pm

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF INCOME
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2013
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net revenues before provision for doubtful accounts	$ 0	$ 5,734,385	$ 2,789,348	$ (28,644)	$ 8,495,089
Less: Provision for doubtful accounts	0	657,106	470,110	0	1,127,216
Net revenues	0	5,077,279	2,319,238	(28,644)	7,367,873
Operating charges:					
Salaries, wages and benefits	0	2,573,205	1,031,415	0	3,604,620
Other operating expenses	0	1,047,856	531,747	(26,808)	1,552,795
Supplies expense	0	510,078	311,011	0	821,089
Depreciation and amortization	0	236,958	100,214	0	337,172
Lease and rental expense	0	62,518	37,076	(1,836)	97,758
Electronic health records incentive income	0	(43,027)	(17,997)	0	(61,024)
	0	4,387,588	1,993,466	(28,644)	6,352,410
Income from operations	0	689,691	325,772	0	1,015,463
Interest expense	139,793	3,365	2,973	0	146,131
Interest (income) expense, affiliate	0	84,640	(84,640)	0	0
Equity in net income of consolidated affiliates	(597,020)	(141,004)	0	738,024	0
Income before income taxes	457,227	742,690	407,439	(738,024)	869,332
Provision for income taxes	(53,506)	262,346	106,469	0	315,309
Net income	510,733	480,344	300,970	(738,024)	554,023
Less: Income attributable to noncontrolling interests	0	0	43,290	0	43,290
Net income attributable to UHS	$ 510,733	$ 480,344	$ 257,680	$ (738,024)	$ 510,733

SUPPLEMENTAL #1

June 29, 2016
12:31 pm

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2015

(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net income	$ 680,528	$ 701,995	$ 330,278	$ (962,103)	$ 750,698
Other comprehensive income (loss):					
Unrealized derivative gains on cash flow hedges	4,970	0	0	0	4,970
Amortization of terminated hedge	(336)	0	0	0	(336)
Minimum pension liability	2,177	2,177	0	(2,177)	2,177
Foreign currency translation adjustment	(1,728)	(1,728)	0	1,728	(1,728)
Other comprehensive income before tax	5,083	449	0	(449)	5,083
Income tax expense related to items of other comprehensive income	2,980	817	0	(817)	2,980
Total other comprehensive income, net of tax	2,103	(368)	0	368	2,103
Comprehensive income	682,631	701,627	330,278	(961,735)	752,801
Less: Comprehensive income attributable to noncontrolling interests	0	0	70,170	0	70,170
Comprehensive income attributable to UHS	$ 682,631	$ 701,627	$ 260,108	$ (961,735)	$ 682,631

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2014

(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net income	$ 545,343	$ 585,429	$ 304,995	$ (830,771)	$ 604,996
Other comprehensive income (loss):					
Unrealized derivative gains on cash flow hedges	17,668	0	0	0	17,668
Amortization of terminated hedge	(336)	0	0	0	(336)
Minimum pension liability	(14,270)	(14,270)	0	14,270	(14,270)
Foreign currency translation adjustment	(2,431)	(2,431)	0	2,431	(2,431)
Other comprehensive income before tax	631	(16,701)	0	16,701	631
Income tax expense related to items of other comprehensive income	1,053	(5,356)	0	5,356	1,053
Total other comprehensive income, net of tax	(422)	(11,345)	0	11,345	(422)
Comprehensive income	544,921	574,084	304,995	(819,426)	604,574
Less: Comprehensive income attributable to noncontrolling interests	0	0	59,653	0	59,653
Comprehensive income attributable to UHS	$ 544,921	$ 574,084	$ 245,342	$ (819,426)	$ 544,921

SUPPLEMENTAL #1
June 29, 2016
12:31 pm

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2013
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net income	$ 510,733	$ 480,344	$ 300,970	$ (738,024)	$ 554,023
Other comprehensive income (loss):					
Unrealized derivative gains on cash flow hedges	16,963	0	0	0	16,963
Amortization of terminated hedge	(336)	0	0	0	(336)
Minimum pension liability	14,657	14,657	0	(14,657)	14,657
Other comprehensive income before tax	31,284	14,657	0	(14,657)	31,284
Income tax expense related to items of other comprehensive income	11,940	5,670	0	(5,670)	11,940
Total other comprehensive income, net of tax	19,344	8,987	0	(8,987)	19,344
Comprehensive income	530,077	489,331	300,970	(747,011)	573,367
Less: Comprehensive income attributable to noncontrolling interests	0	0	43,290	0	43,290
Comprehensive income attributable to UHS	$ 530,077	$ 489,331	$ 257,680	$ (747,011)	$ 530,077

