UNIVERSAL HEALTH SERVICES INC
Form 10-Q
August 08, 2013
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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, 2013

OR

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

For the transition period from to

Commission file number 1-10765

UNIVERSAL HEALTH SERVICES, INC.

(Exact name of registrant as specified in its charter)

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

UNIVERSAL CORPORATE CENTER

367 SOUTH GULPH ROAD

KING OF PRUSSIA, PENNSYLVANIA 19406

(Address of principal executive offices) (Zip Code)

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

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

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

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

Large accelerated filer x	Accelerated filer ¨
Non-accelerated filer ¨	Smaller reporting company ¨

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ¨ No 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, 2013:

Class A	6,595,708
Class B	90,905,041
Class C	664,000
Class D	30,053

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In this Report on Form 10-Q for the quarterly period ended June 30, 2013, we, us, our and the Company refer to Universal Health Services, Inc and its subsidiaries. UHS is a registered trademark of UHS of Delaware, Inc., the management company for, and a wholly-owned subsidiary of Universal Health Services, Inc. Universal Health Services, Inc. is a holding company and operates through its subsidiaries including its management company, UHS of Delaware, Inc. All healthcare and management operations are conducted by subsidiaries of Universal Health Services, Inc. To the extent any reference to UHS or UHS facilities in this report including letters, narratives or other forms contained herein relates to our healthcare or management operations it is referring to Universal Health Services, Inc. s subsidiaries including UHS of Delaware, Inc. Further, the terms we, us, our or the Company in such context similarly refer to the operations of Universal Health Services Inc. s subsidiaries including UHS of Delaware, Inc. Any reference to employees or employment contained herein refers to employment with or employees of the subsidiaries of Universal Health Services, Inc. including UHS of Delaware, Inc.

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PART I. FINANCIAL INFORMATION

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONDENSED CONSOLIDATED STATEMENTS OF INCOME

(amounts in thousands, except per share amounts)

(unaudited)

	Three months ended June 30,		Six months ended June 30,	
	2013	2012	2013	2012
Net revenues before provision for doubtful accounts	$ 2,081,662	$ 1,907,789	$ 4,160,010	$ 3,849,412
Less: Provision for doubtful accounts	246,687	184,706	493,403	333,293
Net revenues	1,834,975	1,723,083	3,666,607	3,516,119
Operating charges:				
Salaries, wages and benefits	897,334	854,863	1,799,630	1,726,977
Other operating expenses	325,562	345,061	706,569	696,361
Supplies expense	202,344	197,816	406,986	403,176
Depreciation and amortization	81,682	72,983	161,494	144,775
Lease and rental expense	24,082	23,983	48,747	47,425
Electronic health records incentive income	(83)	(1,955)	(4,795)	(1,955)
	1,530,921	1,492,751	3,118,631	3,016,759
Income from operations	304,054	230,332	547,976	499,360
Interest expense, net	38,236	45,888	78,174	92,598
Income before income taxes	265,818	184,444	469,802	406,762
Provision for income taxes	98,015	67,000	172,064	146,748
Net income	167,803	117,444	297,738	260,014
Less: Income attributable to noncontrolling interests	15,962	9,883	26,113	23,846
Net income attributable to UHS	$ 151,841	$ 107,561	$ 271,625	$ 236,168
Basic earnings per share attributable to UHS	$ 1.55	$ 1.11	$ 2.77	$ 2.44
Diluted earnings per share attributable to UHS	$ 1.53	$ 1.10	$ 2.75	$ 2.41
Weighted average number of common shares basic	98,033	96,691	97,872	96,642
Add: Other share equivalents	1,178	1,038	1,019	1,118
Weighted average number of common shares and equivalents diluted	99,211	97,729	98,891	97,760

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

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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONDENSED CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

(amounts in thousands, unaudited)

	Three months ended June 30,		Six months ended June 30,	
	2013	2012	2013	2012
Net income	$ 167,803	$ 117,444	$ 297,738	$ 260,014
Other comprehensive income (loss):				
Unrealized derivative gains on cash flow hedges	5,282	212	9,817	1,827
Amortization of terminated hedge	(84)	(84)	(168)	(168)
Other comprehensive income before tax	5,198	128	9,649	1,659
Income tax expense related to items of other comprehensive income	1,960	50	3,638	632
Total other comprehensive income, net of tax	3,238	78	6,011	1,027
Comprehensive income	171,041	117,522	303,749	261,041
Less: Comprehensive income attributable to noncontrolling interests	15,962	9,883	26,113	23,846
Comprehensive income attributable to UHS	$ 155,079	$ 107,639	$ 277,636	$ 237,195

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

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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONDENSED CONSOLIDATED BALANCE SHEETS

(amounts in thousands, unaudited)

	June 30, 2013	December 31, 2012
Assets		
Current assets:		
Cash and cash equivalents	$ 12,558	$ 23,471
Accounts receivable, net	1,149,477	1,067,197
Supplies	100,324	99,000
Other current assets	86,733	87,936
Deferred income taxes	134,888	104,461
Assets of facilities held for sale	0	25,431
Total current assets	1,483,980	1,407,496
Property and equipment	5,519,819	5,368,345
Less: accumulated depreciation	(2,116,414)	(1,986,110)
	3,403,405	3,382,235
Other assets:		
Goodwill	3,041,346	3,036,765
Deferred charges	66,910	75,888
Other	321,612	298,459
	$ 8,317,253	$ 8,200,843
Liabilities and Stockholders Equity		
Current liabilities:		
Current maturities of long-term debt	$ 73,579	$ 2,589
Accounts payable and accrued liabilities	958,952	889,557
Liabilities of facilities held for sale	0	850
Federal and state taxes	16,619	1,062
Total current liabilities	1,049,150	894,058
Other noncurrent liabilities	310,948	395,355
Long-term debt	3,473,106	3,727,431
Deferred income taxes	206,818	183,747
Redeemable noncontrolling interests	233,417	234,303
Equity:		
UHS common stockholders equity	2,991,457	2,713,345
Noncontrolling interest	52,357	52,604
Total equity	3,043,814	2,765,949
	$ 8,317,253	$ 8,200,843

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

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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

(amounts in thousands, unaudited)

	Six months ended June 30,	
	2013	**2012**
Cash Flows from Operating Activities:		
Net income	$ 297,738	$ 260,014
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation & amortization	161,677	148,703
Stock-based compensation expense	13,579	10,996
Gains on sales of assets and businesses, net of losses	(2,277)	0
Changes in assets & liabilities, net of effects from acquisitions and dispositions:		
Accounts receivable	(82,224)	(63,937)
Accrued interest	13,199	15,873
Accrued and deferred income taxes	18,365	3,955
Other working capital accounts	32,421	(13,085)
Other assets and deferred charges	9,069	13,866
Other	4,083	2,050
Accrued insurance expense, net of commercial premiums paid	(22,590)	42,241
Payments made in settlement of self-insurance claims	(37,038)	(47,814)
Net cash provided by operating activities	406,002	372,862
Cash Flows from Investing Activities:		
Property and equipment additions, net of disposals	(175,944)	(182,351)
Proceeds received from sale of assets and businesses	34,008	53,461
Acquisition of property and businesses	(1,320)	(11,476)
Costs incurred for purchase and implementation of electronic health records application	(33,396)	(28,008)
Return of deposit on terminated purchase agreement	0	6,500
Net cash used in investing activities	(176,652)	(161,874)
Cash Flows from Financing Activities:		
Reduction of long-term debt	(196,096)	(195,686)
Additional borrowings	11,000	0
Repurchase of common shares	(21,373)	(2,927)
Dividends paid	(9,795)	(9,673)
Issuance of common stock	2,735	2,575
Profit distributions to noncontrolling interests	(26,734)	(13,565)
Net cash used in financing activities	(240,263)	(219,276)
Decrease in cash and cash equivalents	(10,913)	(8,288)
Cash and cash equivalents, beginning of period	23,471	41,229
Cash and cash equivalents, end of period	$ 12,558	$ 32,941
Supplemental Disclosures of Cash Flow Information:		
Interest paid	$ 54,067	$ 62,158

Income taxes paid, net of refunds	$ 152,553	$ 141,571

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

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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, 2013. In this Quarterly Report, we, us, our 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, 2012.

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

Relationship with Universal Health Realty Income Trust:

At June 30, 2013, we held approximately 6.2% 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 condensed consolidated statements of income, of $585,000 and $520,000 during the three-month periods ended June 30, 2013 and 2012, respectively, and $1.2 million and $1.0 million during the six-month periods ended June 30, 2013 and 2012, respectively. Our pre-tax share of income from the Trust was $213,000 and $591,000 for the three-month periods ended June 30, 2013 and 2012, respectively, and $513,000 and $891,000 for the six-month periods ended June 30, 2013 and 2012, respectively. The carrying value of this investment was $8.8 million and $9.3 million at June 30, 2013 and December 31, 2012, respectively, and is included in other assets in the accompanying condensed consolidated balance sheets. The market value of this investment, based on the closing price of the Trust s stock on the respective dates, was $34.0 million at June 30, 2013 and $39.9 million at December 31, 2012.

Total rent expense under the operating leases on the hospital facilities with the Trust was $3.9 million and $4.1 million during the three-month periods ended June 30, 2013 and 2012, respectively, and $8.0 million and $8.3 million for the six month periods ended June 30, 2013 and 2012, respectively. In addition, certain of our subsidiaries are tenants in several medical office buildings owned by limited liability companies in which the Trust holds either 100% ownership interests or non-controlling majority ownership interests.

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

Hospital Name	Type of Facility	Annual Minimum Rent	End of Lease Term	Renewal Term (years)
McAllen Medical Center	Acute Care	$ 5,485,000	December, 2016	15(a)
Wellington Regional Medical Center	Acute Care	$ 3,030,000	December, 2016	15(b)
Southwest Healthcare System, Inland Valley Campus	Acute Care	$ 2,648,000	December, 2016	15(b)
The Bridgeway	Behavioral Health	$ 930,000	December, 2014	10(c)

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

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

(c) We have two 5-year renewal options at fair market value lease rates (2015 through 2024).

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 and his wife. As a result of these agreements, based on actuarial tables and other assumptions, during the life expectancies of the insureds, we would pay approximately $25 million in premiums and certain trusts, owned by our chief executive officer, would pay approximately $8 million in premiums. Based on the projected premiums mentioned

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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. These agreements did not have a material effect on our consolidated financial statements or results of operations during 2012 or the first six months of 2013.

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 Chief Executive Officer (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 liability, and interest rate swaps.

Outside owners hold noncontrolling, minority ownership interests of: (i) approximately 28% in our five acute care facilities located in Las Vegas, Nevada; (ii) 20% in an acute care facility located in Washington, D.C.; (iii) approximately 11% in an acute care facility located in Laredo, Texas, and; (iv) 20% in a behavioral health care facility located in Philadelphia, Pennsylvania. The redeemable noncontrolling interest balances of $233 million and $234 million as of June 30, 2013 and December 31, 2012, respectively, and the noncontrolling interest balances of $52 million and $53 million as of June 30, 2013 and December 31, 2012, respectively, consist primarily of the third-party ownership interests in these hospitals.

In connection with the five acute care facilities located in Las Vegas, Nevada, the minority ownership interests of which are reflected as redeemable noncontrolling interests on our Consolidated Balance Sheet, the outside owners have certain put rights , that are currently exercisable, that if exercised, require us to purchase the minority member s interests at fair market value. The put rights are exercisable upon the occurrence of: (i) certain specified financial conditions falling below established thresholds; (ii) breach of the management contract by the managing member (a subsidiary of ours), or; (iii) if the minority member s ownership percentage is reduced to less than certain thresholds. In connection with the behavioral health care facility located in Philadelphia, Pennsylvania, the minority ownership interest of which is also reflected as redeemable noncontrolling interests on our Consolidated Balance Sheet, the outside owner has a put option to put its entire ownership interest to us at any time. If exercised, the put option requires us to purchase the minority member s interest at fair market value. As of June 30, 2013, we believe the fair market value of the minority ownership interests in these facilities approximates the book value of the redeemable noncontrolling interests.

(4) Long-term debt and cash flow hedges

Debt:

On May 16, 2013, we entered into a third amendment (the Third Amendment) to the credit agreement, dated as of November 15, 2010 (as amended from time to time, the Credit Agreement), among UHS, the several banks and other financial institutions from time to time parties thereto, JPMorgan Chase Bank, N.A., as administrative agent and the other agents party thereto. The Third Amendment was effective on May 16, 2013. The Third Amendment provides for a reduction in the interest rates payable in connection with certain borrowings under the Credit Agreement. Upon the effectiveness of the Third Amendment, UHS replaced its existing $745.9 million senior secured Tranche B term loan with a new senior secured Tranche B-1 term loan in the same amount on substantially the same terms as the Tranche B term loan, other than lower interest rates. Borrowings under the Tranche B-1 term loan bear interest at a rate per annum equal to, at our election, one, two, three or six month LIBOR, plus an applicable margin of 2.25% or ABR plus an applicable margin of 1.25%. The minimum ABR and LIBOR rates for the Tranche B term loan of 2.0% and 1.0%, respectively, were eliminated.

In September, 2012, we entered into a second amendment (Second Amendment) to our Credit Agreement which provided for: (i) a new $900 million Term Loan-A (Term Loan A2) at the same interest rates as our existing Term Loan A and a final maturity date of August 15, 2016; (ii) the extension of the maturity date on a substantial portion of our $800 million revolving credit facility commitment with $777 million of the commitment extended to mature on August 15, 2016 and the remaining $23 million commitment scheduled to mature on November 15, 2015 (there were no borrowings outstanding pursuant to our revolving credit facility as of June 30, 2013), and; (iii) the extension of the maturity date on a substantial portion of our Term Loan-A borrowings which, based upon the outstanding Term Loan-A borrowings as of June 30, 2013, $919 million is scheduled to mature on August 15, 2016 and the remaining $44 million is scheduled to mature on November 15, 2015. The Second Amendment also provides for increased flexibility for refinancing and certain other modifications but substantially all other terms of the Credit Agreement remain unchanged.

In September, 2012, we used $700 million of the proceeds from the new Term Loan A2 facility to extinguish a portion of our higher priced, Term Loan-B facility. Pricing under the new Term Loan A2 facility was 1% lower than the Term Loan-B facility and did not include a LIBOR Floor whereas, at that time, the Term Loan-B facility had a 1% LIBOR Floor (which has since been eliminated as part of the above-mentioned Third Amendment in May, 2013). During the third quarter of 2012, in connection with the extinguishment of a portion of our Term Loan-B facility, we recorded a pre-tax charge of $29 million to write-off the related portion of the Term Loan-B deferred financing costs.

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The Credit Agreement, as amended, is a senior secured facility which provided for an initial aggregate commitment amount of $3.43 billion, comprised of an $800 million revolving credit facility, a $988 million Term Loan-A facility, a $746 million Term Loan-B facility and a $900 million Term Loan-A2 facility. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Credit Agreement is secured by substantially all of the assets of the Company and our material subsidiaries and guaranteed by our material subsidiaries.

