UNIVERSAL HEALTH SERVICES INC
Form 10-Q
August 05, 2016

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-Q

(MARK ONE)

x QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the quarterly period ended June 30, 2016

OR

o TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to

Commission file number 1-10765

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 x No o

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 x No o

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	x	Accelerated filer	o
Non-accelerated filer	o	Smaller reporting company	o

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

Indicate the number of shares outstanding of each of the issuer's classes of common stock, as of the latest practicable date. Common shares outstanding, as of July 31, 2016:

Class A	6,595,308
Class B	90,096,909
Class C	663,940
Class D	22,388

UNIVERSAL HEALTH SERVICES, INC.

INDEX

This Quarterly Report on Form 10-Q is for the quarter ended June 30, 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		Six months ended	
	June 30,		June 30,	
	2016	2015	2016	2015
Net revenues before provision for doubtful accounts	$2,638,848	$2,452,680	$5,258,441	$4,832,781
Less: Provision for doubtful accounts	207,993	177,476	377,788	332,224
Net revenues	2,430,855	2,275,204	4,880,653	4,500,557
Operating charges:				
Salaries, wages and benefits	1,130,933	1,044,064	2,279,072	2,075,767
Other operating expenses	585,995	535,711	1,147,579	1,041,677
Supplies expense	254,422	240,979	509,672	479,720
Depreciation and amortization	101,411	97,257	205,460	196,255
Lease and rental expense	24,806	23,196	49,258	46,087
Electronic health records incentive income	0	(1,395)	0	(1,395)
	2,097,567	1,939,812	4,191,041	3,838,111
Income from operations	333,288	335,392	689,612	662,446
Interest expense, net	30,442	27,684	60,042	57,721
Income before income taxes	302,846	307,708	629,570	604,725
Provision for income taxes	107,397	106,304	218,402	208,998
Net income	195,449	201,404	411,168	395,727
Less: Income attributable to noncontrolling interests	9,872	19,211	34,832	39,235
Net income attributable to UHS	$185,577	$182,193	$376,336	$356,492
Basic earnings per share attributable to UHS	$1.91	$1.84	$3.86	$3.60
Diluted earnings per share attributable to UHS	$1.89	$1.80	$3.81	$3.54
Weighted average number of common shares - basic	97,109	99,004	97,358	98,957
Add: Other share equivalents	1,280	1,923	1,284	1,830
Weighted average number of common shares and equivalents - diluted	98,389	100,927	98,642	100,787

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		Six months ended	
	June 30,		June 30,	
	2016	2015	2016	2015
Net income	$195,449	$201,404	$411,168	$395,727
Other comprehensive income (loss):				
Unrealized derivative gains (losses) on cash flow hedges	(3,769)	806	(18,068)	4,938
Amortization of terminated hedge	(83)	(84)	(167)	(168)
Unrealized loss on marketable security	(621)	-	(621)	-
Foreign currency translation adjustment	(4,163)	2,626	1,823	2,208
Other comprehensive income (loss) before tax	(8,636)	3,348	(17,033)	6,978
Income tax expense (benefit) related to items of other comprehensive income (loss)	(1,667)	715	(7,027)	2,212
Total other comprehensive income (loss), net of tax	(6,969)	2,633	(10,006)	4,766
Comprehensive income	188,480	204,037	401,162	400,493
Less: Comprehensive income attributable to noncontrolling interests	9,872	19,211	34,832	39,235
Comprehensive income attributable to UHS	$178,608	$184,826	$366,330	$361,258

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONDENSED CONSOLIDATED BALANCE SHEETS

(amounts in thousands, unaudited)

	June 30, 2016	December 31, 2015
Assets		
Current assets:		
Cash and cash equivalents	$56,273	$61,228
Accounts receivable, net	1,344,916	1,302,429
Supplies	117,710	116,037
Deferred income taxes	2,849	135,120
Other current assets	85,005	103,490
Total current assets	1,606,753	1,718,304
Property and equipment	6,722,246	6,530,569
Less: accumulated depreciation	(2,819,773)	(2,694,591)
	3,902,473	3,835,978
Other assets:		
Goodwill	3,585,892	3,596,114
Deferred charges	15,319	16,688
Other	430,493	448,360
	$9,540,930	$9,615,444
Liabilities and Stockholders' Equity		
Current liabilities:		
Current maturities of long-term debt	$94,802	$62,722
Accounts payable and accrued liabilities	1,169,241	1,033,697
Federal and state taxes	3,991	3,987
Total current liabilities	1,268,034	1,100,406
Other noncurrent liabilities	306,561	278,834
Long-term debt	3,499,375	3,368,634
Deferred income taxes	90,251	315,900
Redeemable noncontrolling interests	8,782	242,509
Equity:		
UHS common stockholders' equity	4,302,978	4,249,647
Noncontrolling interest	64,949	59,514
Total equity	4,367,927	4,309,161
	$9,540,930	$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)

	Six months ended June 30,	
	2016	2015
Cash Flows from Operating Activities:		
Net income	$411,168	$395,727
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation & amortization	205,460	196,255
Stock-based compensation expense	24,693	20,474
Changes in assets & liabilities, net of effects from acquisitions and dispositions:		
Accounts receivable	(45,729)	(95,013)
Accrued interest	9,158	(1,520)
Accrued and deferred income taxes	17,997	10,870
Other working capital accounts	123,315	(10,899)
Other assets and deferred charges	(8,149)	4,074
Other	52,050	2,163
Accrued insurance expense, net of commercial premiums paid	44,231	50,511
Payments made in settlement of self-insurance claims	(33,012)	(41,039)
Net cash provided by operating activities	801,182	531,603
Cash Flows from Investing Activities:		
Property and equipment additions, net of disposals	(247,715)	(170,580)
Acquisition of property and businesses	(27,525)	(34,500)
Net cash used in investing activities	(275,240)	(205,080)
Cash Flows from Financing Activities:		
Reduction of long-term debt	(843,351)	(255,658)
Additional borrowings and related funds	1,022,239	5,200
Acquisition of noncontrolling interests in majority owned businesses	(418,000)	0
Financing costs	(10,734)	0
Repurchase of common shares	(239,139)	(68,157)
Dividends paid	(19,484)	(19,804)
Issuance of common stock	4,362	4,039
Excess income tax benefits related to stock-based compensation	35,247	28,489
Profit distributions to noncontrolling interests	(59,615)	(23,295)
Proceeds received from sale/leaseback of real property	0	12,765
Net cash used in financing activities	(528,475)	(316,421)
Effect of exchange rate changes on cash and cash equivalents	(2,422)	293
(Decrease) increase in cash and cash equivalents	(4,955)	10,395
Cash and cash equivalents, beginning of period	61,228	32,069
Cash and cash equivalents, end of period	$56,273	$42,464

Supplemental Disclosures of Cash Flow Information:		
Interest paid	$53,558	$55,718
Income taxes paid, net of refunds	$165,947	$166,637
Noncash purchases of property and equipment	$42,747	$34,488

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(1) General

This Quarterly Report on Form 10-Q is for the quarterly period ended June 30, 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 June 30, 2016, we held approximately 5.8% 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 June 30, 2016 and 2015, respectively, and approximately $1.5 million and $1.4 million during the six-month periods ended June 30, 2016 and 2015, respectively.