SUPPLEMENTAL #1

June 29, 2016
12:31 pm

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING BALANCE SHEET
AS OF DECEMBER 31, 2015
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Assets					
Current assets:					
Cash and cash equivalents	$ 0	$ 47,192	$ 14,036	$ 0	$ 61,228
Accounts receivable, net	0	918,699	383,730	0	1,302,429
Supplies	0	72,499	43,538	0	116,037
Deferred income taxes	132,975	2,145	0	0	135,120
Other current assets	0	89,973	13,517	0	103,490
Total current assets	132,975	1,130,508	454,821	0	1,718,304
Investments in subsidiaries	7,760,156	1,876,415	0	(9,636,571)	0
Intercompany receivable	80,764	0	747,709	(828,473)	0
Intercompany note receivable	0	0	1,242,937	(1,242,937)	0
Property and equipment	0	4,722,050	1,808,519	0	6,530,569
Less: accumulated depreciation	0	(1,845,746)	(848,845)	0	(2,694,591)
	0	2,876,304	959,674	0	3,835,978
Other assets:					
Goodwill	0	3,070,061	526,053	0	3,596,114
Deferred charges	25,877	5,530	3,950	0	35,357
Other	14,251	394,998	39,111	0	448,360
	$ 8,014,023	$ 9,353,816	$ 3,974,255	$(11,707,981)	$ 9,634,113
Liabilities and Stockholders' Equity					
Current liabilities:					
Current maturities of long-term debt	$ 60,368	$ 1,223	$ 1,131	$ 0	$ 62,722
Accounts payable and accrued liabilities	19,996	744,137	269,564	0	1,033,697
Federal and state taxes	3,987	0	0	0	3,987
Total current liabilities	84,351	745,360	270,695	0	1,100,406
Intercompany payable	0	828,473	0	(828,473)	0
Intercompany note payable	0	1,242,937	0	(1,242,937)	0
Other noncurrent liabilities	1,982	206,287	70,565	0	278,834
Long-term debt	3,362,143	16,790	8,370	0	3,387,303
Deferred income taxes	315,900	0	0	0	315,900
Redeemable noncontrolling interests	0	0	242,509	0	242,509
Equity:					
UHS common stockholders' equity	4,249,647	6,313,969	3,322,602	(9,636,571)	4,249,647
Noncontrolling interest	0	0	59,514	0	59,514
Total equity	4,249,647	6,313,969	3,382,116	(9,636,571)	4,309,161
	$ 8,014,023	$ 9,353,816	$ 3,974,255	$(11,707,981)	$ 9,634,113

SUPPLEMENTAL #1

June 29, 2016
12:31 pm

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

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

SUPPLEMENTAL #1
June 29, 2016
12:31 pm

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2015
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net cash (used in) provided by operating activities	$ (21,287)	$ 655,439	$ 386,746	$ 0	$ 1,020,898
Cash Flows from Investing Activities:					
Property and equipment additions, net of disposals	0	(209,355)	(169,966)	0	(379,321)
Acquisition of property and businesses		(513,382)	(20,273)		(533,655)
Proceeds received from sale of assets and businesses	0	647	2,744	0	3,391
Increase in insurance subsidiary investments	0	(3,300)	0	0	(3,300)
Net cash used in investing activities	0	(725,390)	(187,495)	0	(912,885)
Cash Flows from Financing Activities:					
Reduction of long-term debt	(42,133)	(3,459)	(22,574)	0	(68,166)
Additional borrowings	234,400	0	0	0	234,400
Financing costs	(515)	0	0	0	(515)
Repurchase of common shares	(209,782)	0	0	0	(209,782)
Dividends paid	(39,532)	0	0	0	(39,532)
Issuance of common stock	8,441	0	0	0	8,441
Excess income tax benefits related to stock-based compensation	47,364	0	0	0	47,364
Profit distributions to noncontrolling interests	0	0	(62,220)	0	(62,220)
Proceeds received from sale/leaseback of real property	0	0	12,765	0	12,765
Changes in intercompany balances with affiliates, net	23,044	100,427	(123,471)	0	0
Net cash provided by (used in) financing activities	21,287	96,968	(195,500)	0	(77,245)
Effect of exchange rate changes on cash and cash equivalents	0	(1,609)	0	0	(1,609)
Increase in cash and cash equivalents	0	25,408	3,751	0	29,159
Cash and cash equivalents, beginning of period	0	21,784	10,285	0	32,069
Cash and cash equivalents, end of period	$ 0	$ 47,192	$ 14,036	$ 0	$ 61,228