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, Term Loan-A and Term Loan-A2 borrowings and 1.25% for Term Loan B 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, Term Loan-A and Term Loan-A2 borrowings and 2.25% for Term Loan-B borrowings. The current applicable margins are 0.75% for ABR-based loans, 1.75% for LIBOR-based loans under the revolving credit, Term Loan-A and Term Loan-A2 facilities and 2.25% under the Term Loan-B facility.

As of June 30, 2013, we had no borrowings outstanding pursuant to the terms of our $800 million revolving credit facility and we had $769 million of available borrowing capacity, net of $10 million of outstanding borrowings pursuant to a short-term, on-demand credit facility and $21 million of outstanding letters of credit. The $10 million of outstanding borrowings under a short-term, on-demand credit facility as of June 30, 2013 are classified as long-term on our Consolidated Balance Sheet since we have the intent and ability to refinance through available borrowings under the terms of our Credit Agreement.

During the first six months of 2013, we made scheduled principal payments of $36 million on the Term Loan-A and Term Loan A2 facilities. Quarterly installment payments (Installment Payments) are due on the Term Loan-A and Term Loan-A2 facilities which, during 2013 and 2014, approximate $36 million during the remaining six months of 2013 and $72 million in 2014. No Installment Payments are due on the Term Loan-B facility. The Installment Payments due on the Term Loan-A and Term Loan-A2 facilities during the remainder of 2013 and the first six months of 2014 are classified as current maturities of long-term debt on our Consolidated Balance Sheet as of June 30, 2013.

Our accounts receivable securitization program (Securitization) with a group of conduit lenders and liquidity banks was amended in October, 2010. We increased the size of the Securitization from $200 million to $240 million (the Commitments), and extended the maturity date to October 25, 2013. In May, 2012, we further increased the size of the securitization by $35 million to $275 million. Substantially all of the patient-related accounts receivable of our acute care hospitals (Receivables) serve as collateral for the outstanding borrowings. The interest rate on the borrowings is based on the commercial paper rate plus a spread of 0.475% and there is a facility fee of 0.375% required on 102% on the Commitments. 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, 2013, we had $260 million of outstanding borrowings and $15 million of additional capacity pursuant to the terms of our accounts receivable securitization program. In the event we do not either enter into a new financing agreement, or an agreement to extend the scheduled maturity date of the Securitization, we expect to have the borrowing capacity and intend to refinance the Securitization upon its scheduled maturity utilizing borrowings under our Credit Agreement. Therefore, outstanding borrowings as of June 30, 2013 under the Securitization are classified as long-term on our Consolidated Balance Sheet.

Our $250 million, 7.00% senior unsecured notes (the Unsecured Notes) are scheduled to mature on October 1, 2018. The Unsecured Notes were issued on September 29, 2010 and registered in April, 2011. Interest on the Unsecured Note is payable semiannually in arrears on April 1st and October 1st of each year. The Unsecured Notes can be redeemed in whole at anytime subject to a make-whole call at treasury rate plus 50 basis points prior to October 1, 2014. They are also redeemable in whole or in part at a price of: (i) 103.5% on or after October 1, 2014; (ii) 101.75% on or after October 1, 2015, and; (iii) 100% on or after October 1, 2016. These Unsecured Notes are guaranteed by a group of subsidiaries (each of which is a 100% directly or indirectly owned subsidiary of Universal Health Services, Inc.) which fully and unconditionally guarantee the Unsecured Notes on a joint and several basis, subject to certain customary automatic release provisions.

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

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

Our Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens and indebtedness, transactions with affiliates and dividends; 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, 2013.

As of June 30, 2013, the carrying value of our debt was $3.55 billion and the fair-value of our debt was $3.60 billion. The fair value of our debt was computed based upon quotes received from financial institutions and 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 2012 and the first six months of 2013 and determined the hedges to be highly effective. We also determined that any portion of the hedges deemed to be ineffective was de minimis and therefore there was no material effect on our consolidated financial position, operations or cash flows. The counterparties to the interest rate swap agreements expose us to credit risk in the event of nonperformance. However, at June 30, 2013, each swap agreement entered into by us was in a net liability position which would require us to make the net settlement payments to the counterparties. We do not anticipate nonperformance by our counterparties. We do not hold or issue derivative financial instruments for trading purposes.

During the first quarter of 2011, we entered into a forward starting interest rate cap on a total notional amount of $450 million from December, 2011 to December, 2012 reducing to $400 million from December, 2012 to December, 2013 whereby we paid a premium of $740,000 in exchange for the counterparty agreeing to pay the difference between 7.00% and three-month LIBOR if the three-month LIBOR rate rises above 7.00% during the term of the cap. If the three-month LIBOR does not reach 7.00% during the term of the cap, no payment is made to us.

We also entered into six additional forward starting interest rate swaps in the first quarter of 2011 whereby we pay a fixed rate on a total notional amount of $425 million and receive three-month LIBOR. Three of these swaps with a total notional amount of $225 million became effective in March, 2011 and will mature in May, 2015. The average fixed rate payable on these swaps is 1.91%. The three remaining interest rate swaps with total notional amounts of $100 million, $25 million and $75 million became effective in December, 2011 and have/had fixed rates of 2.50%, 1.96% and 1.32%, and maturity dates in December, 2014, December, 2013 and December, 2012, respectively.

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During the fourth quarter of 2010, we entered into four forward starting interest rate swaps whereby we pay a fixed rate on a total notional amount of $600 million and receive three-month LIBOR. Each of the four swaps became effective in December, 2011 and will mature in May, 2015. The average fixed rate payable on these swaps is 2.38%.

We measure our interest rate swaps at fair value on a recurring basis. The fair value of our interest rate swaps is based primarily on quotes from banks. We consider those inputs to be level 2 in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with derivative instruments and hedging activities. The fair value of our interest rate swaps was an aggregate gross and net liability of $31 million at June 30, 2013, of which $18 million is included accounts payable and accrued liabilities and $13 million is included in other noncurrent liabilities on the accompanying balance sheet. The fair value of our interest rate swaps was an aggregate gross and net liability of $41 million at December 31, 2012, substantially all of which is included in other noncurrent liabilities on the accompanying balance sheet.

(5) Commitments and Contingencies

Professional and General Liability, Workers Compensation Liability and Property Insurance

Professional and General Liability and Workers Compensation Liability:

Effective January 1, 2008, most of our subsidiaries became self-insured for professional and general liability exposure up to $10 million per occurrence. Prior to our acquisition of Psychiatric Solutions, Inc. (PSI) in November, 2010, our subsidiaries purchased several excess policies through commercial insurance carriers which provide for coverage in excess of $10 million up to $200 million per occurrence and in the aggregate. However, we are 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.

Prior to our acquisition in November, 2010, the PSI subsidiaries were commercially insured for professional and general liability insurance claims in excess of a $3 million self-insured retention to a limit of $75 million. PSI utilized its captive insurance company and that captive insurance company remains in place after our acquisition of PSI to manage the self-insured retention for all former PSI subsidiaries for claims incurred prior to January 1, 2011. The captive insurance company also continues to insure all professional and general liability claims, regardless of date incurred, for the former PSI subsidiaries located in Florida and Puerto Rico.

Since our acquisition of PSI on November 15, 2010, the former PSI subsidiaries are self-insured for professional and general liability exposure up to $3 million per occurrence and our legacy subsidiaries (which are not former PSI subsidiaries) are self-insured for professional and general liability exposure up to $10 million per occurrence. Effective November, 2010, our subsidiaries (including the former PSI subsidiaries) were provided with several excess policies through commercial insurance carriers which provide for coverage in excess of the applicable per occurrence self-insured retention (either $3 million or $10 million) up to $200 million per occurrence and in the aggregate. 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. The 9 behavioral health facilities acquired from Ascend Health Corporation in October, 2012 have general and professional liability policies through commercial insurance carriers which provide for up to $20 million of aggregate coverage, subject to a $10,000 per occurrence deductible. These facilities, like our other facilities, are also provided excess coverage through commercial insurance carriers for coverage in excess of the underlying commercial policy limitations up to $200 million per occurrence and in the aggregate.

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, 2013, the total accrual for our professional and general liability claims, including the estimated claims related to the facilities acquired from PSI, was $217 million, of which $48 million is included in current liabilities. As of December 31, 2012, the total accrual for our professional and general liability claims, including the estimated claims related to the facilities acquired from PSI, was $279 million, of which $48 million is included in current liabilities.

During the second quarter of 2013, pursuant to a reserve analysis, we recorded reductions to our professional and general liability self-insurance reserves (relating to years prior to 2013) amounting to $65 million in the aggregate. The favorable changes in our estimated future claims payments relating to years prior to 2013 were due to: (i) an increased weighting given to company-specific metrics (to 100% from 75%), and

decreased general industry metrics (to 0% from 25%), related to projected incidents per exposure, historical

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claims experience and loss development factors; (ii) historical data which measured the realized favorable impact of medical malpractice tort reform experienced in several states in which we operate, and; (iii) a decrease in claims related to certain higher risk specialties (such as obstetrical) due to a continuation of the company-wide patient safety initiative undertaken during the last several years. As the number of our facilities and our patient volumes have increased, thereby providing for a statistically significant data group, and taking into consideration our long-history of company-specific risk management programs and claims experience, our reserve analyses have included a greater emphasis on our historical professional and general liability experience which has developed favorably as compared to general industry trends.

The total accrual for our workers compensation liability claims was $68 million as of June 30, 2013 and $66 million as of December 31, 2012, of which $35 million is included in current liabilities as of each date.

Property Insurance:

We have commercial property insurance policies covering catastrophic losses, including windstorm damage, up to a $1 billion policy limit per occurrence, subject to a $250,000 deductible for the majority of our properties (the properties acquired from Psychiatric Solutions, Inc. are subject to a $50,000 deductible). Losses resulting from named windstorms are subject to deductibles between 3% and 5% of the declared total insurable value of the property. In addition, we have commercial property insurance policies covering catastrophic losses resulting from earthquake and flood damage, each subject to aggregated loss limits (as opposed to per occurrence losses). Our earthquake limit is $250 million, subject to a deductible of $250,000, except for facilities located within documented fault zones. Earthquake losses that affect facilities located in fault zones within the United States are subject to a $100 million limit and will have applied deductibles ranging from 1% to 5% of the declared total insurable value of the property. The earthquake limit in Puerto Rico is $25 million. Flood losses have either a $250,000 or $500,000 deductible, based upon the location of the facility. The 9 behavioral health facilities acquired from Ascend Health Corporation in October, 2012 have commercial property insurance policies which provide for full replacement cost coverage, subject to a $10,000 deductible.

Other

As of June 30, 2013 and December 31, 2012, our accounts receivable includes approximately $30 million and $70 million, respectively, due from Illinois. Although the outstanding balance has been reduced significantly during the second quarter of 2013 as a result of substantial cash remittances received from the state (approximately $72 million was due from Illinois as of March 31, 2013), collection of the outstanding receivables continues to be delayed due to state budgetary and funding pressures. Approximately $7 million as of June 30, 2013 and $51 million as of December 31, 2012, of the receivables due from Illinois were outstanding in excess of 60 days, as of each respective date. Although the remaining accounts receivable due from Illinois 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. Failure to ultimately collect all outstanding amounts due from Illinois would have an adverse impact on our future consolidated results of operations and cash flows.

As of June 30, 2013 we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds which totaled $91 million consisting of: (i) $70 million related to our self-insurance programs, and; (ii) $21 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 litigation, as outlined below.

Office of Inspector General (OIG) and Other Government Investigations

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

In July, 2012, one of our subsidiaries, Peachford Behavioral Health System of Atlanta located in Atlanta, Georgia, received a subpoena from the OIG for the Department of Health and Human Services requesting various documents from 2004 to the present. We have provided all requested documents. 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.

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In February, 2013, the OIG served a subpoena requesting various documents from January 2008 to the present directed at Universal Health Services, Inc. (UHS) concerning it and UHS of Delaware, Inc., and several UHS owned 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 United States Department of Justice of its intent to proceed with an investigation following requests for documents from January, 2007 to the present 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 present, and; (iii) The Meadows Psychiatric Center received a subpoena from the OIG in February, 2013 requesting certain documents from 2008 to the present. 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 present. In June, 2013, the OIG served a subpoena on Coastal Harbor Health System in Savannah, Georgia requesting documents from January, 2009 to the present. In July 2013, another subpoena was issued to Wekiva Springs and River Point requesting additional records. At present, we are uncertain as to the focus, scope or extent of the investigations, liability of the facilities and/or potential financial exposure, if any, in connection with these matters. Unrelated to these matters, the Keys of Carolina was closed and the real property was sold in January, 2013.

Matters Relating to PSI:

The following matters pertain to PSI or former PSI facilities (owned by subsidiaries of Psychiatric Solutions, Inc.) 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:

Garden City Employees Retirement System v. PSI:

This is a purported shareholder class action lawsuit filed in the United States District Court for the Middle District of Tennessee against PSI and the former directors in 2009 alleging violations of federal securities laws. We intend to defend the case vigorously. Should we be deemed liable in this matter, we believe we would be entitled to commercial insurance recoveries for amounts paid by us, subject to certain limitations and deductibles. Included in our consolidated balance sheets as of December 31, 2012 and 2011, is an estimated reserve (current liability) and corresponding commercial insurance recovery (current asset) which did not have a material impact on our financial statements. Although we believe the commercial insurance recoveries are adequate to satisfy potential liability and related legal fees in connection with this matter, we can provide no assurance that the ultimate liability will not exceed the commercial insurance recoveries which would make us liable for the excess.

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 have been 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 been collected and delivered to the DOJ. 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. 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.

Virginia Department of Medical Assistance Services Recoupment Claims:

The Virginia Department of Medical Assistance Services (DMAS) has conducted audits at seven former PSI Residential Treatment Centers operated in the Commonwealth of Virginia to confirm compliance with provider rules under the state s Medicaid Provider Services Manual (Manual). As a result of those audits, DMAS claims the facilities failed to comply with the requirements of the Manual and has requested repayment of Medicaid payments to those facilities. PSI had previously filed appeals to repayment demands at each facility which are currently pending. We have recently reached a preliminary settlement of this matter which requires finalization of a definitive agreement and approval of Virginia state officials. The aggregate refund of Medicaid payments made to those facilities, as requested by DMAS, and the settlement amount is not material to our consolidated financial position or results of operations.

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General:

The healthcare industry is subject to numerous laws and regulations which include, among other things, matters such as government healthcare participation requirements, various licensure, certifications, and accreditations, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government action has increased with respect to investigations and/or allegations concerning possible violations of fraud and abuse and false claims statutes and/or regulations by healthcare providers. Currently, and from time to time, some of our facilities are subjected to inquiries and/or actions and receive notices of potential non-compliance of laws and regulations from various federal and state agencies. Providers that are found to have violated these laws and regulations may be excluded from participating in government healthcare programs, subjected to potential licensure, certification, and/or accreditation revocation, subjected to fines or penalties or required to repay amounts received from the government for previously billed patient services. We monitor all aspects of our business and have developed a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards. Because the law in this area is complex and constantly evolving, governmental investigation or litigation may result in interpretations that are inconsistent with industry practices, including ours. Although we believe our policies, procedures and practices comply with governmental regulations, there is no assurance that we will not be faced with sanctions, fines or penalties in connection with such inquiries or actions, including with respect to the investigations and other matters discussed herein. Even if we were to ultimately prevail, such inquiries and/or actions 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, 2012. The corporate overhead allocations, as reflected below, are utilized for internal reporting purposes and are comprised of each period s projected corporate-level operating expenses (excluding interest expense). The overhead expenses are captured and allocated directly to each segment, to the extent possible, with the non-directly allocated overhead expenses allocated based upon each segment s respective percentage of total facility-based operating expenses.