Our pre-tax share of income from the Trust was approximately $250,000 and $800,000 during the three-month periods ended June 30, 2016 and 2015, respectively, and approximately $500,000 and $1.0 million for the six-month periods ended June 30, 2016 and 2015, respectively. Included in our share of the Trust's income for the three and six months ended June 30, 2015, is our share of a gain realized by the Trust in connections with a property exchange transaction completed during the second quarter of 2015. The carrying value of this investment was approximately $8.2 million and $8.7 million at June 30, 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 $45.0 million at June 30, 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 June 30, 2016 and 2015, and approximately $8 million for each of the six-month periods ended June 30, 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 those 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 was approximately $900,000 annually.

In June, 2016, we provided the required notice to the Trust, exercising the 5-year renewal options on McAllen Medical Center, Wellington Regional Medical Center and Southwest Healthcare System, Inland Valley Campus. The renewals extend the lease terms on these facilities, at existing lease rates, through December, 2021.

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, 2021	10(a)
Wellington Regional Medical Center	$3,030,000	December, 2021	10(b)
Southwest Healthcare System, Inland Valley Campus	$2,648,000	December, 2021	10(b)

(a) We have two 5-year renewal options at existing lease rates (through 2031).
(b) We have 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 CEO, 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.

In May, 2016, we purchased the minority ownership interests held by a third-party in our six acute care hospitals located in Las Vegas, Nevada (including Henderson Hospital which is currently under construction) for an aggregate cash payment of $445 million which included both the purchase price ($418 million) and the return of reserve capital ($27 million). The ownership interests purchased, which range from 26.1% to 27.5%, were previously reflected as redeemable noncontrolling interests on our Condensed Consolidated Balance Sheet.

As of June 30, 2016, outside owners held noncontrolling, minority ownership interests of: (i) 20% in an acute care facility located in Washington, D.C.; (ii) approximately 11% in an acute care facility located in Laredo, Texas; (iii) 20% in a behavioral health care facility located in Philadelphia, Pennsylvania, and; (iv) approximately 5% in an acute care facility located in Las Vegas, Nevada. The noncontrolling interest and redeemable noncontrolling interest balances of $65 million and $9 million, respectively, as of June 30, 2016, consist primarily of the third-party ownership interests in these hospitals.

In connection with a behavioral health care facility located in Philadelphia, Pennsylvania, the minority ownership interest of which is 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, Cash Flow Hedges and Foreign Currency Forward Exchange Contracts

Debt:

On June 7, 2016, we entered into a Fifth Amendment (the “Fifth Amendment”) to our credit agreement dated as of November 15, 2010, as amended on March 15, 2011, September 21, 2012, May 16, 2013 and August 7, 2014, among UHS, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders (“Credit Agreement”). The Fifth Amendment increased the size of the term loan A facility by $200 million and those proceeds were utilized to repay outstanding borrowings under the revolving credit facility of the Credit Agreement. The Credit Agreement, as amended, which is scheduled to mature in August, 2019, consists of: (i) an $800 million revolving credit facility (no borrowings outstanding as of June 30, 2016), and; (ii) a term loan A facility with $1.897 billion of borrowings outstanding as of June 30, 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 June 30, 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 June 30, 2016, we had no borrowings outstanding pursuant to the terms of our $800 million revolving credit facility and we had $751 million of available borrowing capacity, net of $15 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 June 30, 2016, we had $280 million of outstanding borrowings and $120 million of additional borrowing capacity pursuant to the terms of the Securitization.

As of June 30, 2016, we had combined aggregate principal of $1.4 billion from the following senior secured notes:

- $300 million aggregate principal amount of 3.75% senior secured notes due in 2019 (“2019 Notes”) which were issued on August 7, 2014.

- $700 million aggregate principal amount of 4.75% senior secured notes due in 2022 (“2022 Notes”) which were issued as follows:

- $300 million aggregate principal amount issued on August 7, 2014 at par.
- $400 million aggregate principal amount issued on June 3, 2016 at 101.5% to yield 4.35%.

- $400 million aggregate principal amount of 5.00% senior secured notes due in 2026 ("2026 Notes") which were issued on June 3, 2016.

Interest is payable on the 2019 Notes and the 2022 Notes on February 1 and August 1 of each year until the maturity date of August 1, 2019 for the 2019 Notes and August 1, 2022 for the 2022 Notes. Interest on the 2026 Notes is payable on June 1 and December 1 until the maturity date of June 1, 2026. The 2019 Notes, 2022 Notes and 2026 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 2019 Notes, 2022 Notes and 2026 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.

In June, 2016, we repaid the $400 million, 7.125% senior secured notes which matured on June 30, 2016.

Our Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens and indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage and minimum interest coverage ratios. We are in compliance with all required covenants as of June 30, 2016.

At June 30, 2016, the carrying value and fair value of our debt were each approximately $3.6 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 six 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 June 30, 2016, the fair value of our interest rate swaps was a net liability of $19 million of which $8 million is included in other current liabilities and $11 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.

Foreign Currency Forward Exchange Contracts:

We use forward exchange contracts to hedge our net investment in foreign operations against movements in exchange rates. The effective portion of the unrealized gains or losses on these contracts is recorded in foreign currency translation adjustment within accumulated other comprehensive income and remains there until either the sale or liquidation of the subsidiary. The cash flows from these contracts are reported as operating activities in the Consolidated Statements of Cash Flows. For the six-month periods ended June 30, 2016 and 2015, we recorded net cash inflows/(outflows) of $50 million and ($3 million), respectively, associated with these forward exchange contracts.

(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 June 30, 2016, the total accrual for our professional and general liability claims was $215 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.

At each of June 30, 2016 and 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). Commercially insured earthquake coverage for our facilities is subject to various deductibles and limitations including: (i) $500 million limitation for our facilities located in Nevada; (ii) $130 million limitation for our facilities located in California; (iii) $100 million limitation for our facilities located in fault zones within the United States; (iv) $40 million limitation for our facility located in Puerto Rico, and; (v) $250 million limitation for many of our facilities located in other states. 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 our behavioral health facilities located in the U.K. are provided on an all risk basis up to a £180 million limit that includes coverage for real and personal property as well as business interruption losses.