SUPPLEMENTAL #1
June 29, 2016
12:31 pm

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2014
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net cash provided by operating activities	$ 18,579	$ 687,101	$ 330,196	$ 0	$ 1,035,876
Cash Flows from Investing Activities:					
Property and equipment additions, net of disposals	0	(230,102)	(161,048)	0	(391,150)
Acquisition of property and businesses	0	(422,081)	(9,305)	0	(431,386)
Proceeds received from sale of assets and businesses	0	11,450	3,728	0	15,178
Costs incurred for purchase and implementation of electronic health records application	0	(13,488)	0	0	(13,488)
Increase in insurance subsidiary investments	0	(12,000)	0	0	(12,000)
Net cash used in investing activities	0	(666,221)	(166,625)	0	(832,846)
Cash Flows from Financing Activities:					
Reduction of long-term debt	(866,748)	(867)	(11,514)	0	(879,129)
Additional borrowings	830,000	0	0	0	830,000
Financing costs	(14,976)	0	0	0	(14,976)
Repurchase of common shares	(100,749)	0	0	0	(100,749)
Dividends paid	(29,665)	0	0	0	(29,665)
Issuance of common stock	6,863	0	0	0	6,863
Excess income tax benefits related to stock-based compensation	33,912	0	0	0	33,912
Profit distributions to noncontrolling interests	0	0	(33,680)	0	(33,680)
Changes in intercompany balances with affiliates, net	122,784	(5,444)	(117,340)	0	0
Net cash used in financing activities	(18,579)	(6,311)	(162,534)	0	(187,424)
Effect of exchange rate changes on cash and cash equivalents	0	(775)	0	0	(775)
Increase in cash and cash equivalents	0	13,794	1,037	0	14,831
Cash and cash equivalents, beginning of period	0	7,990	9,248	0	17,238
Cash and cash equivalents, end of period	$ 0	$ 21,784	$ 10,285	$ 0	$ 32,069

SUPPLEMENTAL #1

June 29, 2016
12:31 pm

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2015
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net cash provided by operating activities	$ 17,946	$ 587,083	$ 279,212	$ 0	$ 884,241
Cash Flows from Investing Activities:					
Property and equipment additions, net of disposals	0	(269,419)	(89,074)	0	(358,493)
Acquisition of property and businesses	0	(8,094)	(4,542)	0	(12,636)
Proceeds received from sale of assets and businesses	0	7,916	29,566	0	37,482
Costs incurred for purchase and implementation of electronic health records application	0	(49,811)	0	0	(49,811)
Net cash used in investing activities	0	(319,408)	(64,050)	0	(383,458)
Cash Flows from Financing Activities:					
Reduction of long-term debt	(429,996)	(109)	(10,119)	0	(440,224)
Additional borrowings	15,761	0	0	0	15,761
Financing costs	(231)	0	0	0	(231)
Repurchase of common shares	(27,201)	0	0	0	(27,201)
Dividends paid	(19,621)	0	0	0	(19,621)
Issuance of common stock	5,708	0	0	0	5,708
Excess income tax benefits related to stock-based compensation	20,121	0	0	0	20,121
Profit distributions to noncontrolling interests	0	0	(61,329)	0	(61,329)
Changes in intercompany balances with affiliates, net	417,513	(271,525)	(145,988)	0	0
Net cash used in financing activities	(17,946)	(271,634)	(217,436)	0	(507,016)
Decrease in cash and cash equivalents	0	(3,959)	(2,274)	0	(6,233)
Cash and cash equivalents, beginning of period	0	11,949	11,522	0	23,471
Cash and cash equivalents, end of period	$ 0	$ 7,990	$ 9,248	$ 0	$ 17,238

SUPPLEMENTAL #1
June 29, 2016
12:31 pm

SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS

(amounts in thousands)