	Three months ended June 30, 2013			
	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 3,321,154	$ 1,598,383		$ 4,919,537
Gross outpatient revenues	$ 1,708,200	$ 193,703	$ 10,625	$ 1,912,528
Total net revenues	$ 894,646	$ 929,470	$ 10,859	$ 1,834,975
Income/(loss) before allocation of corporate overhead and income taxes	$ 118,390	$ 240,556	($ 93,128)	$ 265,818

Allocation of corporate overhead	($ 46,109)	($ 22,461)	$ 68,570	0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 72,281	$ 218,095	($ 24,558)	$ 265,818
Total assets as of 6/30/13	$ 3,126,223	$ 4,919,566	$ 271,464	$ 8,317,253

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	Six months ended June 30, 2013			
	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 6,828,424	$ 3,174,531		$ 10,002,955
Gross outpatient revenues	$ 3,359,775	$ 379,505	$ 21,473	$ 3,760,753
Total net revenues	$ 1,803,380	$ 1,839,014	$ 24,213	$ 3,666,607
Income/(loss) before allocation of corporate overhead and income taxes	$ 199,019	$ 461,331	($ 190,548)	$ 469,802
Allocation of corporate overhead	($ 92,221)	($ 44,828)	$ 137,049	0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 106,798	$ 416,503	($ 53,499)	$ 469,802
Total assets as of 6/30/13	$ 3,126,223	$ 4,919,566	$ 271,464	$ 8,317,253

	Three months ended June 30, 2012			
	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 3,034,707	$ 1,416,820		$ 4,451,527
Gross outpatient revenues	$ 1,540,569	$ 162,162	$ 12,723	$ 1,715,454
Total net revenues	$ 843,597	$ 870,267	$ 9,219	$ 1,723,083
Income/(loss) before allocation of corporate overhead and income taxes	$ 63,817	$ 223,324	($ 102,697)	$ 184,444
Allocation of corporate overhead	($ 39,363)	($ 20,974)	$ 60,337	0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 24,454	$ 202,350	($ 42,360)	$ 184,444
Total assets as of 6/30/12	$ 2,892,535	$ 4,420,939	$ 445,174	$ 7,758,648

	Six months ended June 30, 2012			
	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 6,312,862	$ 2,832,358		$ 9,145,220
Gross outpatient revenues	$ 3,089,419	$ 322,835	$ 24,993	$ 3,437,247
Total net revenues	$ 1,770,128	$ 1,730,587	$ 15,404	$ 3,516,119
Income/(loss) before allocation of corporate overhead and income taxes	$ 194,127	$ 424,249	($ 211,614)	$ 406,762
Allocation of corporate overhead	($ 78,722)	($ 41,938)	$ 120,660	0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 115,405	$ 382,311	($ 90,954)	$ 406,762
Total assets as of 6/30/12	$ 2,892,535	$ 4,420,939	$ 445,174	$ 7,758,648

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

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

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

	Three months ended June 30,		Six months ended June 30,	
	(amounts in thousands)			
	2013	2012	2013	2012
Basic and Diluted:				
Net income attributable to UHS	$ 151,841	$ 107,561	$ 271,625	$ 236,168
Less: Net income attributable to unvested restricted share grants	(88)	(126)	(157)	(294)
Net income attributable to UHS basic and diluted	$ 151,753	$ 107,435	$ 271,468	$ 235,874
Weighted average number of common shares basic	98,033	96,691	97,872	96,642
Net effect of dilutive stock options and grants based on the treasury stock method	1,178	1,038	1,019	1,118
Weighted average number of common shares and equivalents diluted	99,211	97,729	98,891	97,760
Earnings per basic share attributable to UHS	$ 1.55	$ 1.11	$ 2.77	$ 2.44
Earnings per diluted share attributable to UHS	$ 1.53	$ 1.10	$ 2.75	$ 2.41

The Net effect of dilutive stock options and grants based on the treasury stock method , for all periods presented above, excludes certain outstanding stock options applicable to each period since the effect would have been anti-dilutive. There were no significant anti-dilutive stock options during the three and six months ended June 30, 2013. The excluded weighted-average stock options totaled 2.6 million for each of the three months and six months ended June 30, 2012. All classes of our common stock have the same dividend rights.

Stock-Based Compensation: During the three-month periods ended June 30, 2013 and 2012, compensation cost of $6.1 million ($3.8 million after-tax) and $4.7 million ($2.9 million after-tax), respectively, was recognized related to outstanding stock options. During the six-month periods ended June 30, 2013 and 2012, compensation cost of $12.8 million ($8.0 million after-tax) and $9.6 million ($6.0 million after-tax), respectively, was recognized related to outstanding stock options. In addition, during the three-month periods ended June 30, 2013 and 2012, compensation cost of approximately $307,000 ($191,000 after-tax) and $593,000 ($369,000 after-tax), respectively, was recognized related to restricted stock. During the six-month periods ended June 30, 2013 and 2012, compensation cost of approximately $712,000 ($443,000 after-tax) and $1.2 million ($727,000 after-tax), respectively, was recognized related to restricted stock. As of June 30, 2013 there was $52.3 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 2.8 years. There were 2,777,400 stock options granted (net of cancellations) during the first six months of 2013 with a weighted-average grant date fair value of $13.31 per share.

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(8) Dispositions and acquisitions

Six-month periods ended June 30, 2013 and 2012:

Acquisitions:

During the first six months of 2013, we spent approximately $1 million in connection with the acquisition of real property located in Pennsylvania.

During the first six months of 2012, we spent $11 million in connection with the acquisition of a physician practice and various real properties.

Divestitures:

During the first six months of 2013, we received aggregate cash proceeds of approximately $34 million for the divestiture of Peak Behavioral Health Services (Peak), a 104-bed behavioral health care facility located in Santa Teresa, New Mexico, and certain real property, including three previously closed behavioral health care facilities. In connection with the receipt of antitrust clearance from the Federal Trade Commission in connection with our acquisition of Ascend Health Corporation in October of 2012, we agreed to divest Peak Behavioral Health Services. The assets and liabilities for Peak were reflected as held for sale on our Consolidated Balance Sheet as of December 31, 2012. The pre-tax net gain on these divestitures did not have a material impact on our consolidated results of operations during the three or six-month periods ended June 30, 2013.

During the first six months of 2012, we received aggregate cash proceeds of approximately $53 million for the divestiture of: (i) the Hospital San Juan Capestrano, a 108-bed behavioral health care facility located in Rio Piedras, Puerto Rico, that was sold in January, 2012 pursuant to our agreement with the Federal Trade Commission in connection with our acquisition of Psychiatric Solutions, Inc., and; (ii) the real property of a previously closed behavioral health care facility. The pre-tax net gain on these divestitures did not have a material impact on our consolidated results of operations during the first six months of 2012.

(9) Dividends

We declared and paid dividends of $4.9 million, or $.05 per share, during the second quarter of 2013 and $4.8 million, or $.05 per share, during the second quarter of 2012. We declared and paid dividends of $9.8 million and $9.7 million during the six-month periods ended June 30, 2013 and 2012, respectively.

(10) Pension Plan

The following table shows the components of net periodic pension cost for our defined benefit pension plan as of June 30, 2013 and 2012 (amounts in thousands):

	Three months ended June 30,		Six months ended June 30,	
	2013	2012	2013	2012
Service cost	$ 277	$ 286	$ 530	$ 572
Interest cost	1,230	1,165	2,264	2,330
Expected return on assets	(2,435)	(2,111)	(3,801)	(3,651)
Recognized actuarial loss	717	1,055	1,653	2,110
Net periodic pension cost	$ (211)	$ 395	$ 646	$ 1,361

During the six months ended June 30, 2013, there were no contributions made to our pension plan.

(11) Income Taxes

As of January 1, 2013, our unrecognized tax benefits were approximately $7 million. The amount, if recognized, that would affect the effective tax rate is approximately $4 million. During the quarter ended June 30, 2013, 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, 2013, we have approximately $2 million of accrued interest and penalties. The U.S. federal statute of limitations remains open for the 2009 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.

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

(12) Supplemental Condensed Consolidating Financial Information

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

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

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONDENSED CONSOLIDATING STATEMENTS OF INCOME

FOR THE THREE MONTHS ENDED JUNE 30, 2013

(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net revenues before provision for doubtful accounts	$ 0	$ 1,416,011	$ 672,949	$ (7,298)	$ 2,081,662
Less: Provision for doubtful accounts	0	150,294	96,393	0	246,687
Net revenues	0	1,265,717	576,556	(7,298)	1,834,975
Operating charges:					
Salaries, wages and benefits	0	639,421	257,913	0	897,334
Other operating expenses	0	193,388	139,063	(6,889)	325,562
Supplies expense	0	123,894	78,450	0	202,344
Depreciation and amortization	0	57,597	24,085	0	81,682
Lease and rental expense	0	15,536	8,955	(409)	24,082
Electronic health records incentive income	0	(452)	369	0	(83)
	0	1,029,384	508,835	(7,298)	1,530,921
Income from operations	0	236,333	67,721	0	304,054
Interest expense	36,772	846	618	0	38,236
Interest (income) expense, affiliate	0	24,391	(24,391)	0	0
Equity in net income of consolidated affiliates	(174,539)	(38,497)	0	213,036	0
Income before income taxes	137,767	249,593	91,494	(213,036)	265,818
Provision for income taxes	(14,074)	93,570	18,519	0	98,015

Net income	151,841	156,023	72,975	(213,036)	167,803
Less: Income attributable to noncontrolling interests	0	0	15,962	0	15,962
Net income attributable to UHS	$ 151,841	$ 156,023	$ 57,013	$ (213,036)	$ 151,841

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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONDENSED CONSOLIDATING STATEMENTS OF INCOME

FOR THE SIX MONTHS ENDED JUNE 30, 2013

(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net revenues before provision for doubtful accounts	$ 0	$ 2,837,863	$ 1,336,155	$ (14,008)	$ 4,160,010
Less: Provision for doubtful accounts	0	300,062	193,341	0	493,403
Net revenues	0	2,537,801	1,142,814	(14,008)	3,666,607
Operating charges:					
Salaries, wages and benefits	0	1,285,015	514,615	0	1,799,630
Other operating expenses	0	437,807	282,266	(13,504)	706,569
Supplies expense	0	252,604	154,382	0	406,986
Depreciation and amortization	0	113,376	48,118	0	161,494
Lease and rental expense	0	31,211	18,040	(504)	48,747
Electronic health records incentive income	0	(3,568)	(1,227)	0	(4,795)
	0	2,116,445	1,016,194	(14,008)	3,118,631
Income from operations	0	421,356	126,620	0	547,976
Interest expense	74,718	1,700	1,756	0	78,174
Interest (income) expense, affiliate	0	48,782	(48,782)	0	0
Equity in net income of consolidated affiliates	(317,745)	(70,278)	0	388,023	0
Income before income taxes	243,027	441,152	173,646	(388,023)	469,802
Provision for income taxes	(28,598)	158,893	41,769	0	172,064
Net income	271,625	282,259	131,877	(388,023)	297,738
Less: Income attributable to noncontrolling interests	0	0	26,113	0	26,113
Net income attributable to UHS	$ 271,625	$ 282,259	$ 105,764	$ (388,023)	$ 271,625

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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONDENSED CONSOLIDATING STATEMENTS OF INCOME

FOR THE THREE MONTHS ENDED JUNE 30, 2012

(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net revenues before provision for doubtful accounts	$ 0	$ 1,293,848	$ 620,494	$ (6,553)	$ 1,907,789
Less: Provision for doubtful accounts	0	105,390	79,316	0	184,706
Net revenues	0	1,188,458	541,178	(6,553)	1,723,083
Operating charges:					
Salaries, wages and benefits	0	608,937	245,926	0	854,863
Other operating expenses	0	223,553	127,967	(6,459)	345,061
Supplies expense	0	122,524	75,292	0	197,816
Depreciation and amortization	0	50,997	21,986	0	72,983
Lease and rental expense	0	14,394	9,683	(94)	23,983
Electronic health records incentive income	0	(1,955)	0	0	(1,955)
	0	1,018,450	480,854	(6,553)	1,492,751
Income from operations	0	170,008	60,324	0	230,332
Interest expense	44,298	838	752	0	45,888
Interest (income) expense, affiliate	0	22,783	(22,783)	0	0
Equity in net income of consolidated affiliates	(134,904)	(28,548)	0	163,452	0
Income before income taxes	90,606	174,935	82,355	(163,452)	184,444
Provision for income taxes	(16,955)	62,521	21,434	0	67,000
Net income	107,561	112,414	60,921	(163,452)	117,444
Less: Income attributable to noncontrolling interests	0	0	9,883	0	9,883
Net income attributable to UHS	$ 107,561	$ 112,414	$ 51,038	$ (163,452)	$ 107,561

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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONDENSED CONSOLIDATING STATEMENTS OF INCOME

FOR THE SIX MONTHS ENDED JUNE 30, 2012

(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net revenues before provision for doubtful accounts	$ 0	$ 2,627,313	$ 1,234,978	$ (12,879)	$ 3,849,412
Less: Provision for doubtful accounts	0	194,768	138,525	0	333,293
Net revenues	0	2,432,545	1,096,453	(12,879)	3,516,119
Operating charges:					
Salaries, wages and benefits	0	1,230,001	496,976	0	1,726,977
Other operating expenses	0	459,381	249,670	(12,690)	696,361
Supplies expense	0	250,833	152,343	0	403,176
Depreciation and amortization	0	102,257	42,518	0	144,775
Lease and rental expense	0	29,238	18,376	(189)	47,425
Electronic health records incentive income	0	(1,955)	0	0	(1,955)
	0	2,069,755	959,883	(12,879)	3,016,759
Income from operations	0	362,790	136,570	0	499,360
Interest expense	89,452	1,625	1,521	0	92,598
Interest (income) expense, affiliate	0	45,565	(45,565)	0	0
Equity in net income of consolidated affiliates	(291,382)	(69,625)	0	361,007	0
Income before income taxes	201,930	385,225	180,614	(361,007)	406,762
Provision for income taxes	(34,238)	136,629	44,357	0	146,748
Net income	236,168	248,596	136,257	(361,007)	260,014
Less: Income attributable to noncontrolling interests	0	0	23,846	0	23,846
Net income attributable to UHS	$ 236,168	$ 248,596	$ 112,411	$ (361,007)	$ 236,168

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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME

FOR THE THREE MONTHS ENDED JUNE 30, 2013

(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net income	$ 151,841	$ 156,023	$ 72,975	$ (213,036)	$ 167,803
Other comprehensive income (loss):					
Unrealized derivative gains on cash flow hedges	5,282	0	0	0	5,282
Amortization of terminated hedge	(84)	0	0	0	(84)
Other comprehensive income before tax	5,198	0	0	0	5,198
Income tax expense related to items of other comprehensive income	1,960	0	0	0	1,960
Total other comprehensive income, net of tax	3,238	0	0	0	3,238
Comprehensive income	155,079	156,023	72,975	(213,036)	171,041
Less: Comprehensive income attributable to noncontrolling interests	0	0	15,962	0	15,962
Comprehensive income attributable to UHS	$ 155,079	$ 156,023	$ 57,013	$ (213,036)	$ 155,079