Other

Our accounts receivable as of June 30, 2016 and December 31, 2015 include amounts due from Illinois of approximately $24 million and $28 million, respectively. Collection of the outstanding receivables continues to be delayed due to state budgetary and funding pressures. Approximately $9 million as of June 30, 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 June 30, 2016 and December 31, 2015 includes approximately $38 million and $80 million, respectively, due from Texas in connection with Medicaid supplemental payment programs. The $38 million due from Texas as of June 30, 2016 consists of $22 million related to uncompensated care program and disproportionate share hospital revenues and $16 million related to Delivery Service Reform Incentive Payment program revenues. Although the accounts receivable due from Illinois and Texas could remain outstanding for the foreseeable future, since we expect to eventually collect all amounts due to us, no related reserves have been established in our consolidated financial statements. However, we can provide no assurance that we will eventually collect all amounts due to us from Illinois and/or Texas. Failure to ultimately collect all outstanding amounts due from these states would have an adverse impact on our future consolidated results of operations and cash flows.

As of June 30, 2016 we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds which totaled $130 million consisting of: (i) $105 million related to our self-insurance programs, and; (ii) $25 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 six-month period ended June 30, 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 six-month period ended June 30, 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. In July, 2016, CMS conducted their full certification survey and we subsequently received notification that Texoma was found to be in compliance with the applicable Medicare Conditions of Participation. As a result, the termination notice has been rescinded and the requirements of the agreement have been successfully completed.

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. To date, none of the federal share payments have been recouped. 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 June 30, 2016			
	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$4,682,682	$1,995,992	$-	$6,678,674
Gross outpatient revenues	$2,838,852	$229,243	$-	$3,068,095
Total net revenues	$1,253,328	$1,174,755	$2,772	$2,430,855
Income/(loss) before allocation of corporate overhead and income taxes	$137,372	$272,916	$(107,442)	$302,846
Allocation of corporate overhead	$(42,691)	$(38,726)	$81,417	$0
Income/(loss) after allocation of corporate overhead and before income taxes	$94,681	$234,190	$(26,025)	$302,846
Total assets as of June 30, 2016	$3,497,571	$5,920,483	$122,876	$9,540,930

	Six months ended June 30, 2016			
	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$9,648,219	$3,955,562	$-	$13,603,781
Gross outpatient revenues	$5,606,181	$450,886	$-	$6,057,067
Total net revenues	$2,540,475	$2,335,801	$4,377	$4,880,653
Income/(loss) before allocation of corporate overhead and income taxes	$323,290	$538,501	$(232,221)	$629,570
Allocation of corporate overhead	$(85,340)	$(77,442)	$162,782	$0
Income/(loss) after allocation of corporate overhead and before income taxes	$237,950	$461,059	$(69,439)	$629,570

Total assets as of June 30, 2016	$3,497,571	$5,920,483	$122,876	$9,540,930

	Three months ended June 30, 2015			
	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$4,188,933	$1,865,070	$-	$6,054,003
Gross outpatient revenues	$2,403,044	$217,013	$8,284	$2,628,341
Total net revenues	$1,164,516	$1,106,860	$3,828	$2,275,204
Income/(loss) before allocation of corporate overhead and income taxes	$140,584	$268,413	$(101,289)	$307,708
Allocation of corporate overhead	$(49,422)	$(29,721)	$79,143	$0
Income/(loss) after allocation of corporate overhead and before income taxes	$91,162	$238,692	$(22,146)	$307,708
Total assets as of June 30, 2015	$3,425,974	$5,320,163	$311,743	$9,057,880

	Six months ended June 30, 2015			
	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$8,517,700	$3,688,495	$-	$12,206,195
Gross outpatient revenues	$4,687,756	$421,582	$16,111	$5,125,449
Total net revenues	$2,310,456	$2,183,205	$6,896	$4,500,557
Income/(loss) before allocation of corporate overhead and income taxes	$295,784	$521,855	$(212,914)	$604,725
Allocation of corporate overhead	$(98,848)	$(59,387)	$158,235	$0
Income/(loss) after allocation of corporate overhead and before income taxes	$196,936	$462,468	$(54,679)	$604,725
Total assets as of June 30, 2015	$3,425,974	$5,320,163	$311,743	$9,057,880

(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 June 30,		Six months ended June 30,	
(amounts in thousands)	2016	2015	2016	2015
Basic and Diluted:				
Net income attributable to UHS	$185,577	$182,193	$376,336	$356,492
Less: Net income attributable to unvested restricted share grants	(84)	(71)	(173)	(139)
Net income attributable to UHS – basic and diluted	$185,493	$182,122	$376,163	$356,353
Weighted average number of common shares - basic	97,109	99,004	97,358	98,957
Net effect of dilutive stock options and grants based on the treasury stock method	1,280	1,923	1,284	1,830
Weighted average number of common shares and equivalents - diluted	98,389	100,927	98,642	100,787
Earnings per basic share attributable to UHS:	$1.91	$1.84	$3.86	$3.60
Earnings per diluted share attributable to UHS:	$1.89	$1.80	$3.81	$3.54

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 2.9 million for the six months ended June 30, 2016. There were no significant anti-dilutive stock options during the three months ended June 30, 2016. The excluded weighted-average stock options totaled 1.5 million for the six months ended June 30, 2015. There were no significant anti-dilutive stock options during the three months ended June 30, 2015. All classes of our common stock have the same dividend rights.

Stock-Based Compensation: During the three-month periods ended June 30, 2016 and 2015, compensation cost of $10.9 million and $9.1 million, respectively, was recognized related to outstanding stock options. During the six-month periods ended June 30, 2016 and 2015, compensation cost of $23.6 million and $19.5 million, respectively, was recognized related to outstanding stock options. In addition, during the three-month periods ended June 30, 2016 and 2015, compensation cost of approximately $340,000 and $274,000, respectively, was recognized related to restricted stock. During the six-month periods ended June 30, 2016 and 2015, compensation cost of approximately $659,000 and $493,000, respectively, was recognized related to restricted stock. As of June 30, 2016 there was $103.9 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 3.0 years. There were 2,896,050 stock options granted (net of cancellations) during the first six months of 2016 with a weighted-average grant date fair value of $23.79 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 $24.7 million and $20.5 million during the six-month periods ended June 30, 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 six months of 2016 and 2015, we generated $35.2 million and $28.5 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 and purchase of third-party ownership interests

Six-month period ended June 30, 2016:

Acquisitions:

During the first six months of 2016, we paid approximately $28 million to acquire various businesses and property.

In addition, during the second quarter of 2016, we paid $445 million in connection with the purchase of the minority ownership interests held by a third-party in our six acute care hospitals located in the Las Vegas, Nevada market which includes both the purchase price ($418 million) and return of reserve capital ($27 million). 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.

Six-month period ended June 30, 2015:

Acquisitions:

During the first six months 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 $9.7 million, or $.10 per share, during the second quarter of 2016 and $9.9 million or $.10 per share during the second quarter of 2015. We declared and paid dividends of $19.5 million and $19.8 million during the six-month periods ended June 30, 2016 and 2015, respectively.