Allowance for Doubtful Accounts Receivable:	Balance at beginning of period	Charges to costs and expenses	Acquisitions of business	Write-off of uncollectible accounts	Balance at end of period
Year ended December 31, 2015	$ 324,648	$ 741,273	$ -	$ (667,124)	$ 398,797
Year ended December 31, 2014	$ 395,035	$ 698,983	$ 506	$ (769,876)	$ 324,648
Year ended December 31, 2013	$ 311,387	$ 1,127,216	$ -	$ (1,043,568)	$ 395,035

Valuation Allowance for Deferred Tax Assets:	Balance at beginning of period	Charges to costs and expenses	Acquisitions of business	Write-offs	Balance at end of period
Year ended December 31, 2015	$ 52,764	$ (197)	$ -	$ -	$ 52,567
Year ended December 31, 2014	$ 46,841	$ 5,923	$ -	$ -	$ 52,764
Year ended December 31, 2013	$ 44,511	$ 2,330	$ -	$ -	$ 46,841

Supplemental #2
-ORIGINAL-

Keystone Memphis, LLC
d/b/a Compass
Intervention Center

CN1606-025

SUPPLEMENTAL #2
July 19, 2016
11:45 am

TRAUGER & TUKE
ATTORNEYS AT LAW
THE SOUTHERN TURF BUILDING
222 FOURTH AVENUE NORTH
NASHVILLE, TENNESSEE 37219-2117
TELEPHONE (615) 256-8585
TELECOPIER (615) 256-7444

July 19, 2016

By hand delivery

Melanie M. Hill
Executive Director
Tennessee Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: Keystone Memphis, LLC, a limited liability company, d/b/a Compass Intervention Center Certificate of Need to establish a children's psychiatric hospital

Dear Ms. Hill:

This letter transmits the supplemental response and four copies to the referenced certificate of need application. Also enclosed is the affidavit. Please date stamp two copies and return them to me in the enclosed envelope.

The contact person for this application is Jeremy Pitzer, Chief Executive Officer, Compass Intervention Center. His office telephone number is (901) 758-2002.

As always, thank you for your courtesies.

Very truly yours,

Byron R. Trauger

Enclosures

cc: Jeremy Pitzer, Chief Executive Officer, Compass Intervention Center
Paul W. Ambrosius, Esq.

SUPPLEMENTAL #2
July 19, 2016
11:45 am

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Shelby

NAME OF FACILITY: Compass Intervention Center

I, Jeremy Pitzer, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

CEO
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 15th day of July, 2016, witness my hand at office in the County of Shelby, State of Tennessee.

Terri Sweet
NOTARY PUBLIC

My commission expires 10/5/19, _____.

HF-0043

Revised 7/02

TERRI SWEET
STATE OF TENNESSEE NOTARY PUBLIC
SHELBY COUNTY
MY COMMISSION EXPIRES 10-5-2019

SUPPLEMENTAL #2

July 19, 2016
11:45 am

1. **Section A, Applicant Profile Item 5**

   It is noted the management fee paid to UHS of Delaware, Inc. by Compass in 2015 was $330,480 and will be $439,560 in 2016. However, please clarify the reason the fee will not be applied to this proposed project and why it is not allocated in the Projected Data Chart. Please note any revised management fee allocation in the Projected Data Chart will impact other financial calculation responses in the application.

   The fee is unrelated to the project in that it is variable annually, and determined by the total allocation and number of facilities under management. Future allocations are not impacted by the proposed project; the fee allocated in future years will not change based upon the proposed project being approved or not.

2. **Section A, Applicant Profile Item 9**

   The first row in the bed complement data chart is incorrect. Please revise and submit.

   The first column of the Bed Complement Data Chart has been corrected. Please see the replacement on the following page.

SUPPLEMENTAL #2
July 19, 2016
11:45 am

9. Bed Complement Data

Please indicate current and proposed distribution and certification of facility beds.

		Current Beds Licensed	Current Beds *CON	Staffed Beds	Beds Proposed	TOTAL Beds at Completion
A.	Medical					
B.	Surgical					
C.	Long-Term Care Hospital					
D.	Obstetrical					
E.	ICU/CCU					
F.	Neonatal					
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child/Adolescent Psychiatric	0	0	0	48	48
K.	Rehabilitation					
L.	Nursing Facility (non-Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P.	ICF/MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency	30	0	30	0	30
S.	Swing Beds					
T.	Mental Health Residential Treatment	78	0	62	0	78
U.	Residential Hospice					
	TOTAL	108	0	92	48	156

*CON-Beds approved but not yet in service

10. Medicare Provider Number Will apply for Medicare number and validation

Certification Type Hospital

11. Medicaid Provider Number 5441352

Certification Type Current--Psychiatric Residential Treatment Facility, will apply as Hospital