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME
FOR THE SIX MONTHS ENDED JUNE 30, 2013
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net income	$ 271,625	$ 282,259	$ 131,877	$ (388,023)	$ 297,738
Other comprehensive income (loss):					
Unrealized derivative gains on cash flow hedges	9,817	0	0	0	9,817
Amortization of terminated hedge	(168)	0	0	0	(168)
Other comprehensive income before tax	9,649	0	0	0	9,649
Income tax expense related to items of other comprehensive income	3,638	0	0	0	3,638
Total other comprehensive income, net of tax	6,011	0	0	0	6,011
Comprehensive income	277,636	282,259	131,877	(388,023)	303,749
Less: Comprehensive income attributable to noncontrolling interests	0	0	26,113	0	26,113

Comprehensive income attributable to UHS	$ 277,636	$ 282,259	$ 105,764	$ (388,023)	$ 277,636

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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME

FOR THE THREE MONTHS ENDED JUNE 30, 2012

(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net income	$ 107,561	$ 112,414	$ 60,921	$ (163,452)	$ 117,444
Other comprehensive income (loss):					
Unrealized derivative gains on cash flow hedges	212	0	0	0	212
Amortization of terminated hedge	(84)	0	0	0	(84)
Other comprehensive income before tax	128	0	0	0	128
Income tax expense related to items of other comprehensive income	50	0	0	0	50
Total other comprehensive income, net of tax	78	0	0	0	78
Comprehensive income	107,639	112,414	60,921	(163,452)	117,522
Less: Comprehensive income attributable to noncontrolling interests	0	0	9,883	0	9,883
Comprehensive income attributable to UHS	$ 107,639	$ 112,414	$ 51,038	$ (163,452)	$ 107,639

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME
FOR THE SIX MONTHS ENDED JUNE 30, 2012
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net income	$ 236,168	$ 248,596	$ 136,257	$ (361,007)	$ 260,014
Other comprehensive income (loss):					
Unrealized derivative gains on cash flow hedges	1,827	0	0	0	1,827
Amortization of terminated hedge	(168)	0	0	0	(168)
Other comprehensive income before tax	1,659	0	0	0	1,659
Income tax expense related to items of other comprehensive income	632	0	0	0	632
Total other comprehensive income, net of tax	1,027	0	0	0	1,027
Comprehensive income	237,195	248,596	136,257	(361,007)	261,041
Less: Comprehensive income attributable to noncontrolling interests	0	0	23,846	0	23,846

Comprehensive income attributable to UHS	$ 237,195	$ 248,596	$ 112,411	$ (361,007)	$ 237,195

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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONDENSED CONSOLIDATING BALANCE SHEET

AS OF JUNE 30, 2013

(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Assets					
Current assets:					
Cash and cash equivalents	$ 0	$ 3,570	$ 8,988	$ 0	$ 12,558
Accounts receivable, net	3,977	780,362	365,138	0	1,149,477
Supplies	0	62,380	37,944	0	100,324
Other current assets	2,477	74,488	9,768	0	86,733
Deferred income taxes	91,321	43,567	0	0	134,888
Total current assets	97,775	964,367	421,838	0	1,483,980
Investments in subsidiaries	6,099,224	1,394,110	0	(7,493,334)	0
Intercompany receivable	453,498	0	462,047	(915,545)	0
Intercompany note receivable	0	0	1,007,453	(1,007,453)	0
Property and equipment	0	3,981,118	1,538,701	0	5,519,819
Less: accumulated depreciation	0	(1,384,909)	(731,505)	0	(2,116,414)
	0	2,596,209	807,196	0	3,403,405
Other assets:					
Goodwill	820	2,544,014	496,512	0	3,041,346
Deferred charges	58,717	5,702	2,491	0	66,910
Other	8,646	237,414	75,552	0	321,612
	$ 6,718,680	$ 7,741,816	$ 3,273,089	$ (9,416,332)	$ 8,317,253
Liabilities and Stockholders Equity					
Current liabilities:					
Current maturities of long-term debt	$ 71,903	$ 591	$ 1,085	$ 0	$ 73,579
Accounts payable and accrued liabilities	42,144	740,872	175,936	0	958,952
Federal and state taxes	16,093	526	0	0	16,619
Total current liabilities	130,140	741,989	177,021	0	1,049,150
Intercompany payable	0	915,545	0	(915,545)	0
Other noncurrent liabilities	18,456	186,685	105,807	0	310,948
Long-term debt	3,428,610	5,245	39,251	0	3,473,106
Intercompany note payable	0	1,007,453	0	(1,007,453)	0
Deferred income taxes	150,017	56,801	0	0	206,818
Redeemable noncontrolling interests	0	0	233,417	0	233,417
UHS common stockholders equity	2,991,457	4,828,098	2,665,236	(7,493,334)	2,991,457
Noncontrolling interest	0	0	52,357	0	52,357

Total equity	2,991,457	4,828,098	2,717,593	(7,493,334)	3,043,814
	$ 6,718,680	$ 7,741,816	$ 3,273,089	$ (9,416,332)	$ 8,317,253

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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONDENSED CONSOLIDATING BALANCE SHEET

AS OF DECEMBER 31, 2012

(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Assets					
Current assets:					
Cash and cash equivalents	$ 0	$ 11,949	$ 11,522	$ 0	$ 23,471
Accounts receivable, net	7,154	741,983	318,060	0	1,067,197
Supplies	0	61,100	37,900	0	99,000
Other current assets	2,188	75,117	10,631	0	87,936
Deferred income taxes	61,364	43,555	322	(780)	104,461
Assets of facilities held for sale	0	0	25,431	0	25,431
Total current assets	70,706	933,704	403,866	(780)	1,407,496
Investments in subsidiaries	5,781,479	1,323,832	0	(7,105,311)	0
Intercompany receivable	644,105	0	360,538	(1,004,643)	0
Intercompany note receivable	0	0	1,007,453	(1,007,453)	0
Property and equipment	0	3,867,471	1,500,874	0	5,368,345
Less: accumulated depreciation	0	(1,288,975)	(697,135)	0	(1,986,110)
	0	2,578,496	803,739	0	3,382,235
Other assets:					
Goodwill	820	2,554,531	481,414	0	3,036,765
Deferred charges	67,831	5,839	2,218	0	75,888
Other	9,645	209,558	79,256	0	298,459
	$ 6,574,586	$ 7,605,960	$ 3,138,484	$ (9,118,187)	$ 8,200,843
Liabilities and Stockholders Equity					
Current liabilities:					
Current maturities of long-term debt	$ 0	$ 990	$ 1,599	$ 0	$ 2,589
Accounts payable and accrued liabilities	10,985	740,484	138,088	0	889,557
Liabilities of facilities held for sale	0	0	850	0	850
Federal and state taxes	0	900	620	(458)	1,062
Total current liabilities	10,985	742,374	141,157	(458)	894,058
Intercompany payable	0	1,004,643	0	(1,004,643)	0
Other noncurrent liabilities	46,048	243,478	105,829	0	395,355
Long-term debt	3,676,940	5,372	45,119	0	3,727,431
Intercompany note payable	0	1,007,453	0	(1,007,453)	0
Deferred income taxes	127,268	56,801	0	(322)	183,747
Redeemable noncontrolling interests	0	0	234,303	0	234,303
UHS common stockholders equity	2,713,345	4,545,839	2,559,472	(7,105,311)	2,713,345

Noncontrolling interest	0	0	52,604	0	52,604
Total equity	2,713,345	4,545,839	2,612,076	(7,105,311)	2,765,949
	$ 6,574,586	$ 7,605,960	$ 3,138,484	$ (9,118,187)	$ 8,200,843

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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS

FOR THE SIX MONTHS ENDED JUNE 30, 2013

(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net cash provided by operating activities	$ **16,014**	$ **242,016**	**147,972**	$ **0**	$ **406,002**
Cash Flows from Investing Activities:					
Property and equipment additions, net of disposals	0	(133,607)	(42,337)	0	(175,944)
Proceeds received from sale of assets and businesses	0	7,552	26,456	0	34,008
Acquisition of property and businesses	0	(1,320)	0	0	(1,320)
Costs incurred for purchase and implementation of electronic health records application	0	(33,396)	0	0	(33,396)
Net cash used in investing activities	**0**	**(160,771)**	**(15,881)**	**0**	**(176,652)**
Cash Flows from Financing Activities:					
Reduction of long-term debt	(189,188)	(526)	(6,382)	0	(196,096)
Additional borrowings	11,000	0	0	0	11,000
Repurchase of common shares	(21,373)	0	0	0	(21,373)
Dividends paid	(9,795)	0	0	0	(9,795)
Issuance of common stock	2,735	0	0	0	2,735
Profit distributions to noncontrolling interests	0	0	(26,734)	0	(26,734)
Changes in intercompany balances with affiliates, net	190,607	(89,098)	(101,509)	0	0
Net cash used in financing activities	**(16,014)**	**(89,624)**	**(134,625)**	**0**	**(240,263)**
Decrease in cash and cash equivalents	0	(8,379)	(2,534)	0	(10,913)
Cash and cash equivalents, beginning of period	0	11,949	11,522	0	23,471
Cash and cash equivalents, end of period	$ 0	$ 3,570	$ 8,988	$ 0	$ 12,558

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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS

FOR THE SIX MONTHS ENDED JUNE 30, 2012

(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net cash provided by operating activities	$ **2,144**	$ **279,941**	**90,777**	$ **0**	$ **372,862**
Cash Flows from Investing Activities:					
Property and equipment additions, net of disposals	0	(153,894)	(28,457)	0	(182,351)
Proceeds received from sale of assets and businesses	0	49,984	3,477	0	53,461
Acquisition of property and businesses	0	(11,476)	0	0	(11,476)
Costs incurred for purchase and implementation of electronic health records application	0	(28,008)	0	0	(28,008)
Return of deposit on terminated purchase agreement	6,500	0	0	0	6,500
Net cash provided by (used in) investing activities	**6,500**	**(143,394)**	**(24,980)**	**0**	**(161,874)**
Cash Flows from Financing Activities:					
Reduction of long-term debt	(191,898)	(2,289)	(1,499)	0	(195,686)
Repurchase of common shares	(2,927)	0	0	0	(2,927)
Dividends paid	(9,673)	0	0	0	(9,673)
Issuance of common stock	2,575	0	0	0	2,575
Profit distributions to noncontrolling interests	0	0	(13,565)	0	(13,565)
Changes in intercompany balances with affiliates, net	193,279	(144,331)	(48,948)	0	0
Net cash used in financing activities	**(8,644)**	**(146,620)**	**(64,012)**	**0**	**(219,276)**
(Decrease) increase in cash and cash equivalents	0	(10,073)	1,785	0	(8,288)
Cash and cash equivalents, beginning of period	0	33,221	8,008	0	41,229
Cash and cash equivalents, end of period	$ 0	$ 23,148	$ 9,793	$ 0	$ 32,941

(13) Recent Accounting Standards

In February 2013, the Financial Accounting Standards Board issued an Accounting Standards Update on reporting of amounts reclassified out of accumulated other comprehensive income. This guidance, which is effective for fiscal years beginning after December 15, 2012, requires companies to provide information about amounts reclassified out of accumulated other comprehensive income by component (the respective line items of the income statement). The adoption of this standard on January 1, 2013 had no impact on our financial position or overall results of operations.

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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, 2013, we owned and/or operated 23 acute care hospitals and 195 behavioral health centers located in 37 states, Washington, D.C., Puerto Rico and the U.S. Virgin Islands. As part of our ambulatory treatment centers division, we manage and/or own outright or in partnerships with physicians, 5 surgical hospitals and surgery and radiation oncology centers located in 4 states. In October, 2012, we acquired Ascend Health Corporation (Ascend). Ascend was the largest private behavioral health provider with 9 owned or leased freestanding inpatient facilities located in 5 states.

Net revenues from our acute care hospitals, surgical hospitals, surgery centers and radiation oncology centers accounted for 49% of our consolidated net revenues during each of the three-month periods ended June 30, 2013 and 2012 and 50% and 51% during the six-month periods ended June 30, 2013 and 2012, respectively. Net revenues from our behavioral health care facilities accounted for 51% of our consolidated net revenues during each of the three-month periods ended June 30, 2013 and 2012 and 50% and 49% during the six-month periods ended June 30, 2013 and 2012, respectively.

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

Forward-Looking Statements and Risk Factors

You should carefully review the information contained in this Quarterly Report, and should particularly consider any risk factors that we set forth in this Quarterly Report and in other reports or documents that we file from time to time with the Securities and Exchange Commission (the SEC). In this Quarterly Report, we state our beliefs of future events and of our future financial performance. This Quarterly Report contains forward-looking statements that reflect our current estimates, expectations and projections about our future results, performance, prospects and opportunities. Forward-looking statements include, among other things, the information concerning our possible future results of operations, business and growth strategies, financing plans, expectations that regulatory developments or other matters will not have a material adverse effect on our business or financial condition, our competitive position and the effects of competition, the projected growth of the industry in which we operate, and the benefits and synergies to be obtained from our completed and any future acquisitions, and statements of our goals and objectives, and other similar expressions concerning matters that are not historical facts. Words such as may, will, should, could, would, predicts, potential, continue, expects, anticipates, future, intends, plans, believes, estimates, appears, projects and similar 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, 2012 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 recently 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 new 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 programs, including Medicare or Medicaid;

an increase in the number of uninsured and self-pay patients treated at our acute care facilities that unfavorably impacts our ability to satisfactorily and timely collect our self-pay patient accounts;

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;

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the outcome of known and unknown litigation, government investigations, false claim act allegations, and liabilities and other claims asserted against us, including 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 continuation or worsening of unfavorable credit market conditions;

competition from other healthcare providers (including physician owned facilities) in certain markets, including McAllen/Edinburg, Texas, the site of one of our largest acute care facilities and Riverside County, California;

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 level of indebtedness has increased substantially as a result of our 2010 acquisition of PSI, and increased more as a result of our acquisition of Ascend Health Corporation in October, 2012, which could, among other things, adversely affect our ability to raise additional capital to fund operations, limit our ability to react to changes in the economy or our industry and could potentially prevent us from meeting our obligations under the agreements related to our indebtedness;

our ability to successfully integrate and improve our recent acquisitions and the availability of suitable acquisitions and divestiture opportunities;

as discussed below in *Sources of Revenue*, we receive revenues from various state and county based programs, including Medicaid in all the states in which we operate, (we receive Medicaid revenues in excess of $90 million annually from each of Texas, Pennsylvania, Washington, D.C., Illinois, Virginia and Massachusetts); CMS-approved Medicaid supplemental programs in certain states including Oklahoma, California 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 (which have been implemented in various forms with respect to our areas of operation in the respective states 2012, 2013 and 2014 fiscal years) 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 continue to 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. Our acute care hospitals may qualify for these EHR incentive payments upon implementation of the EHR application assuming they meet the meaningful use criteria . Certain of our acute care hospitals implemented EHR applications in 2011 and 2012 and we continued the implementation at each of our acute care hospitals, on a facility-by-facility basis, until completion which occurred in June, 2013. As of June 30, 2013, fifteen of our acute care hospitals met the meaningful use criteria and we expect the remainder to do so by the end of 2013. However, there can be no assurance that all of our acute care hospitals will ultimately qualify for these incentive payments and, should we qualify, we are unable to quantify the amount of incentive payments we may receive since the amounts are dependent upon various factors including the implementation timing at each hospital. Should we (our acute care hospitals) qualify for incentive payments, there may 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. 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 standardized amount in 2015 and each subsequent fiscal year. Although we believe that our acute care hospitals will be in compliance with the EHR standards by 2015, there can be no assurance that all of our facilities will be in compliance and therefore not subject to the penalty provision of the HITECH Act;

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

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Congressional committee, known as the Joint Select Committee on Deficit Reduction (the Joint Committee), which was tasked with making recommendations aimed at reducing future federal budget deficits by an additional $1.5 trillion over 10 years. The Joint Committee was unable to reach an agreement by the November 23, 2011 deadline and, as a result, across-the-board cuts to discretionary, national defense and Medicare spending were implemented on March 1, 2013 resulting in Medicare payment reductions of up to 2% per fiscal year (approximately $39 million annual reduction to our Medicare net revenues effective as of April 1, 2013) with a uniform percentage reduction across all Medicare programs. We cannot predict whether Congress will attempt to suspend or restructure the automatic budget cuts or what other deficit reduction initiatives may be proposed by Congress;

as of June 30, 2013 and December 31, 2012, our accounts receivable includes approximately $30 million and $70 million, respectively, due from Illinois. Although the outstanding balance has been reduced significantly during the second quarter of 2013 as a result of substantial cash remittances received from the state (approximately $72 million was due from Illinois as of March 31, 2013), collection of the outstanding receivables continues to be delayed due to state budgetary and funding pressures. Approximately $7 million as of June 30, 2013 and $51 million as of December 31, 2012, of the receivables due from Illinois were outstanding in excess of 60 days, as of each respective date. Although the remaining accounts receivable due from Illinois 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. Failure to ultimately collect all outstanding amounts due from Illinois would have an adverse impact on our future consolidated results of operations and cash flows.