(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 June 30, 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 June 30, 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) 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 $28 million as of June 30, 2016 and $19 million as of December 31, 2015 were recorded as deductions from the carrying value of our long-term debt liabilities. 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 June 30, 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, 5 surgical hospitals and surgery and radiation oncology centers located in 5 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 52% during each of the three and six-month periods ended June 30, 2016 and 51% during each of the three and six-month periods ended June 30, 2015. As a percentage of our consolidated net revenues, net revenues from our behavioral health care operations accounted for 48% during each of the three and six-month periods ended June 30, 2016 and 49% during each of the three and six-month periods ended June 30, 2015.

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," "predict "potential," "continue," "expects," "anticipates," "future," "intends," "plans," "believes," "estimates," "appears," "projects" an 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 $100 million annually from each of Texas, California, Washington, D.C., Nevada, Pennsylvania, Illinois, 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;
- 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 32% and 34% of our net patient revenues during the three-month periods ended June 30, 2016 and 2015, respectively, and 32% and 34% of our net patient revenues for the six-month periods ended June 30, 2016 and 2015, respectively. Revenues from managed care entities, including health maintenance organizations and managed Medicare and Medicaid programs, accounted for 57% and 55% of our net patient revenues during the three-month periods ended June 30, 2016 and 2015, respectively, and 56% and 54% of our net patient revenues during the six-month periods ended June 30, 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 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.

The total accrual for our professional and general liability claims and workers' compensation claims was $283 million as of June 30, 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 11 to the Consolidated Financial Statements, as included herein.

Results of Operations

Three-month periods ended June 30, 2016 and 2015:

The following table summarizes our results of operations and is used in the discussion below for the three-month periods ended June 30, 2016 and 2015 (dollar amounts in thousands):

	Three months ended June 30, 2016		Three months ended June 30, 2015	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$2,638,848		$2,452,680	
Less: Provision for doubtful accounts	207,993		177,476	
Net revenues	2,430,855	100.0 %	2,275,204	100.0 %
Operating charges:				
Salaries, wages and benefits	1,130,933	46.5 %	1,044,064	45.9 %
Other operating expenses	585,995	24.1 %	535,711	23.5 %
Supplies expense	254,422	10.5 %	240,979	10.6 %
Depreciation and amortization	101,411	4.2 %	97,257	4.3 %
Lease and rental expense	24,806	1.0 %	23,196	1.0 %
EHR incentive income	-	—	(1,395)	(0.1)%
Subtotal-operating expenses	2,097,567	86.3 %	1,939,812	85.3 %
Income from operations	333,288	13.7 %	335,392	14.7 %
Interest expense, net	30,442	1.3 %	27,684	1.2 %
Income before income taxes	302,846	12.5 %	307,708	13.5 %
Provision for income taxes	107,397	4.4 %	106,304	4.7 %
Net income	195,449	8.0 %	201,404	8.9 %
Less: Income attributable to noncontrolling interests	9,872	0.4 %	19,211	0.8 %
Net income attributable to UHS	$185,577	7.6 %	$182,193	8.0 %

Net revenues increased 7%, or $156 million, to $2.43 billion during the three-month period ended June 30, 2016 as compared to $2.28 billion during the second quarter of 2015. The net increase was primarily attributable to: (i) a $107 million or 5% 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) $49 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) decreased $5 million to $303 million during the three-month period ended June 30, 2016 as compared to $308 million during the comparable quarter of the prior year. The net decrease in our income before income taxes during the second quarter of 2016, as compared to the comparable quarter of 2015, was due to:

a. a decrease of $3 million at our acute care facilities as discussed below in Acute Care Hospital Services;
b. an increase of $5 million at our behavioral health care facilities, as discussed below in Behavioral Health Services, and;

c. $7 million of other combined net decreases.

Net income attributable to UHS increased $3 million to $186 million during the three-month period ended June 30, 2016 as compared to $182 million during the comparable prior year quarter. The increase during the second quarter of 2016, as compared to the comparable prior year quarter, consisted of:

- a decrease of $5 million in income before income taxes, as discussed above;
- an increase of $9 million resulting from a decrease in the income attributable to noncontrolling interests due primarily to the May, 2016 purchase of the minority ownership interests held by a third-party in our six acute care hospitals located in Las Vegas, Nevada, as discussed herein, and;
- a decrease of $1 million resulting from an increase in the provision for income taxes recorded on the $4 million increase in pre-tax income ($5 million decrease in income before income taxes plus the $9 million decrease in income attributable to noncontrolling interests).

Six-month periods ended June 30, 2016 and 2015:

The following table summarizes our results of operations and is used in the discussion below for the six-month periods ended June 30, 2016 and 2015 (dollar amounts in thousands):

	Six months ended June 30, 2016		Six months ended June 30, 2015	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$5,258,441		$4,832,781	
Less: Provision for doubtful accounts	377,788		332,224	
Net revenues	4,880,653	100.0 %	4,500,557	100.0 %
Operating charges:				
Salaries, wages and benefits	2,279,072	46.7 %	2,075,767	46.1 %
Other operating expenses	1,147,579	23.5 %	1,041,677	23.1 %
Supplies expense	509,672	10.4 %	479,720	10.7 %
Depreciation and amortization	205,460	4.2 %	196,255	4.4 %
Lease and rental expense	49,258	1.0 %	46,087	1.0 %
EHR incentive income	-	—	(1,395)	(0.0)%
Subtotal-operating expenses	4,191,041	85.9 %	3,838,111	85.3 %
Income from operations	689,612	14.1 %	662,446	14.7 %
Interest expense, net	60,042	1.2 %	57,721	1.3 %
Income before income taxes	629,570	12.9 %	604,725	13.4 %
Provision for income taxes	218,402	4.5 %	208,998	4.6 %
Net income	411,168	8.4 %	395,727	8.8 %
Less: Income attributable to noncontrolling interests	34,832	0.7 %	39,235	0.9 %
Net income attributable to UHS	$376,336	7.7 %	$356,492	7.9 %

Net revenues increased 8%, or $380 million, to $4.88 billion during the six-month period ended June 30, 2016 as compared to $4.50 billion during the first six months of 2015. The net increase was primarily attributable to: (i) a $280 million or 6% increase in net revenues generated from our acute care hospital services and behavioral health services operated during both periods, and; (ii) $100 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 $25 million to $630 million during the six-month period ended June 30, 2016 as compared to $605 million during the comparable period of the prior year. The net increase in our income before income taxes during the first six months of 2016, as compared to the comparable period of 2015, was due to:

d. an increase of $28 million at our acute care facilities as discussed below in Acute Care Hospital Services;
e. an increase of $17 million at our behavioral health care facilities, as discussed below in Behavioral Health Services, and;
f. $20 million of other combined net decreases.