12. If this is a new facility, will certification be sought for Medicare and/or Medicaid? See A.12 next page

13. *Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.* Will this project involve the treatment of TennCare participants? YES **If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted *or plans to contract.*** See A.13 next page

8 Replacement page 3 of original application

3. **Section B. I. Project Description**

According to the 2014 Lakeside JAR the hospital staffs 25 psychiatric beds licensed as child and adolescent beds and 24 geriatric beds. The Joint Annual Report does not add up to 49 staffed child and adolescent beds. Please clarify if the Lakeside 2014 Joint Annual Report correctly listed the total of staffed child and adolescent beds.

Thank you for identifying this discrepancy. We read the number wrong in the JAR report, and the 24 beds were allocated to geriatric not pediatric. It has been verified that Lakeside is licensed for 55 child and adolescent inpatient beds, with an average occupancy of 92% on those beds in 2014, and the current capacity to staff all of those beds.

4. **Section B, Project Description, Item II.A**

The square footage and cost per square footage chart is noted. However, please verify calculations for the "Proposed Final Cost/SF" columns (3) and provide a "Total Proposed Final Cost/SF" amount rather than the current total dollar amount ($7,679,726) for the last column.

Please see the corrected square footage chart on the following page.

5. **Section C. (Economic Feasibility) Item 3**

The applicant notes the proposed construction costs ($272.58 SF) are consistent with the published Hospital Construction Costs for years 2013-2015. However, the $272.58 SF costs is not listed on the Square footage and cost per square footage chart. Please clarify. Also, in your response please indicate if the construction costs are "total" costs per square foot.

The square footage chart has been corrected (following page) and the $272.58 cost per sq. /ft. is listed in the appropriate box on the chart, and represents the "Total Proposed Final cost/SF."

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
Clinical/Support Spaces						13,153	13,153			
Admissions						1,250	1,250			
Shell Space (future PHP)						988	988			
Connector Corridor						1,331	1,331			
New Gymnasium						3,138	3,138			
Dining to Servery Renovation					707		707			
Gym to Dining Renovation					1,543		1,543			
B. Unit/Depart. GSF Sub-Total					2,250	19,860	22,110			
C. Mechanical/ Electrical GSF						330	330			
D. Circulation /Structure GSF						5,734	5,734			
E. Total GSF					2,250	25,924	28,174	$228.13	$276.44	$272.58

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JULY 19, 2010
11:45 am

SUPPLEMENTAL #2

6. **Section C, Economic Feasibility, Item 5**

Your response is noted. Please verify the following table identifying the project's gross charge, average deduction from operating revenue, and average net charge per patient day. Please divide the total patient days in Year One of the Projected Data Chart into the total gross charges, deductions from operating revenue total, and total net charges to calculate the charges. Please provide a replacement page 36.

	Year One	Year Two
Average Gross Charge (Gross charges/total days)	$2,027.00	$2,019.61
Average Deduction (Total Deductions/total days)	$1,505.11	$1,321.42
Average net Charge Total Net Operating Revenue/total days)	$521.88	$698.17

The data in the table above has been verified and is correct. The initial calculations that were submitted used only inpatient gross revenue, and the above corrected numbers utilize total gross revenue. Please also see following replacement page 36.

C. Economic Feasibility. 5. Please identify the projects average gross charge, average deduction from operating revenue, and average net charge.

	Year One	Year Two
Average Gross Charge (Gross charges/total days)	$2,027.00	$2,019.61
Average Deduction (Total Deductions/total days)	$1,505.11	$1,321.42
Average net Charge Total Net Operating Revenue/total days)	$521.88	$698.17

C. Economic Feasibility. 6.

A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Current charges will not be impacted by the implementation of this proposal. While charges are periodically adjusted from time to time, there are no plans to change current charges in association with this proposal. The anticipated gross revenue from the proposal is $6,802,625 in Year One and $9,726,400 in Year Two and anticipated net revenue as $1,751,453 in Year One and $3,362,413 in Year Two. As a new service line, the revenues from the proposal will not have any impact on existing charges. (See following current and proposed fee schedules).

Current Schedule of Charges	
Residential Treatment	$1,000.00
Partial Hospital 4-8hrs	$600.00
Intensive Outpatient	$400.00
Psychiatric Evaluation	$185.00
History and Physical	$100.00