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, 2012.

Revenue recognition: We record revenues and related receivables for health care services at the time the services are provided. Medicare and Medicaid revenues represented 36% and 39% of our net patient revenues during the three-month periods ended June 30, 2013 and 2012, respectively, and 36% and 39% during the six-month periods ended June 30, 2013 and 2012, respectively. Revenues from managed care entities, including health maintenance organizations and managed Medicare and Medicaid programs, accounted for 49% and 50% of our net patient revenues during the three-month periods ended June 30, 2013 and 2012, respectively, and 48% and 49% during the six-month periods ended June 30, 2013 and 2012, respectively.

Provision for Doubtful Accounts: On a consolidated basis, we monitor our total self-pay receivables to ensure that the total allowance for doubtful accounts provides adequate coverage based on historical collection experience. Our accounts receivable are recorded net of allowance

for doubtful accounts of $404 million at June 30, 2013 and $311 million at December 31, 2012.

As of June 30, 2013 and December 31, 2012, our accounts receivable includes approximately $30 million and $70 million, respectively, due from Illinois. Although the outstanding balance has been reduced significantly during the second quarter of 2013 as a result of substantial cash remittances received from the state (approximately $72 million was due from Illinois as of March 31, 2013), collection of the outstanding receivables continues to be delayed due to state budgetary and funding pressures. Approximately $7 million as of June 30, 2013 and $51 million as of December 31, 2012, of the receivables due from Illinois were outstanding in excess of 60 days, as of each respective date. Although the remaining accounts receivable due from Illinois 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. Failure to ultimately collect all outstanding amounts due from Illinois would have an adverse impact on our future consolidated results of operations and cash flows.

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

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

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

Self-Insured 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. 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, 2013, the total accrual for our professional and general liability claims, including the estimated claims related to the facilities acquired from PSI, was $217 million, of which $48 million is included in current liabilities. As of December 31, 2012, the total accrual for our professional and general liability claims, including the estimated claims related to the facilities acquired from PSI, was $279 million, of which $48 million is included in current liabilities.

During the second quarter of 2013, pursuant to a reserve analysis, we recorded reductions to our professional and general liability self-insurance reserves (relating to years prior to 2013) amounting to $65 million in the aggregate. The favorable changes in our estimated future claims payments relating to years prior to 2013 were due to: (i) an increased weighting given to company-specific metrics (to 100% from 75%), and decreased general industry metrics (to 0% from 25%), related to projected incidents per exposure, historical claims experience and loss development factors; (ii) historical data which measured the realized favorable impact of medical malpractice tort reform experienced in several states in which we operate, and; (iii) a decrease in claims related to certain higher risk specialties (such as obstetrical) due to a continuation of the company-wide patient safety initiative undertaken during the last several years. As the number of our facilities and our patient volumes have increased, thereby providing for a statistically significant data group, and taking into consideration our long-history of company-specific risk management programs and claims experience, our reserve analyses have included a greater emphasis on our historical professional and general liability experience which has developed favorably as compared to general industry trends.

Recent Accounting Standards: For a summary of accounting standards, please see *Note 13 to the Consolidated Financial Statements*, as included herein.

Results of Operations

Three-month periods ended June 30, 2013 and 2012:

The following table summarizes our results of operations and is used in the discussion below for the three-month periods ended June 30, 2013 and 2012 (dollar amounts in thousands):

	Three months ended June 30, 2013		Three months ended June 30, 2012	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$ 2,081,662		$ 1,907,789	
Less: Provision for doubtful accounts	246,687		184,706	
Net revenues	1,834,975	100.0%	1,723,083	100.0%
Operating charges:				
Salaries, wages and benefits	897,334	48.9%	854,863	49.6%
Other operating expenses	325,562	17.7%	345,061	20.0%
Supplies expense	202,344	11.0%	197,816	11.5%
Depreciation and amortization	81,682	4.5%	72,983	4.2%
Lease and rental expense	24,082	1.3%	23,983	1.4%
EHR incentive income	(83)	0.0%	(1,955)	-0.1%
Subtotal-operating expenses	1,530,921	83.4%	1,492,751	86.6%
Income from operations	304,054	16.6%	230,332	13.4%
Interest expense, net	38,236	2.1%	45,888	2.7%
Income before income taxes	265,818	14.5%	184,444	10.7%
Provision for income taxes	98,015	5.3%	67,000	3.9%
Net income	167,803	9.1%	117,444	6.8%
Less: Income attributable to noncontrolling interests	15,962	0.9%	9,883	0.6%
Net income attributable to UHS	$ 151,841	8.3%	$ 107,561	6.2%

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Net revenues increased 6.5% or $112 million to $1.83 billion during the three-month period ended June 30, 2013 as compared to $1.72 billion during the comparable quarter of 2012. The net increase was attributable to: (i) a $69 million or 4.0% increase in net revenues generated at our acute care hospitals and behavioral health care facilities owned during both periods (which we refer to as same facility), and; (ii) other combined net increase of $43 million consisting primarily of the revenues generated during the second quarter of 2013 at the nine behavioral health facilities acquired from Ascend Health Corporation in October, 2012.

Income before income taxes (before deduction for income attributable to noncontrolling interests) increased $81 million to $266 million during the three-month period ended June 30, 2013 as compared to $184 million during the comparable quarter of 2012. The net increase in our income before income taxes during the second quarter of 2013, as compared to the comparable prior year quarter, was due to:

a. an increase of $2 million at our acute care facilities as discussed below in Acute Care Hospital Services, excluding impact of the items mentioned in c. and f. below;

b. an increase of $10 million at our behavioral health care facilities, as discussed below in Behavioral Health Services, excluding the impact of the item mentioned in c. and e. below;

c. an increase of $65 million resulting from a reduction to our professional and general liability self-insurance reserves relating to years prior to 2013, based upon a reserve analysis ($51 million is applicable to our acute care hospitals and $14 million is applicable to our behavioral health care facilities);

d. an increase of $8 million due to a decrease in interest expense resulting from a decrease in our average effective interest rate, partially offset by an increase in our average outstanding borrowings;

e. a decrease of $6 million consisting of the 2011 portion of net Medicaid supplemental revenues recorded during the second quarter of 2012 related to new programs initiated in certain states in which we operate behavioral health care facilities;

f. an increase of $1 million related to the incentive income, net of expenses, recorded during the second quarter of 2013, as compared to the second quarter of 2012, in connection with the implementation of EHR applications at our acute care hospitals, and;

g. $1 million of other combined net increases.

Net income attributable to UHS increased $44 million to $152 million during the three-month period ended June 30, 2013 as compared to $108 million during the comparable quarter of 2012. The increase during the second quarter of 2013, as compared to the comparable prior year quarter, consisted of:

an increase of $81 million in income before income taxes, as discussed above;

a decrease of $6 million due to an increase in income attributable to noncontrolling interests, and;

a decrease of $31 million resulting from an increase in the provision for income taxes resulting primarily from the income tax provision recorded on the $75 million increase in pre-tax income ($81 million increase in income before income taxes and the $6 million decrease in income due to an increase in the income attributable to noncontrolling interests) as well as the income tax

provision recorded during the second quarter of 2013 on the gain realized on the sale of Peak Behavioral Health Services (see *Provision for Income Taxes and Effective Tax Rates*).

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Six-month periods ended June 30, 2013 and 2012:

The following table summarizes our results of operations and is used in the discussion below for the six-month periods ended June 30, 2013 and 2012 (dollar amounts in thousands):

	Six months ended June 30, 2013		Six months ended June 30, 2012	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$ 4,160,010		$ 3,849,412	
Less: Provision for doubtful accounts	493,403		333,293	
Net revenues	3,666,607	100.0%	3,516,119	100.0%
Operating charges:				
Salaries, wages and benefits	1,799,630	49.1%	1,726,977	49.1%
Other operating expenses	706,569	19.3%	696,361	19.8%
Supplies expense	406,986	11.1%	403,176	11.5%
Depreciation and amortization	161,494	4.4%	144,775	4.1%
Lease and rental expense	48,747	1.3%	47,425	1.3%
EHR incentive income	(4,795)	-0.1%	(1,955)	-0.1%
Subtotal-operating expenses	3,118,631	85.1%	3,016,759	85.8%
Income from operations	547,976	14.9%	499,360	14.2%
Interest expense, net	78,174	2.1%	92,598	2.6%
Income before income taxes	469,802	12.8%	406,762	11.6%
Provision for income taxes	172,064	4.7%	146,748	4.2%
Net income	297,738	8.1%	260,014	7.4%
Less: Income attributable to noncontrolling interests	26,113	0.7%	23,846	0.7%
Net income attributable to UHS	$ 271,625	7.4%	$ 236,168	6.7%

Net revenues increased 4.3%, or $150 million, to $3.67 billion during the six-month period ended June 30, 2013 as compared to $3.52 billion during the comparable period of 2012. The net increase was attributable to: (i) a $96 million or 2.8% increase in net revenues generated at our acute care hospitals and behavioral health care facilities, on a same facility basis, and; (ii) other combined net increase of $54 million consisting primarily of the revenues generated during the first six months of 2013 at the nine behavioral health facilities acquired from Ascend Health Corporation in October, 2012, partially offset by other combined net decreases due primarily to $36 million of net revenues recorded during the first six months of 2012 resulting from an industry-wide settlement with the United States Department of Health and Human Services, the Secretary of Health and Human Services, and the Centers for Medicare and Medicaid Services, related to underpayments of Medicare inpatient prospective payments during a number of prior years.

Income before income taxes (before deduction for income attributable to noncontrolling interests) increased $63 million to $470 million during the six-month period ended June 30, 2013 as compared to $407 million during the comparable period of 2012. The net increase in our income before income taxes during the first six months of 2013, as compared to the comparable prior year period, was due to:

a. a decrease of $25 million at our acute care facilities as discussed below in Acute Care Hospital Services, excluding impact of the items mentioned in c., d. and f. below;

b. an increase of $37 million at our behavioral health care facilities, as discussed below in Behavioral Health Services, excluding the impact of the item mentioned in c., g. and h. below;

c. an increase of $65 million resulting from a reduction to our professional and general liability self-insurance reserves relating to years prior to 2013, based upon a reserve analysis ($51 million is applicable to our acute care hospitals and $14 million is applicable to our behavioral health care facilities);

d. a decrease of $33 million (net of related expenses) resulting from the pre-tax income recorded during the first six months of 2012 related to the above-mentioned agreement with the United States Department of Health and Human Services, the Secretary of Health and Human Services, and the Centers for Medicare and Medicaid Services;

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e. an increase of $14 million due to a decrease in interest expense resulting from a decrease in our average effective interest rate, partially offset by an increase in our average outstanding borrowings;

f. a net aggregate increase of $11 million resulting from the following unfavorable items recorded during the first six months of 2012: (i) the revised Supplemental Security Income ratios utilized for calculating Medicare disproportionate share hospital reimbursements for federal fiscal years 2006 through 2009 ($7 million unfavorable impact), and; (ii) the write-off of receivables related to revenues recorded during 2011 at two of our acute care hospitals located in Florida resulting from reductions in certain county reimbursements due to reductions in federal matching Inter-Governmental Transfer funds ($4 million unfavorable impact);

g. a decrease of $7 million resulting from the pre-tax income recorded during the first six months of 2012 representing the 2011 portion of the net Medicaid supplemental reimbursements earned pursuant to the Oklahoma Supplemental Hospital Offset Payment Program;

h. a decrease of $6 million consisting of the 2011 portion of net Medicaid supplemental revenues recorded during the second quarter of 2012 related to new programs initiated in certain states in which we operate behavioral health care facilities, and;

i. $7 million of other combined net increases.

Net income attributable to UHS increased $36 million, to $272 million during the six-month period ended June 30, 2013 as compared to $236 million during the comparable prior year period. The increase during the first six months of 2013, as compared to the comparable prior year period, consisted of:

an increase of $63 million in income before income taxes, as discussed above;

a decrease of $2 million due to an increase in income attributable to noncontrolling interests, and;

a decrease of $25 million resulting from an increase in the provision for income taxes resulting primarily from the income tax provision recorded on the $61 million increase in pre-tax income ($63 million increase in income before income taxes and the $2 million decrease in income due to an increase in the income attributable to noncontrolling interests) as well as the income tax provision recorded during the second quarter of 2013 on the gain realized on the sale of Peak Behavioral Health Services (see *Provision for Income Taxes and Effective Tax Rates*).

Acute Care Hospital Services

Same Facility Basis Acute Care Hospitals

We believe that providing our results on a Same Facility basis, which includes the operating results for facilities owned 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 reduction to our professional and general liability self-insurance reserves, the impact of the EHR applications and 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.