Net income attributable to UHS increased $20 million to $376 million during the six-month period ended June 30, 2016 as compared to $356 million during the comparable prior year period. The increase during the first six months of 2016, as compared to the comparable prior year period, consisted of:

- an increase of $25 million in income before income taxes, as discussed above;
- an increase of $4 million resulting from a decrease in the income attributable to noncontrolling interests due primarily to the above-mentioned purchase of the minority ownership interests held by a third-party in our six acute care hospitals located in Las Vegas, Nevada, and;
- a decrease of $9 million resulting from an increase in the provision for income taxes recorded on the $29 million increase in pre-tax income ($25 million increase in income before income taxes plus the $4 million decrease 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 and six-month periods ended June 30, 2016 and 2015 (dollar amounts in thousands):

	Three months ended June 30, 2016		Three months ended June 30, 2015		Six months ended June 30, 2016		Six months ended June 30, 2015	
	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$1,406,742		$1,291,991		$2,815,703		$2,549,461	
Less: Provision for doubtful accounts	178,986		149,297		318,741		273,647	
Net revenues	1,227,756	100.0 %	1,142,694	100.0 %	2,496,962	100.0 %	2,275,814	100.0 %
Operating charges:								
Salaries, wages and benefits	506,099	41.2 %	465,045	40.7 %	1,015,495	40.7 %	920,989	40.5 %
	300,770	24.5 %	267,903	23.4 %	585,816	23.5 %	521,000	22.9 %

Other operating expenses												
Supplies expense	203,263	16.6	%	191,243	16.7	%	410,031	16.4	%	382,525	16.8	%
Depreciation and amortization	55,530	4.5	%	56,463	4.9	%	114,576	4.6	%	113,543	5.0	%
Lease and rental expense	13,629	1.1	%	12,367	1.1	%	26,671	1.1	%	24,920	1.1	%
Subtotal-operating expenses	1,079,291	87.9	%	993,021	86.9	%	2,152,589	86.2	%	1,962,977	86.3	%
Income from operations	148,465	12.1	%	149,673	13.1	%	344,373	13.8	%	312,837	13.7	%
Interest expense, net	822	0.1	%	1,174	0.1	%	1,643	0.1	%	2,191	0.1	%
Income before income taxes	$147,643	12.0	%	$148,499	13.0	%	$342,730	13.7	%	$310,646	13.6	%

Three-month periods ended June 30, 2016 and 2015:

During the three-month period ended June 30, 2016, as compared to the comparable prior year quarter, net revenues from our acute care hospital services, on a same facility basis, increased $85 million or 7.4%. Income before income taxes (and before income attributable to noncontrolling interests) decreased $1 million or 1% to $148 million or 12.0% of net revenues during the second quarter of 2016 as compared to $149 million or 13.0% of net revenues during the comparable prior year quarter.

During the three-month period ended June 30, 2016, net revenue per adjusted admission increased 1.3% and net revenue per adjusted patient day increased 2.4%, as compared to the comparable quarter of the prior year. During the three-month period ended June 30, 2016, as compared to the comparable prior year quarter, inpatient admissions to our acute care hospitals increased 2.5% and adjusted

admissions (adjusted for outpatient activity) increased 3.9%. Patient days at these facilities increased 1.4% and adjusted patient days increased 2.8% during the three-month period ended June 30, 2016 as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities was 4.6 days during each of the three-month periods ended June 30, 2016 and 2015. The occupancy rate, based on the average available beds at these facilities, was 59% during each of the three-month periods ended June 30, 2016 and 2015.

Six-month periods ended June 30, 2016 and 2015:

During the six-month period ended June 30, 2016, as compared to the comparable prior year period, net revenues from our acute care hospital services, on a same facility basis, increased $221 million or 9.7%. Income before income taxes (and before income attributable to noncontrolling interests) increased $32 million or 10% to $343 million or 13.7% of net revenues during the first six months of 2016 as compared to $311 million or 13.6% of net revenues during the comparable prior year period.

During the six-month period ended June 30, 2016, net revenue per adjusted admission increased 2.2% and net revenue per adjusted patient day increased 4.8%, as compared to the comparable period of the prior year. During the six-month period ended June 30, 2016, as compared to the comparable prior year period, inpatient admissions to our acute care hospitals increased 4.5% and adjusted admissions increased 5.8%. Patient days at these facilities increased 1.8% and adjusted patient days increased 3.1% during the six-month period ended June 30, 2016 as compared to the comparable prior year period. The average length of inpatient stay at these facilities was 4.6 days and 4.8 days during the six-month periods ended June 30, 2016 and 2015, respectively. The occupancy rate, based on the average available beds at these facilities, was 61% during each of the six-month periods ended June 30, 2016 and 2015.

All Acute Care Hospitals

The following table summarizes the results of operations for all our acute care operations during the three and six-month periods ended June 30, 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 June 30, 2016		Three months ended June 30, 2015		Six months ended June 30, 2016		Six months ended June 30, 2015	
	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$1,432,246		$1,313,813		$2,859,148		$2,584,103	
Less: Provision for doubtful accounts	178,918		149,297		318,673		273,647	
Net revenues	1,253,328	100.0 %	1,164,516	100.0 %	2,540,475	100.0 %	2,310,456	100.0 %

Operating charges:												
Salaries, wages and benefits	507,745	40.5	%	465,045	39.9	%	1,019,767	40.1	%	921,817	39.9	%
Other operating expenses	324,496	25.9	%	289,729	24.9	%	624,457	24.6	%	552,384	23.9	%
Supplies expense	203,520	16.2	%	191,243	16.4	%	410,288	16.2	%	382,525	16.6	%
Depreciation and amortization	65,482	5.2	%	65,769	5.6	%	134,097	5.3	%	132,230	5.7	%
Lease and rental expense	13,891	1.1	%	12,367	1.1	%	26,933	1.1	%	24,920	1.1	%
EHR incentive income	-	—		(1,395)	(0.1)	%	-	—		(1,395)	(0.1)	%
Subtotal-operating expenses	1,115,134	89.0	%	1,022,758	87.8	%	2,215,542	87.2	%	2,012,481	87.1	%
Income from operations	138,194	11.0	%	141,758	12.2	%	324,933	12.8	%	297,975	12.9	%
Interest expense, net	822	0.1	%	1,174	0.1	%	1,643	0.1	%	2,191	0.1	%
Income before income taxes	$137,372	11.0	%	$140,584	12.1	%	$323,290	12.7	%	$295,784	12.8	%

Three-month periods ended June 30, 2016 and 2015:

During the three-month period ended June 30, 2016, as compared to the comparable prior year quarter, net revenues from our acute care hospital services increased $89 million or 7.6% due primarily to the above-mentioned $85 million or 7.4% increase in net revenues on a same facility basis. Income before income taxes decreased $3 million or 2% to $137 million during the second quarter of 2016 as compared to $141 million during the second quarter of 2015. The decrease in income before income taxes at our acute care facilities resulted from:

·a $1 million decrease at our acute care facilities on a same facility basis, as discussed above, and;

·a decrease of $2 million from other combined net changes.