The following table summarizes the results of operations for our acute care facilities, on a same facility and all acute care basis, and is used in the discussion below for the three and six-month periods ended June 30, 2013 and 2012 (dollar amounts in thousands):

	Three months ended June 30, 2013	Three months ended June 30, 2012	Six months ended June 30, 2013	Six months ended June 30, 2012

	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$ 1,102,240		$ 1,008,742		$ 2,229,017		$ 2,036,084	
Less: Provision for doubtful accounts	216,053		164,144		434,096		289,508	
Net revenues	886,187	100.0%	844,598	100.0%	1,794,921	100.0%	1,746,576	100.0%
Operating charges:								
Salaries, wages and benefits	398,765	45.0%	383,335	45.4%	802,442	44.7%	775,648	44.4%
Other operating expenses	198,999	22.5%	170,000	20.1%	397,852	22.2%	349,216	20.0%
Supplies expense	156,953	17.7%	155,147	18.4%	317,557	17.7%	314,455	18.0%
Depreciation and amortization	47,200	5.3%	45,325	5.4%	94,699	5.3%	92,581	5.3%
Lease and rental expense	14,028	1.6%	14,858	1.8%	28,629	1.6%	29,210	1.7%
Subtotal-operating expenses	815,945	92.1%	768,665	91.0%	1,641,179	91.4%	1,561,110	89.4%
Income from operations	70,242	7.9%	75,933	9.0%	153,742	8.6%	185,466	10.6%
Interest expense, net	1,124	0.1%	1,204	0.1%	2,261	0.1%	2,382	0.1%
Income before income taxes	69,118	7.8%	74,729	8.8%	151,481	8.4%	183,084	10.5%

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Three-month periods ended June 30, 2013 and 2012:

During the three-month period ended June 30, 2013, as compared to the comparable prior year quarter, net revenues at our acute care hospitals, on a same facility basis, increased $42 million, or 4.9%, to $886 million during the second quarter of 2013 as compared to $845 million during the second quarter of 2012. Income before income taxes (and before income attributable to noncontrolling interests) decreased $6 million or 8% to $69 million or 7.8% of net revenues during the second quarter of 2013 as compared to $75 million or 8.8% of net revenues during the comparable prior year quarter.

During the three-month period ended June 30, 2013, as compared to the comparable prior year quarter, inpatient admissions to our acute care facilities increased 1.6% and adjusted admissions (adjusted for outpatient activity) increased 2.0%. Patient days at these facilities increased 0.7% during the second quarter of 2013 and adjusted patient days increased 1.2% during the three-month period ended June 30, 2013 as compared to the comparable prior year quarter. During the three-month period ended June 30, 2013, net revenue per adjusted admission increased 2.9% and net revenue per adjusted patient day increased 3.7%, as compared to the comparable quarter of the prior year. The average length of inpatient stay at these facilities was 4.5 days during each of the three-month periods ended June 30, 2013 and 2012. The occupancy rate, based on the average available beds at these facilities, was 56% during each of the three-month periods ended June 30, 2013 and 2012.

Six-month periods ended June 30, 2013 and 2012:

During the six-month period ended June 30, 2013, as compared to the comparable period of 2012, net revenues at our acute care hospitals, on a same facility basis, increased $48 million, or 2.8%, to $1.79 billion during the first six months of 2013 as compared to $1.75 billion during the first six months of 2012. Income before income taxes (and before income attributable to noncontrolling interests) decreased $32 million or 17% to $151 million or 8.4% of net revenues during the first six months of 2013 as compared to $183 million or 10.5% of net revenues during the comparable period of 2012.

During the six-month period ended June 30, 2013, as compared to the comparable period of 2012, inpatient admissions to our acute care facilities remained relatively unchanged and adjusted admissions increased 0.2%. Patient days at these facilities increased 0.5% during the first six months of 2013 and adjusted patient days increased 0.7% during the six-month period ended June 30, 2013 as compared to the comparable period of the prior year. During the six-month period ended June 30, 2013, net revenue per adjusted admission increased 2.5% and net revenue per adjusted patient day increased 2.1%, as compared to the comparable period of 2012. The average length of inpatient stay at these facilities was 4.5 days during each of the six-month periods ended June 30, 2013 and 2012. The occupancy rate, based on the average available beds at these facilities, was 55% and 56% during the six-month periods ended June 30, 2013 and 2012, respectively.

Charity care and uninsured discounts:

A significant portion of the patients treated throughout our portfolio of acute care hospitals are uninsured patients which, in part, has resulted from an increase in the number of 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. 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 accounts receivable, net. 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.

Uncompensated care:

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, 2013 and 2012:

Amounts in millions	**Three Months Ended**				**Six Months Ended**			
	June 30, 2013	**%**	**June 30, 2012**	**%**	**June 30, 2013**	**%**	**June 30, 2012**	**%**
Charity care	$ 172	67%	$ 196	74%	$ 314	64%	$ 458	79%

Uninsured discounts	86	33%	70	26%	175	36%	123	21%
Total uncompensated care	$ 258	100%	$ 266	100%	$ 489	100%	$ 581	100%

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The decrease in charity care and uninsured discounts recorded at our acute care hospitals during the 2013 periods, as compared to the comparable 2012 periods, was offset by an increase in the provision for doubtful accounts which amounted to $216 million and $164 million during the three-month periods ended June 30, 2013 and 2012, respectively, and $434 million and $290 million during the six-month periods ended June 30, 2013 and 2012, respectively.

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, which as mentioned above increased during the three and six-month periods ended June 30, 2013, as compared to the comparable periods of 2012, 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 (excluding provision for doubtful accounts) divided by gross patient service revenue for those facilities. An increase in the level of uninsured patients to our facilities and the resulting adverse trends in the provision for doubtful accounts and uncompensated care provided could have a material unfavorable impact on our future operating results.

Amounts in millions:	**Three Months Ended**		**Six Months Ended**	
	June 30, 2013	**June 30, 2012**	**June 30, 2013**	**June 30, 2012**
Estimated cost of providing charity care	$ 28	$ 32	$ 51	$ 75
Estimated cost of providing uninsured discounts related care	14	11	28	20
Estimated cost of providing uncompensated care	$ 42	$ 43	$ 79	$ 95

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, 2013 and 2012 which includes our acute care results on a same facility basis, as well as the impact of other items, as mentioned below (dollar amounts in thousands):

	Three months ended June 30, 2013		**Three months ended June 30, 2012**		**Six months ended June 30, 2013**		**Six months ended June 30, 2012**	
	Amount	**% of Net Revenues**	**Amount**	**% of Net Revenues**	**Amount**	**% of Net Revenues**	**Amount**	**% of Net Revenues**
Net revenues before provision for doubtful accounts	$ 1,110,699		$ 1,007,741		$ 2,237,476		$ 2,059,636	
Less: Provision for doubtful accounts	216,053		164,144		434,096		289,508	
Net revenues	894,646	100.0%	843,597	100.0%	1,803,380	100.0%	1,770,128	100.0%
Operating charges:								
Salaries, wages and benefits	400,024	44.7%	391,278	46.4%	804,535	44.6%	783,591	44.3%
Other operating expenses	149,925	16.8%	170,396	20.2%	348,886	19.3%	352,210	19.9%
Supplies expense	157,011	17.6%	155,147	18.4%	317,621	17.6%	314,455	17.8%
Depreciation and amortization	54,211	6.1%	48,852	5.8%	107,197	5.9%	96,108	5.4%
Lease and rental expense	14,044	1.6%	14,858	1.8%	28,656	1.6%	29,210	1.7%
EHR incentive income	(83)	0.0%	(1,955)	-0.2%	(4,795)	-0.3%	(1,955)	-0.1%
Subtotal-operating expenses	775,132	86.6%	778,576	92.3%	1,602,100	88.8%	1,573,619	88.9%
Income from operations	119,514	13.4%	65,021	7.7%	201,280	11.2%	196,509	11.1%

Interest expense, net	1,124	0.1%	1,204	0.1%	2,261	0.1%	2,382	0.1%
Income before income taxes	118,390	13.2%	63,817	7.6%	199,019	11.0%	194,127	11.0%

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Three-month periods ended June 30, 2013 and 2012:

Income before income taxes increased $55 million or 86% to $118 million during the second quarter of 2013 as compared to $64 million during the second quarter of 2012. The increase in income before income taxes at our acute care facilities resulted from:

- a $6 million decrease at our acute care facilities on a same facility basis, as discussed above;
- an increase of $51 million resulting from a reduction to our professional and general liability self-insurance reserves relating to years prior to 2013, based upon a reserve analysis, recorded during the second quarter of 2013;
- an increase of $8 million resulting from the revenues recorded during the second quarter of 2013, that relate to prior years, in connection with a Medicaid supplemental payment plan in California which was approved by CMS during the second quarter of 2013, retroactive to July 1, 2011, and;
- other combined net increase of $2 million.

Six-month periods ended June 30, 2013 and 2012:

Income before income taxes increased $5 million or 3% to $199 million during the first six months of 2013 as compared to $194 million during the comparable period of 2012. The increase in income before income taxes at our acute care facilities resulted from:

- a $32 million decrease at our acute care facilities on a same facility basis, as discussed above;
- the above-mentioned increase of $51 million resulting from a reduction to our professional and general liability self-insurance reserves relating to years prior to 2013, recorded during the second quarter of 2013;
- an increase of $8 million resulting from the revenues recorded during the second quarter of 2013, that relate to prior years, in connection with a Medicaid supplemental payment plan in California which was approved by CMS during the second quarter of 2013, retroactive to July 1, 2011;
- a net unfavorable change of $33 million (net of related expenses) resulting from the pre-tax income recorded during the first six months of 2012 related to the above-mentioned agreement with the United States Department of Health and Human Services, the Secretary of Health and Human Services, and the Centers for Medicare and Medicaid Services, and;
- an aggregate favorable change of $11 million resulting from the recording, during the first six months of 2012, of a $7 million reduction to net revenues from the revised Supplemental Security Income ratios utilized for calculating Medicare disproportionate share hospital reimbursements for federal fiscal years 2006 through 2009 and a $4 million reduction to net revenues resulting from the write-off of receivables related to revenues recorded during 2011 at two of our acute care hospitals located in Florida resulting from reductions in certain county reimbursements due to reductions in federal matching Inter-Governmental Transfer funds.

Behavioral Health Services

The following table summarizes the results of operations for our behavioral health care facilities, on a same facility basis, and is used in the discussion below for the three and six-month periods ended June 30, 2013 and 2012 (dollar amounts in thousands):

Same Facility Behavioral Health

	Three months ended June 30, 2013		Three months ended June 30, 2012		Six months ended June 30, 2013		Six months ended June 30, 2012	
	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$ 913,307		$ 878,030		$ 1,803,872		$ 1,744,997	
Less: Provision for doubtful accounts	28,483		20,486		55,071		43,504	
Net revenues	884,824	100.0%	857,544	100.0%	1,748,801	100.0%	1,701,493	100.0%
Operating charges:								
Salaries, wages and benefits	431,014	48.7%	422,129	49.2%	857,627	49.0%	845,290	49.7%
Other operating expenses	157,814	17.8%	148,248	17.3%	308,956	17.7%	298,729	17.6%
Supplies expense	42,120	4.8%	41,337	4.8%	82,578	4.7%	85,471	5.0%
Depreciation and amortization	24,459	2.8%	22,210	2.6%	48,268	2.8%	44,415	2.6%
Lease and rental expense	8,114	0.9%	8,132	0.9%	16,275	0.9%	16,165	1.0%
Subtotal-operating expenses	663,521	75.0%	642,056	74.9%	1,313,704	75.1%	1,290,070	75.8%
Income from operations	221,303	25.0%	215,488	25.1%	435,097	24.9%	411,423	24.2%
Interest expense, net	336	0.0%	384	0.0%	1,194	0.1%	761	0.0%
Income before income taxes	220,967	25.0%	215,104	25.1%	433,903	24.8%	410,662	24.1%

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Three-month periods ended June 30, 2013 and 2012:

On a same facility basis during the second quarter of 2013, as compared to the second quarter of 2012, net revenues at our behavioral health care facilities increased 3% or $27 million to $885 million from $858 million. Income before income taxes increased $6 million or 3% to $221 million or 25.0% of net revenues during the three-month period ended June 30, 2013, as compared to $215 million or 25.1% of net revenues during the comparable prior year quarter.

On a same facility basis, inpatient admissions and adjusted admissions to our behavioral health facilities increased 5.2% and 5.4%, respectively, during the three-month period ended June 30, 2013 as compared to the comparable quarter of 2012. Patient days and adjusted patient days increased 1.6% and 1.8%, respectively, during the three-month period ended June 30, 2013 as compared to the comparable prior year quarter. During the three-month period ended June 30, 2013, net revenue per adjusted admission decreased 2.1% and net revenue per adjusted patient day increased 1.3%, as compared to the comparable quarter of the prior year. The average length of inpatient stay at these facilities was 13.6 days and 14.1 days during the three-month periods ended June 30, 2013 and 2012, respectively. The occupancy rate, based on the average available beds at these facilities, was 76% and 75% during the three-month periods ended June 30, 2013 and 2012, respectively.

Six-month periods ended June 30, 2013 and 2012:

On a same facility basis during the first six months of 2013, as compared to the comparable period of 2012, net revenues at our behavioral health care facilities increased 3% or $47 million to $1.75 billion from $1.70 billion. Income before income taxes increased $23 million or 6% to $434 million or 24.8% of net revenues during the six-month period ended June 30, 2013, as compared to $411 million or 24.1% of net revenues during the comparable prior year period.

On a same facility basis, inpatient admissions and adjusted admissions to our behavioral health facilities increased 2.8% and 2.9%, respectively, during the six-month period ended June 30, 2013 as compared to the comparable period of 2012. Patient days and adjusted patient days increased 0.7% and 0.8%, respectively, during the six-month period ended June 30, 2013 as compared to the comparable period of 2012. During the six-month period ended June 30, 2013, net revenue per adjusted admission remained relatively unchanged and net revenue per adjusted patient day increased 2.0%, as compared to the comparable period of 2012. The average length of inpatient stay at these facilities was 13.6 days and 13.8 days during the six-month periods ended June 30, 2013 and 2012, respectively. The occupancy rate, based on the average available beds at these facilities, was 76% and 75% during the six-month periods ended June 30, 2013 and 2012, 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, 2013 and 2012 which includes our behavioral health results on a same facility basis, as well as the impact of the facilities acquired or opened within the previous twelve months (including the 9 facilities acquired from Ascend Health Corporation in October, 2012) and other items, as mentioned below (dollar amounts in thousands):

	Three months ended June 30, 2013		Three months ended June 30, 2012		Six months ended June 30, 2013		Six months ended June 30, 2012	
	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$ 960,054		$ 890,817		$ 1,898,205		$ 1,774,405	
Less: Provision for doubtful accounts	30,584		20,550		59,191		43,818	
Net revenues	929,470	100.0%	870,267	100.0%	1,839,014	100.0%	1,730,587	100.0%
Operating charges:								
Salaries, wages and benefits	453,986	48.8%	426,744	49.0%	905,874	49.3%	858,947	49.6%
Other operating expenses	154,912	16.7%	147,155	16.9%	313,158	17.0%	297,887	17.2%
Supplies expense	44,306	4.8%	41,599	4.8%	87,268	4.7%	86,272	5.0%
Depreciation and amortization	25,661	2.8%	22,534	2.6%	50,703	2.8%	45,405	2.6%
Lease and rental expense	9,713	1.0%	8,527	1.0%	19,486	1.1%	17,066	1.0%

Subtotal-operating expenses	688,578	74.1%	646,559	74.3%	1,376,489	74.8%	1,305,577	75.4%
Income from operations	240,892	25.9%	223,708	25.7%	462,525	25.2%	425,010	24.6%
Interest expense, net	336	0.0%	384	0.0%	1,194	0.1%	761	0.0%
Income before income taxes	240,556	25.9%	223,324	25.7%	461,331	25.1%	424,249	24.5%

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Three-month periods ended June 30, 2013 and 2012:

Income before income taxes increased $17 million or 8% to $241 million during the second quarter of 2013 as compared to $223 million during the second quarter of 2012. The increase in income before income taxes at our behavioral health care facilities resulted from:

- a $6 million increase at our behavioral health care facilities on a same facility basis, as discussed above;
- an increase of $14 million resulting from a reduction to our professional and general liability self-insurance reserves relating to years prior to 2013, based upon a reserve analysis, recorded during the second quarter of 2013;
- a net increase of approximately $10 million representing the combined income before income taxes generated at nine behavioral health care facilities acquired during the fourth quarter of 2012 and two behavioral health care facilities that were newly opened during the fourth quarter of 2012 and the second quarter of 2013;
- an unfavorable change of $7 million resulting from the net revenues recorded during the second quarter of 2012 representing the 2011 portion of the net Medicaid supplemental reimbursements earned primarily from new programs approved in Indiana and Ohio which were retroactive to July 1, 2011, and;
- other combined net decrease of $6 million.

Six-month periods ended June 30, 2013 and 2012:

Income before income taxes increased $37 million or 9% to $461 million during the first six months of 2013 as compared to $424 million during the comparable period of 2012. The increase in income before income taxes at our behavioral health care facilities resulted from:

- a $23 million increase at our behavioral health care facilities on a same facility basis, as discussed above;
- the above-mentioned increase of $14 million resulting from a reduction to our professional and general liability self-insurance reserves relating to years prior to 2013, recorded during the second quarter of 2013;
- a net increase of approximately $20 million representing the combined income generated at nine behavioral health care facilities acquired during the fourth quarter of 2012 and two behavioral health care facilities that were newly opened during the fourth quarter of 2012 and the second quarter of 2013;
- an unfavorable change of $7 million resulting from the net revenues recorded during the second quarter of 2012 representing the 2011 portion of the net Medicaid supplemental reimbursements earned primarily from new programs approved in Indiana and Ohio which were retroactive to July 1, 2011;
- an unfavorable change of $7 million resulting from the net revenues recorded during the first six months of 2012 representing the 2011 portion of the net Medicaid supplemental reimbursements earned pursuant to the Oklahoma Supplemental Hospital Offset Payment Program, and;

other combined net decrease of $6 million.

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.

Since a significant portion of our revenues are derived from facilities located in Nevada, Texas and California, we are particularly sensitive to regulatory, economic, environmental and competition changes in those states. Any material change in the current payment programs or regulatory, economic, environmental or competitive conditions in those states could have a disproportionate effect on our overall business results.

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The following table shows the approximate percentages of net patient revenue for the three and six-month periods ended June 30, 2013 and 2012 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:

Acute Care and Behavioral Health Facilities Combined	Percentage of Net Patient Revenues		Percentage of Net Patient Revenues	
	Three Months Ended June 30,		Six Months Ended June 30,	
	2013	2012	2013	2012
Third Party Payors:				
Medicare	21%	24%	22%	24%
Medicaid	15%	15%	14%	15%
Managed Care (HMO and PPOs)	49%	50%	48%	49%
Other Sources	15%	11%	16%	12%
Total	100%	100%	100%	100%

Acute Care Facilities	Percentage of Net Patient Revenues		Percentage of Net Patient Revenues	
	Three Months Ended June 30,		Six Months Ended June 30,	
	2013	2012	2013	2012
Third Party Payors:				
Medicare	24%	29%	26%	29%
Medicaid	7%	7%	6%	7%
Managed Care (HMO and PPOs)	59%	58%	57%	56%
Other Sources	10%	6%	11%	8%
Total	100%	100%	100%	100%

Behavioral Health Facilities	Percentage of Net Patient Revenues		Percentage of Net Patient Revenues	
	Three Months Ended June 30,		Six Months Ended June 30,	
	2013	2012	2013	2012
Third Party Payors:				
Medicare	19%	18%	19%	18%
Medicaid	22%	23%	22%	23%
Managed Care (HMO and PPOs)	40%	41%	40%	40%
Other Sources	19%	18%	19%	19%
Total	100%	100%	100%	100%

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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, 2012, the Centers for Medicare and Medicaid Services (CMS) published its final IPPS 2013 payment rule which provided for a 2.6% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments and Health Care Reform mandated adjustments are considered, we estimate our overall increase from the final federal fiscal year 2013 rule (covering the period of October 1, 2012 through September 30, 2013) will approximate 1.8%. This projected impact from the IPPS 2013 final rule reflects all of the adjustments described in this paragraph, however, it excludes the impact of potential reductions related to the Budget Control Act of 2011, as discussed below.

In August, 2013, CMS published its final IPPS 2014 payment rule which provides for a 2.5% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments and Health Care Reform mandated adjustments are considered, we estimate our overall increase from the final federal fiscal year 2014 rule (covering the period of October 1, 2013 through September 30, 2014) will approximate 1.0%. This projected impact from the IPPS 2014 final rule includes both the impact of the American Taxpayer Relief Act (ATRA) of 2012 documentation and coding adjustment and the required changes to the Medicare Disproportionate Share Hospital 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. Although we expect the final IPPS 2014 payment rule to have a favorable impact on our Medicare fee for service payments for federal fiscal year 2014, we do not believe the impact will be material to our consolidated financial statements.

In August, 2011, the Budget Control Act of 2011 (the 2011 Act) was enacted into law. Included in this law are the imposition of annual spending limits for most federal agencies and programs aimed at reducing budget deficits by $917 billion between 2012 and 2021, according to a report released by the Congressional Budget Office. Among its other provisions, the law established a bipartisan Congressional committee, known as the Joint Committee, which was responsible for developing recommendations aimed at reducing future federal budget deficits by an additional $1.5 trillion over 10 years. The Joint Committee was unable to reach an agreement by the November 23, 2011 deadline and, as a result, across-the-board cuts to discretionary, national defense and Medicare spending were implemented on March 1, 2013 resulting in Medicare payment reductions of up to 2% per fiscal year (approximately $39 million annual reduction to our Medicare net revenues effective as of April 1, 2013) with a uniform percentage reduction across all Medicare programs.

On January 2, 2013, the ATRA of 2012 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. In the 2014 IPPS proposed rule, CMS is proposing a -0.8% recoupment adjustment as the first step in this recovery process. CMS expects to make similar adjustments in federal fiscal years 2015, 2016, and 2017 in order to recover the entire $11 billion. This adjustment is reflected in the 2014 IPPS estimated impact amount noted above.

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On January 1, 2005, CMS implemented a new Psychiatric Prospective Payment System (Psych PPS) for inpatient services furnished by psychiatric hospitals under the Medicare program. This system replaced the cost-based reimbursement guidelines with a per diem Psych PPS with adjustments to account for certain facility and patient characteristics. The Psych PPS also contained provisions for outlier payments and an adjustment to a psychiatric hospital s base payment if it maintains a full-service emergency department. In April, 2011 CMS published its final Psych PPS rule for the fifteen month period July 1, 2011 to September 30, 2012. The market basket increase for this time period was 2.95%, which included a 0.25% reduction required by the federal Health Care Reform legislation enacted in 2010. In August, 2012, CMS published its final Psych PPS rate notice for the federal fiscal year beginning October 1, 2012. That final notice contained a Psych PPS market basket update of 2.7%, which was reduced by 0.7% to reflect a productivity adjustment, and reduced by 0.1% to reflect an other adjustment required by the Social Security Act for rate years 2010 through 2019. In July, 2013, CMS published its final Psych PPS rate notice for the federal fiscal year 2014. The final notice contains a Psych PPS market basket update of 2.6% which is reduced by 0.5% to reflect a productivity adjustment, and reduced by 0.1% to reflect an other adjustment required by the Social Security Act.

In November, 2011, CMS published its annual final Medicare Outpatient Prospective Payment System (OPPS) rule for 2012. The market basket increase to the OPPS base rate is 3.0%. In addition, as outlined in the Sources of Revenues and Health Care Reform discussion below, CMS is also required by federal law to reduce the update factor by 0.1% in federal fiscal year 2012 and to reduce the annual update by a productivity adjustment which is 1.1%. In the final rule, CMS also implemented a significant decrease in the 2012 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, our overall Medicare OPPS payment decrease for 2012 was estimated to be approximately 0.7%. Excluding the behavioral health partial hospitalization rate impact, our Medicare OPPS payment increase for 2012 was approximately 2.1%.

In November, 2012, CMS published its annual final Medicare OPPS rule for 2013. The market basket increase to the OPPS base rate is 2.6%. In addition, as outlined in the Sources of Revenues and Health Care Reform discussion below, CMS is also required by federal law to reduce the update factor by 0.1% in federal fiscal year 2013 and to reduce the annual update by a productivity adjustment which is 0.7%. In the final rule, CMS is also implementing a significant increase in the 2013 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, our overall Medicare OPPS payment increase for 2013 is estimated to be 3.5%. Excluding the behavioral health division partial hospitalization rate impact, our Medicare OPPS payment increase for 2013 is estimated to be 1.7%.

In July, 2013, CMS published its annual proposed Medicare OPPS rule for 2014. The proposed hospital market basket increase is 2.5%. The Medicare statute requires a productivity adjustment reduction of 0.4% and 0.3% reduction to the 2014 OPPS market basket reducing the proposed 2014 OPPS market basket update to 1.8%. In the proposed rule, CMS proposes to reduce the 2014 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 2014 will aggregate to a net decrease of 0.7%. Excluding the behavioral health division partial hospitalization rate impact, our Medicare OPPS payment increase for 2014 is estimated to be 0.2%.

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

We receive Medicaid revenues in excess of $90 million annually from each of Texas, Pennsylvania, Washington, D.C., Illinois, Virginia and Massachusetts, making us particularly sensitive to reductions in Medicaid and other state based revenue programs (which have been implemented in various forms with respect to our areas of operation in the respective 2013 state fiscal years) as well as regulatory, economic, environmental and competitive changes in those states. Based upon the state budgets for the 2013 fiscal year (which generally began at various times during the second half of 2012), we estimate that, on a blended basis, our aggregate Medicaid rates were reduced by approximately 1% (or approximately $15 million annually) from the average rates in effect during the states 2012 fiscal years (which generally ended during the third quarter of 2012). Based upon the state budgets for the 2014 fiscal year (which will generally begin at various times during the second half of 2013), we estimate that, on a blended basis, our aggregate Medicaid rates will be reduced by approximately 1% (or approximately $15 million annually) from the average rates in effect during the states 2013 fiscal years.

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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.

Certain of our acute care hospitals located in various counties of Texas (Hidalgo, Maverick, Potter and Webb) participate in CMS-approved private Medicaid supplemental payment (UPL) programs. 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 UPL payments from the Medicaid program and indigent care payments from third-party, affiliated hospitals. The UPL 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. We recorded net UPL and affiliated hospital indigent care revenues of $10 million and $7 million during the three-month periods ended June 30, 2013 and 2012, respectively, and $20 million and $12 million during the six-month periods ended June 30, 2013 and 2012, respectively.

For state fiscal year 2013, 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 Texas Health and Human Services Commission (THHSC) transitioned away from UPL payments to new waiver incentive payment programs. 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 transition years two through five, THHSC will make incentive payments under the program after certain qualifying criteria are met by hospitals. UPL payments are also subject to an aggregate statewide caps based on CMS approved Medicaid waiver amounts. In February, 2013, THHSC proposed a rule that indicates that any required statewide UPL payment reductions will be applied a pro rata basis to all UPL payment recipients. Although our future UPL payments in Texas may be adversely impacted by this proposed rule, we are unable to estimate the potential impact on us since the amount of the statewide pro rata UPL payment reduction, if any, has not yet been determined by THHSC. Beginning in 2013, we are entitled to additional Medicaid UPL payments pursuant to an indigent care affiliation agreement entered into between a government entity and one of our acute care hospitals located in Texas (estimated to have a net favorable pre-tax impact of approximately $11 million annually). Consistent with other Medicaid UPL programs in Texas, these potential additional Medicaid UPL payments will be contingent on voluntary IGTs made by the government entity. In June, 2013, the state of Texas passed legislation that permits certain South Texas counties in which we operate acute care hospitals to create new hospital funding districts that are authorized to assess local mandatory payments on acute care hospitals located in these counties. Similar to the state Provider Taxes described below, mandatory payments collected by the applicable counties will be required to transfer these funds to the state with the purpose of securing additional federal matching dollars under the aforementioned Section 1115 Medicaid Waiver. Although this new legislation is expected to have a favorable impact on our future results of operations, we are unable to estimate the impact at this time.

In California, a Medicaid state plan amendment (SPA) was submitted to CMS by the state requesting and extension of a prior provider tax and related Medicaid supplemental payment program retroactive to July 1, 2011 through December 31, 2013. In June, 2012, CMS approved a portion of the SPA which did not have a material impact on our consolidated financial statements during the three or six-month periods ended June 30, 2013 or 2012. In June, 2013, CMS approved the Medicaid managed care component of the SPA which was retroactive to July 1, 2011. The net aggregate benefit for the period of July 1, 2011 through June 30, 2013 was $11 million (of which $8 million was applicable to prior years) which is included in our financial results for the three and six-month periods ended June 30, 2013.

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 of 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 dollars as part of their respective state Medicaid programs. We derive a related Medicaid reimbursement benefit from assessed Provider Taxes in the form of Medicaid claims based payment increases and/or lump sum Medicaid supplemental payments. Including the impact of programs approved in Oklahoma, Indiana and Ohio during the first six months of 2012 and the above-mentioned managed care component of the California SPA which was approved during the second quarter of 2013 (retroactive to July, 2011), we earned an aggregate net benefit of approximately $27 million and $12 million during the three-month periods ended June 301, 2013 and 2012, respectively, and approximately $39 million and $28 million during the six-month periods ended June 30, 2013 and 2012, respectively. We estimate that our aggregate net benefit from Provider Tax programs will approximate $67 million during 2013 (including the above-mentioned prior year impact of $8 million recorded during the second quarter of 2013 in connection with the managed care portion of the California SPA). Included in the 2013 estimated aggregate net benefit from Provider Tax programs is approximately $14 million earned in Oklahoma, $13 million in California and $9 million in Arkansas. 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.

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State 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 disproportionate share hospital (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 2013 DSH fiscal year (covering the period of October 1, 2012 through September 30, 2013). In February, 2013, the THHSC published a proposed rule that included amounts that are expected to be similar to the 2012 fiscal year program amounts, assuming the Texas DSH program is funded by the public hospitals for the state s 2013 DSH fiscal year. In connection with the Texas and South Carolina DSH programs, included in our financial results was an aggregate of $10 million and $12 million during the three-month periods ended June 30, 2013 and 2012, respectively, and $20 million and $23 million during the six-month periods ended June 30, 2013 and 2012, respectively. Assuming that the Texas and South Carolina programs are renewed for each state s 2014 fiscal years, at amounts similar to the 2013 fiscal year estimates, we estimate our aggregate reimbursements pursuant to these programs to be approximately $43 million during 2013. Failure to renew these DSH 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 DSH payments to qualify for future DSH funds under these programs, or reductions in reimbursements (see below), could have a material adverse effect on our future results of operations.