Six-month periods ended June 30, 2016 and 2015:

During the six-month period ended June 30, 2016, as compared to the comparable prior year period, net revenues from our acute care hospital services increased $230 million or 10.0% due primarily to the above-mentioned $221 million or 9.7% increase in net revenues on a same facility basis. Income before income taxes increased $28 million or 9% to $323 million during the first six months of 2016 as compared to $296 million during the first six months of 2015. The increase in income before income taxes at our acute care facilities resulted from:

·a $32 million increase at our acute care facilities on a same facility basis, as discussed above, and;
·a decrease of $4 million from other combined net changes.

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 and six-month periods ended June 30, 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 $397 million and $399 million at June 30, 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 and six-month periods ended June 30, 2016 and 2015:

Uncompensated care:

Amounts in millions	Three Months Ended				Six Months Ended			
	June 30, 2016	%	June 30, 2015	%	June 30, 2016	%	June 30, 2015	%
Charity care	$147	43 %	$ 117	44 %	$333	49 %	$ 249	45 %
Uninsured discounts	192	57 %	146	56 %	351	51 %	301	55 %
Total uncompensated care	$339	100%	$ 263	100%	$684	100%	$ 550	100%

As reflected on the tables above in All Acute Care Hospitals, the provision for doubtful accounts at our acute care hospitals amounted to approximately $179 million and $149 million during the three-month periods ended June 30, 2016 and 2015, respectively, and approximately $319 million and $274 million during the six-month periods ended June 30, 2016 and 2015, respectively. During the three and six-month periods ended June 30, 2016, as compared to the comparable periods 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 June 30, 2016	June 30, 2015	Six Months Ended June 30, 2016	June 30, 2015
Estimated cost of providing charity care	$23	$ 20	$49	$ 38
Estimated cost of providing uninsured discounts related care	29	24	51	46
Estimated cost of providing uncompensated care	$52	$ 44	$100	$ 84

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 and six-month periods ended June 30, 2016 and 2015 (dollar amounts in thousands):

Same Facility—Behavioral Health

	Three months ended June 30, 2016		Three months ended June 30, 2015		Six months ended June 30, 2016		Six months ended June 30, 2015	
	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$1,131,930		$1,109,586		$2,250,974		$2,192,704	
Less: Provision for doubtful accounts	28,420		27,879		57,755		58,144	
Net revenues	1,103,510	100.0 %	1,081,707	100.0 %	2,193,219	100.0 %	2,134,560	100.0 %
Operating charges:								
Salaries, wages and benefits	536,078	48.6 %	515,336	47.6 %	1,071,840	48.9 %	1,023,304	47.9 %
Other operating expenses	210,436	19.1 %	208,317	19.3 %	414,401	18.9 %	407,776	19.1 %
Supplies expense	46,734	4.2 %	47,954	4.4 %	93,232	4.3 %	94,061	4.4 %
Depreciation and amortization	31,503	2.9 %	29,613	2.7 %	62,951	2.9 %	59,060	2.8 %
Lease and rental expense	9,772	0.9 %	10,175	0.9 %	19,595	0.9 %	19,613	0.9 %
Subtotal-operating expenses	834,523	75.6 %	811,395	75.0 %	1,662,019	75.8 %	1,603,814	75.1 %
Income from operations	268,987	24.4 %	270,312	25.0 %	531,200	24.2 %	530,746	24.9 %
Interest expense, net	446	0.0 %	465	0.0 %	898	0.0 %	940	0.0 %
	$268,541	24.3 %	$269,847	24.9 %	$530,302	24.2 %	$529,806	24.8 %

Income before income taxes

Three-month periods ended June 30, 2016 and 2015:

On a same facility basis during the second quarter of 2016, as compared to the second quarter of 2015, net revenues generated from our behavioral health services increased 2% or $22 million to $1.10 billion from $1.08 billion. Income before income taxes decreased $1 million or 1% to $269 million or 24.3% of net revenues during the three-month period ended June 30, 2016, as compared to $270 million or 24.9% of net revenues during the comparable prior year quarter.

During the three-month period ended June 30, 2016, net revenue per adjusted admission increased 2.4% and net revenue per adjusted patient day increased 1.9%, as compared to the comparable quarter of 2015. On a same facility basis, inpatient admissions to our behavioral health facilities were unchanged and adjusted admissions decreased 0.3% during the three-month period ended June 30, 2016 as compared to the comparable quarter of 2015. Patient days and adjusted patient days increased 0.6% and 0.2%, respectively, during the three-month period ended June 30, 2016 as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities remained unchanged at 12.8 days during each of the three-month periods ended June 30, 2016 and 2015. The occupancy rate, based on the average available beds at these facilities, was 77% during each of the three-month periods ended June 30, 2016 and 2015.

In certain market in which we operate, the ability of our behavioral health facilities to fully meet the demand for their services has been unfavorably impacted by a shortage of clinicians which includes psychiatrists, nurses and mental health technicians which has, at times, caused the closure of a portion of available bed capacity. As a result, we have instituted certain initiatives at the impacted facilities designed to enhance recruitment and retention of clinical staff. Although we believe the impact on these facilities is temporary, we can provide no assurance that these factors will not continue to unfavorably impact our patient volumes, to some degree, throughout the remainder of 2016.

Six-month periods ended June 30, 2016 and 2015:

On a same facility basis during the first six months of 2016, as compared to the comparable period of 2015, net revenues generated from our behavioral health services increased 3% or $59 million to $2.19 billion from $2.13 billion. Income before income taxes was relatively unchanged at $530 million or 24.2% of net revenues during the six-month period ended June 30, 2016, as compared to $530 million or 24.8% of net revenues during the comparable prior year period.

During the six-month period ended June 30, 2016, net revenue per adjusted admission increased 2.1% and net revenue per adjusted patient day increased 1.9%, as compared to the comparable period of 2015. On a same facility basis, inpatient admissions to our behavioral health facilities increased 0.8% and adjusted admissions increased 0.5% during the six-month period ended June 30, 2016 as compared to the comparable period of 2015. Patient days and adjusted patient days increased 0.9% and 0.7%, respectively, during the six-month period ended June 30, 2016 as compared to the comparable prior year period. The average length of inpatient stay at these facilities remained unchanged at 12.8 days during each of the six-month periods ended June 30, 2016 and 2015. The occupancy rate, based on the average available beds at these facilities, was 76% and 77% during the six-month periods ended June 30, 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 and six-month periods ended June 30, 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 June 30, 2016		Three months ended June 30, 2015		Six months ended June 30, 2016		Six months ended June 30, 2015	
	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$1,203,826		$1,134,967		$2,394,916		$2,241,668	
Less: Provision for doubtful accounts	29,071		28,107		59,115		58,463	
Net revenues	1,174,755	100.0 %	1,106,860	100.0 %	2,335,801	100.0 %	2,183,205	100.0 %
Operating charges:								
Salaries, wages and benefits	567,280	48.3 %	522,156	47.2 %	1,132,152	48.5 %	1,036,031	47.5 %
Other operating expenses	240,714	20.5 %	227,236	20.5 %	477,729	20.5 %	448,415	20.5 %
Supplies expense	48,664	4.1 %	48,369	4.4 %	97,000	4.2 %	94,914	4.3 %

Depreciation and amortization	33,887	2.9	%	29,657	2.7	%	67,419	2.9	%	60,363	2.8	%
Lease and rental expense	10,856	0.9	%	10,564	1.0	%	22,118	0.9	%	20,687	0.9	%
Subtotal-operating expenses	901,401	76.7	%	837,982	75.7	%	1,796,418	76.9	%	1,660,410	76.1	%
Income from operations	273,354	23.3	%	268,878	24.3	%	539,383	23.1	%	522,795	23.9	%
Interest expense, net	438	0.0	%	465	0.0	%	882	0.0	%	940	0.0	%
Income before income taxes	$272,916	23.2	%	$268,413	24.2	%	$538,501	23.1	%	$521,855	23.9	%

Three-month periods ended June 30, 2016 and 2015:

During the three-month period ended June 30, 2016, as compared to the comparable prior year quarter, net revenues generated from our behavioral health services increased $68 million or 6.1% due to: (i) the above-mentioned $22 million or 2.0% increase in net revenues on a same facility basis, and; (ii) $46 million of other combined net increases consisting primarily of the revenues generated at the 4 facilities located in the U.K. acquired during the third quarter of 2015 in connection with our acquisition of Alpha Hospitals Holdings Limited ("Alpha") and the 4 inpatient facilities and 8 outpatient centers acquired during the fourth quarter of 2015 in connection with our acquisition of Foundations Recovery Network, LLC ("Foundations").

Income before income taxes increased $5 million or 2% to $273 million or 23.2% of net revenues during the second quarter of 2016 as compared to $268 million or 24.2% during the second quarter of 2015. The increase resulted from: (i) a $1 million decrease at our behavioral health care facilities on a same facility basis, as discussed above, and; (ii) other combined net increase of $6 million due primarily from the income before income taxes generated during the second quarter of 2016 at the facilities acquired in the Alpha and Foundations transactions.

Six-month periods ended June 30, 2016 and 2015:

During the six-month period ended June 30, 2016, as compared to the comparable prior year period, net revenues generated from our behavioral health services increased $153 million or 7.0% due to: (i) the above-mentioned $59 million or 2.7% increase in net revenues on a same facility basis, and; (ii) $94 million of other combined net increases consisting primarily of the revenues generated at the facilities acquired in the Alpha and Foundations transactions.

Income before income taxes increased $17 million or 3% to $539 million or 23.1% of net revenues during the first six months of 2016 as compared to $522 million or 23.9% during the comparable period of 2015. The increase resulted primarily from the income before income taxes generated during the first six months of 2016 at the facilities acquired in the Alpha and Foundations transactions.

Sources of Revenue

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

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

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

typically more difficult than from governmental or business payers which unfavorably impacts the collectability of our patient accounts.

The following table shows the approximate percentages of net patient revenue for the three and six-month periods ended June 30, 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 June 30, 2016	2015	Percentage of Net Patient Revenues Six Months Ended June 30, 2016	2015
Third Party Payors:				
Medicare	20 %	21 %	20 %	21 %
Medicaid	12 %	13 %	12 %	13 %
Managed Care (HMO and PPOs)	57 %	55 %	56 %	54 %
Other Sources	11 %	11 %	12 %	12 %
Total	100 %	100 %	100 %	100 %

Acute Care Facilities	Percentage of Net Patient Revenues Three Months Ended June 30, 2016	2015	Percentage of Net Patient Revenues Six Months Ended June 30, 2016	2015
Third Party Payors:				
Medicare	25 %	25 %	26 %	26 %
Medicaid	7 %	8 %	7 %	7 %
Managed Care (HMO and PPOs)	66 %	65 %	64 %	62 %
Other Sources	2 %	2 %	3 %	5 %
Total	100 %	100 %	100 %	100 %

Behavioral Health Facilities	Percentage of Net Patient Revenues Three Months Ended June 30, 2016	2015	Percentage of Net Patient Revenues Six Months Ended June 30, 2016	2015
Third Party Payors:				
Medicare	14 %	16 %	14 %	16 %
Medicaid	16 %	19 %	16 %	19 %

Managed Care (HMO and PPOs)	48	%	45	%	48	%	45	%
Other Sources	22	%	20	%	22	%	20	%
Total	100	%	100	%	100	%	100	%

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

Under the Medicare program, for inpatient services, our general acute care hospitals receive reimbursement under the inpatient prospective payment system ("IPPS"). Under the IPPS, hospitals are paid a predetermined fixed payment amount for each hospital discharge. The fixed payment amount is based upon each patient's Medicare severity diagnosis related group ("MS-DRG"). Every MS-DRG is assigned a payment rate based upon the estimated intensity of hospital resources necessary to treat the average patient with that particular diagnosis. The MS-DRG payment rates are based upon historical national average costs and do not consider the actual costs incurred by a hospital in providing care. This MS-DRG assignment also affects the predetermined capital rate paid with each MS-DRG. The MS-DRG and capital payment rates are adjusted annually by the predetermined geographic adjustment factor for the geographic region in which a particular hospital is located and are weighted based upon a statistically normal distribution of severity. While we generally will not receive payment from Medicare for inpatient services, other than the MS-DRG payment, a hospital may qualify for an "outlier" payment if a particular patient's treatment costs are extraordinarily high and exceed a specified threshold. MS-DRG rates are adjusted by an update factor each federal fiscal year, which begins on October 1. The index used to adjust the MS-DRG rates, known as the "hospital market basket index," gives consideration to the inflation experienced by hospitals in purchasing goods and services. Generally, however, the percentage increases in the MS-DRG payments have been lower than the projected increase in the cost of goods and services purchased by hospitals.

In August, 2016, CMS published its IPPS 2017 final payment rule which provides for a 2.7% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments and 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 0.95%. Including the estimated decreases to our DSH payments (approximating -0.8%), we estimate our overall decrease from the final IPPS 2017 rule (covering the period of October 1, 2016 through September 30, 2017) will approximate -0.2%. This projected impact from the IPPS 2017 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 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 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). In October, 2015 as part of the 2016 Medicare Outpatient Prospective Payment System ("OPPS") final rule (additional related disclosure below), CMS will 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 . Additionally, CMS also announced that Recovery Audit Contractors ("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 final payment rule, CMS: (i) reversed the Two-Midnight rule's 0.2% reduction in hospital payments, and; (ii) implemented a temporary one-time increase of 0.8% in FFY2017 payments to offset cuts in the preceding fiscal years affected by the prior 0.2% reduction.

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, 2016, CMS published its Psych PPS final rule for the federal fiscal year 2017. Under this final rule, payments to psychiatric hospitals and units are estimated to increase by 2.3% compared to federal fiscal year 2016. This amount includes the effect of the 2.8% market basket update less a 0.2% adjustment as required by the Affordable Care Act and a 0.3% productivity adjustment.

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

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

In July, 2016, CMS published its OPPS proposed rule for 2017. The hospital market basket increase is 2.8%. The Medicare statute requires a productivity adjustment reduction of 0.5% and 0.75% reduction to the 2017 OPPS market basket resulting in a 2016 OPPS market basket update at 1.6%. When other statutorily required adjustments and hospital patient service mix are considered, we estimate that our overall Medicare OPPS update for 2017 will aggregate to a net decrease of -0.4% which includes a -11.1% decrease to behavioral health division partial hospitalization rates. When the behavioral health division’s partial hospitalization rate impact is excluded, we estimate that our Medicare 2017 OPPS payments will result in 2.2% increase in payment levels for our acute care division, as compared to 2016.

In October, 2015, CMS published its OPPS final rule for 2016. The hospital market basket increase is 2.8%. 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 a -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 $100 million annually from each of Texas, California, Washington, D.C., Nevada, Pennsylvania, Illinois, 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 $10 million and $2 million during the three-month periods ended June 30, 2016 and 2015, respectively, and $17 million and $15 million during the six-month period ended June 30, 2016 and June 30, 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 $82 million and $95 million during the three-month periods ended June 30, 2016 and 2015, respectively, and $160 million and $163 million during the six-month periods ended June 30, 2016 and 2015, respectively. These revenues were offset by Provider Taxes of $39 million during each of the three-month periods ended June 30, 2016 and 2015, and $75 million and $67 million during the six-month periods ended June 30, 2016 and June 30, 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 the year ended December 31, 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 $12 million and $20 million during the three-month periods ended June 30, 2016 and 2015, respectively, and $27 million and $34 million during the six-month periods ended June 30, 2016 and 2015, respectively. These amounts are net of Provider Taxes of $2 million and less than $1 million during the second quarters of 2016 and 2015, respectively, and $3 million during each of the six-month periods ended June 30, 2016 and 2015. 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 the year ended December 31, 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.

Included in our financial results during each of the three and six-month periods ended June 30, 2016 and 2015, were $10 million of net DSRIP revenues/benefit. These amounts were net of provided taxes of $6 million during each of the three and six-month periods ended June 30, 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 the year ended December 31, 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. In connection with this program, our financial results included approximately $1 million and $3 million during the three-month periods ended June 30, 2016 and 2015, respectively, and $5 million and $4 million during the six-month periods ended June 30, 2016 and 2015, respectively. We estimate that our reimbursements pursuant to this program will approximate $10 million during the year ended December 31, 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.

In connection with the implementation of EHR applications at our acute care hospitals, our consolidated results of operations include unfavorable pre-tax impacts, related primarily to depreciation and amortization expense, of approximately $9 million and $7 million during the three-month periods ended June 30, 2016 and 2015, respectively, and $17 million and $15 million during the six-month periods ended June 30, 2016 and 2015, respectively.

Federal regulations require that Medicare EHR incentive payments be computed based on the Medicare cost report that begins in the federal fiscal period in which a hospital meets the applicable “meaningful use” requirements. Since the annual Medicare cost report periods for each of our acute care hospitals ends on December 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.

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, and $8.0 billion for each of FFY 2024 and 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 and $28 million during the three-month periods ended June 30, 2016 and 2015, respectively, and $60 million and $58 million during the six month periods ended June 30, 2016 and 2015, respectively (amounts in thousands):

	Three Months Ended June 30, 2016	Three Months Ended June 30, 2015	Six Months Ended June 30, 2016	Six Months Ended June 30, 2015
Revolving credit & demand notes	$1,744	$520	$3,339	$1,318
$400 million, 7.125% Senior Notes due 2016 (d.)	4,907	7,124	12,031	14,248
$300 million, 3.75% Senior Notes due 2019	2,813	2,813	5,625	5,625
$700 million, 4.75% Senior Notes due 2022 (a.)	5,040	3,562	8,603	7,125
$400 million, 5.00% Senior Notes due 2026 (b.)	1,556	-	1,556	-
Term loan facility A (c.)	8,627	7,519	16,974	15,047
Accounts receivable securitization program (e.)	1,207	748	2,410	1,529
Subtotal-revolving credit, demand notes, senior notes, term loan facilities and accounts receivable securitization program	25,894	22,286	50,538	44,892
Interest rate swap expense, net	2,191	2,032	4,460	6,180
Amortization of financing fees	1,869	1,758	3,649	3,521
Other combined interest expense	1,267	1,654	2,565	3,179

Capitalized interest on major projects	(766)	(41)	(1,127)	(41)
Interest income	(13)	(5)	(43)	(10)
Interest expense, net	$30,442	$27,684	$60,042	$57,721

(a.) On June 3, 2016, we completed the offering of an additional $400 million aggregate principal amount of 4.75% Senior Notes due in 2022 (issued at a yield of 4.35%), the terms of which are identical to the terms of our $300 million aggregate principal amount of 4.75% Senior Notes due in 2022 issued in August, 2014. These Senior Notes, combined, are referred to as $700 million, 4.75% Senior Notes due in 2022.

(b.) On June 3, 2016, we completed the offering of $400 million aggregate principal amount of 5.00% Senior Notes due in 2026.

(c.) On June 7, 2016, we entered into a fifth amendment to our credit agreement dated November 15, 2010, as amended, to increase the size of the Term Loan A facility by $200 million to approximately $1.9 billion. Interest rates were not impacted by the fifth amendment to the credit agreement.

(d.) The $400 million, 7.125% Senior Notes matured and were repaid in June, 2016 utilizing a portion of the funds generated from the debt issuances discussed in (a.), (b.) and (c.) above.

(e.) 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 increased $3 million during the three-month period ended June 30, 2016, and $2 million during the six-month period ended June 30, 2016, as compared to the comparable periods of 2015, due primarily to an increase in the aggregate average outstanding borrowings and weighted average interest rate related to our revolving credit, demand notes, senior notes, term loan facilities and accounts receivable securitization program.

Provision for Income Taxes and Effective Tax Rates:

The effective tax rates, as calculated by dividing the provision for income taxes by income before income taxes, were as follows for the three and six-month periods ended June 30, 2016 and 2015 (dollar amounts in thousands):

	Three months ended		Six month ended	
	June 30, 2016	June 30, 2015	June 30, 2016	June 30, 2015
Provision for income taxes	$107,397	$106,304	$218,402	$208,998
Income before income taxes	302,846	307,708	629,570	604,725
Effective tax rate	35.5 %	34.5 %	34.7 %	34.6 %

In May, 2016, we purchased third-party minority ownership interests in our six acute care hospitals located in Las Vegas, Nevada. Prior to that date, outside owners held 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 and six-month periods ended June 30, 2016 and 2015 (dollar amounts in thousands):

	Three months ended		Six month ended	
	June 30, 2016	June 30, 2015	June 30, 2016	June 30, 2015
Provision for income taxes	$107,397	$106,304	$218,402	$208,998