The Affordable Care Act provides for a significant reduction in Medicaid disproportionate share payments beginning in 2014 (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. Based on the May, 2013 CMS proposed rule, our Medicaid DSH payments in Texas and South Carolina could be reduced by approximately 5% in the 2014 federal fiscal year.

In May, 2013 the state of Texas enacted legislation that would increase the state s contribution of the non-federal DSH share for the 2013 DSH year to $138 million as compared to the $100 million previously expected. Similarly, the state s approved 2014-2015 General Appropriations bill passed in May, 2013 authorized $160 million for 2014 and $140 million for 2015, respectively, for the non-federal DSH share. Until THHSC finalizes the aforementioned proposed DSH rule, we are unable to estimate the potential favorable impact of this increased funding on the 2013, 2014 or 2015 Medicaid DSH amounts.

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 we expect that all of the states in which our eligible hospitals operate will ultimately choose 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.

During 2011, we began implementing EHR applications at certain of our acute care hospitals and continued to do so, on a hospital-by-hospital basis, until completion which occurred at the end of June, 2013. Our acute care hospitals are eligible for Medicare and Medicaid EHR incentive payments upon implementation of the EHR application, assuming they meet the meaningful use criteria. As of June 30, 2013, fifteen of our acute care hospitals met the meaningful use criteria and we expect the remainder to do so by the end of 2013.

In connection with the implementation of EHR applications, our consolidated results of operations include the net unfavorable after-tax impact of approximately $5 million (approximately $8 million pre-tax) during each of the three and six-month periods ended June 30, 2013 and 2012.

As of June 30, 2013, we received an aggregate of approximately $51 million of EHR incentive income cash receipts comprised of $25 million from Medicare and $26 million from Medicaid. These receipts, which are/were reflected as deferred EHR incentive income on our consolidated balance sheet (included in other current liabilities), will be/were recorded as EHR incentive income in our

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consolidated statements of income in the applicable periods pursuant to our EHR incentive income accounting policies, as disclosed above. From 2011 through June 30, 2013, we have recorded an aggregate of approximately $35 million of EHR incentive income. Upon meeting the meaningful use criteria, our hospitals may become entitled to additional Medicaid incentive payments in future periods.

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

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. Although we believe that our acute care hospitals will be in compliance with the EHR standards by 2015, there can be no assurance that all of our facilities will be in compliance and therefore not subject to the penalty provision of the HITECH Act.

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.

Medicaid Emergency Psychiatric Demonstration: The Affordable Care Act established the Medicaid Emergency Psychiatric Demonstration Project Act which created a three-year $75 million demonstration program to allow coverage for adults in freestanding psychiatric facilities. This proposal allows states to remove the Medicaid Institution for Mental Disease (IMD) exclusion for Medicaid patients between the ages of 21-64 who are receiving care in freestanding non-governmental psychiatric hospitals to stabilize their emergency psychiatric condition.

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

In March, 2010, the Health Care and Education Reconciliation Act of 2010 (H.R. 4872, P.L. 111-152), (the Reconciliation Act) and the Patient Protection and Affordable Care Act (P.L. 111-148), (the Affordable Care Act), were enacted into law and created significant changes to health insurance coverage for U.S. citizens as well as material revisions to the federal Medicare and state Medicaid programs. As outlined below, Medicare, Medicaid and other health care industry changes were first implemented beginning in 2010. A summary of the various changes that have been implemented, or are scheduled to be implemented, are noted below.

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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 and by 0.10% in 2012.

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.

Future Medicare Reduction:

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 requires annual aggregate reductions in federal DSH funding from federal fiscal year (FFY) 2014 through FFY 2020. The aggregate annual reduction amounts are:

$500 million for FFY 2014

$600 million for FFY 2015

$600 million for FFY 2016

$1.8 billion for FFY 2017

$5.0 billion for FFY 2018

$5.6 billion for FFY 2019

$4.0 billion for FFY 2020

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 will seek to increase competition among private health insurers by providing for transparent federal and state insurance exchanges starting in 2014. The Affordable Care Act also prohibits private insurers from adjusting insurance premiums based on health status, gender, or other specified factors. We cannot provide assurance that these provisions will not adversely affect the ability of private insurers to pay for services provided to insured patients, or that these changes will not have a negative material impact on our results of operations going forward.

Value-Based Purchasing:

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

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

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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 2014 IPPS proposed rule, CMS proposes to fund the 2014 value-based purchasing program by reducing base operating DRG payment amounts to participating hospitals by 1.25%.

Readmission Reduction Program:

In the Affordable Care Act, Congress also mandated implementation of the hospital readmission reduction program (HRRP). The HRRP assesses penalties on hospitals having excess readmission rates when compared to expected rates, effective for discharges beginning October 1, 2012. In the fiscal year 2013 IPPS final rule, CMS finalized certain policies with regard to payment under the HRRP, including which hospitals are subject to the HRRP, the methodology to calculate the hospital readmission payment adjustment factor, and what portion of the IPPS payment is used to calculate the readmission adjustment factor. In the fiscal year 2014 IPPS proposed rule, CMS proposes revisions to the three 30-day admission measures in the program heart failure, myocardial infarction, and pneumonia to exclude planned readmissions. Under the Affordable Care Act, beginning in fiscal year 2015, CMS may expand the program to include readmissions for additional conditions. We do not believe impact of HRRP for federal fiscal years 2013 and 2014 will have a material adverse effect on our results of operations.

Accountable Care Organizations:

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

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

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

Other Operating Results

The combined net revenues and income before income taxes generated at our surgical hospitals, ambulatory surgery centers and radiation oncology centers was not material to our results of operations during each of the three and six-month periods ended June 30, 2013 and 2012.

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Interest Expense:

Interest expense was $38 million and $46 million during the three-month periods ended June 30, 2013 and 2012, respectively, and $78 million and $93 million during the six-month periods ended June 30, 2013 and 2012, respectively. Below is a schedule of our interest expense for the three and six-month periods ended June 30, 2013 and 2012 (amounts in thousands):

	Three Months Ended June 30, 2013	Three Months Ended June 30, 2012	Six Months Ended June 30, 2013	Six Months Ended June 30, 2012
Revolving credit & demand notes	$ 976	$ 1,540	$ 2,204	$ 3,180
$400 million, 7.125% Senior Notes due 2016	7,124	7,124	14,248	14,248
$250 million, 7.00% Senior Notes due 2018	4,375	4,375	8,750	8,750
Term loan facility A (a.)	5,007	5,576	10,071	11,370
Term loan facility B/B-1 (a.)(b.)	5,828	13,712	12,821	27,825
Term loan facility A2 (a.)	4,407	0	8,781	0
Accounts receivable securitization program	702	707	1,408	1,394
Subtotal-revolving credit, demand notes, Senior Notes, term loan facilities and accounts receivable securitization program	28,419	33,034	58,283	66,767
Interest rate swap expense, net	4,777	5,285	9,451	10,443
Amortization of financing fees	5,449	7,289	10,908	14,566
Other combined interest expense	1,472	1,610	3,474	3,186
Capitalized interest on major projects	(1,863)	(1,310)	(3,915)	(2,315)
Interest income	(18)	(20)	(27)	(49)
Interest expense, net	$ 38,236	$ 45,888	$ 78,174	$ 92,598

(a.) During September, 2012, we completed a second amendment to our credit agreement dated November, 15, 2010, as amended. The second amendment provided for a new $900 million Term Loan A-2 with a final maturity date of August 15, 2016. This amendment also extended the maturity date of the revolving credit facility and the existing Term Loan A by nine months to also mature on August 15, 2016. We used $700 million of the Term Loan A-2 proceeds to repay our higher priced Term Loan B facility. The remainder of the new Term Loan A-2 proceeds was used to pay transaction-related fees and expenses and to repay other floating rate debt.

(b.) During May, 2013 we completed a third amendment to our credit agreement dated November 15, 2010, as amended. The third amendment provides for a reduction in the interest rates payable in connection with certain borrowings under the credit agreement. Specifically, we replaced our existing $745.9 million senior secured Tranche B term loan with a new senior secured Tranche B-1 term loan in the same amount on substantially the same terms as the Tranche B term loan, other than lower interest rates. Borrowings under the Tranche B-1 term loan will bear interest at a rate per annum equal to, at our election, of one, two, three or six month LIBOR, plus an applicable margin of 2.25% or ABR plus an applicable margin of 1.25%. The minimum ABR and LIBOR rates for the Tranche B term loan of 2.0% and 1.0%, respectively, were eliminated.

Interest expense decreased $8 million during the three-month period ended June 30, 2013 as compared to the comparable quarter of 2012. The decrease was due primarily to: (i) a $5 million net decrease in our aggregate average cost of borrowings pursuant to our revolving credit and demand notes, term loan A, A2 and B/B-1 facilities and accounts receivable securitization program, partially offset by an increase in the aggregate average borrowings outstanding under these facilities (due primarily to the borrowings utilized to finance the acquisition of Ascend Health Corporation in the fourth quarter of 2012); (ii) a $2 million decrease in the amortization of financing fees, and; (iii) other combined net decrease of $1 million.

Interest expense decreased $14 million during the six-month period ended June 30, 2013 as compared to the comparable period of 2012. The decrease was due primarily to: (i) a $9 million decrease in our aggregate average cost of borrowings pursuant to our revolving credit and demand notes, term loan A, A2 and B/B-1 facilities and accounts receivable securitization program, partially offset by an increase in the aggregate

average borrowings outstanding under these facilities (due primarily to the borrowings utilized to finance the acquisition of Ascend Health Corporation in the fourth quarter of 2012); (ii) a $4 million decrease in the amortization of financing fees, and; (iii) other combined net decrease of $1 million.

Discontinued Operations

In October of 2012, we completed the divestiture of Auburn Regional Medical Center (Auburn), a 159-bed acute care hospital located in Auburn, Washington. In connection with the receipt of antitrust clearance from the Federal Trade Commission (FTC) in connection with our acquisition of Ascend Health Corporation in October of 2012, we agreed to certain conditions, including the divestiture of Peak Behavioral Health Services (Peak), a 104-bed behavioral health care facility located in Santa Teresa, New Mexico. The divestiture of Peak was completed during the second quarter of 2013.

The operating results for Auburn and Peak are reflected as discontinued operations during each of the periods presented herein. Since the aggregate income from discontinued operations before income tax expense for these facilities is not material to our consolidated financial statements, it is included as a reduction to other operating expenses. The assets and liabilities for Peak were reflected as held for sale on our Consolidated Balance Sheet as of December 31, 2012.

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The following table shows the results of operations for Auburn and Peak, on a combined basis, which were reflected as discontinued operations during each of the periods presented herein (amounts in thousands):

	Three months ended		Six months ended	
	June 30, 2013	June 30, 2012	June 30, 2013	June 30, 2012
Net revenues	$ 3,126	$ 31,081	$ 7,160	$ 63,335
Income (loss) from discontinued operations, before income taxes (a)	3,885	(575)	3,820	534
Income tax (expense) benefit	(1,463)	218	(1,439)	(202)
Income (loss) from discontinued operations, net of income taxes	$ 2,422	($ 357)	$ 2,381	$ 332

(a) Included in the income from discontinued operations, before income taxes for the three and six-month periods ended June 30, 2013 was a $3.1 million gain on the sale of Peak.

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, 2013 and 2012 (dollar amounts in thousands):

	Three months ended		Six months ended	
	June 30, 2013	June 30, 2012	June 30, 2013	June 30, 2012
Provision for income taxes	$ 98,015	$ 67,000	$ 172,064	$ 146,748
Income before income taxes	265,818	184,444	469,802	406,762
Effective tax rate	36.9%	36.3%	36.6%	36.1%

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

The effective tax rates, as calculated by dividing the provision for income taxes by the difference in income before income taxes, minus net income attributable to noncontrolling interests, were as follows for each of the three and six-month periods ended June 30, 2013 and 2012 (dollar amounts in thousands):

	Three months ended		Six months ended	
	June 30, 2013	June 30, 2012	June 30, 2013	June 30, 2012
Provision for income taxes	$ 98,015	$ 67,000	$ 172,064	$ 146,748
Income before income taxes	265,818	184,444	469,802	406,762
Less: Net income attributable to noncontrolling interests	(15,962)	(9,883)	(26,113)	(23,846)

Income before income taxes and after net income attributable to noncontrolling interests	249,856	174,561	443,689	382,916
Effective tax rate	39.2%	38.4%	38.8%	38.3%

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The increase in the effective tax rates for the three and six-month periods ended June 30, 2013, as compared to the comparable prior year periods, was due primarily to the income tax provision recorded on the sale of Peak Behavioral Health Services which was divested in May, 2013. The tax basis gain realized on the sale of Peak Behavioral Health Services exceeded the gain recorded pursuant to generally accepted accounting principles.

Liquidity

Net cash provided by operating activities

Net cash provided by operating activities was $406 million during the six-month period ended June 30, 2013 as compared to $373 million during the comparable period of 2012. The net increase of $33 million was primarily attributable to the following:

- a favorable change of $51 million due to an increase in net income plus/minus depreciation and amortization expense, stock-based compensation expense and gains/losses on sales of assets and businesses;
- an unfavorable change of $65 million in accrued insurance expense, net of commercial premiums paid, due to a reduction recorded during the second quarter of 2013, based upon a reserve analysis, to our professional and general liability self-insurance reserves relating to years prior to 2013;
- a $46 million favorable change in other working capital accounts due primarily to the timing of accounts payable disbursements;
- an $18 million unfavorable change in accounts receivable;
- a $14 million favorable change in accrued and deferred income taxes, and;
- $5 million of other combined net favorable changes.

Days sales outstanding (DSO): Our DSO are calculated by dividing our net revenue by the number of days in the six-month periods. The result is divided into the accounts receivable balance at June 30th of each year to obtain the DSO. Our DSO were 57 days at June 30, 2013 and 53 days at June 30, 2012.

As of June 30, 2013 and December 31, 2012, our accounts receivable includes approximately $30 million and $70 million, respectively, due from Illinois. Although the outstanding balance has been reduced significantly during the second quarter of 2013 as a result of substantial cash remittances received from the state (approximately $72 million was due from Illinois as of March 31, 2013), collection of the outstanding receivables continues to be delayed due to state budgetary and funding pressures. Approximately $7 million as of June 30, 2013 and $51 million as of December 31, 2012, of the receivables due from Illinois were outstanding in excess of 60 days, as of each respective date. Although the remaining accounts receivable due from Illinois 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. Failure to ultimately collect all outstanding amounts due from Illinois would have an adverse impact on our future consolidated results of operations and cash flows.

Net cash used in investing activities

During the first six months of 2013, we used $177 million of net cash in investing activities as follows:

spent $176 million to finance capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities, including: (i) the construction costs related to the newly constructed Temecula Valley Hospital, a 140-bed acute care facility located in Temecula, California, which is scheduled to be completed and opened late in the third quarter of 2013; (ii) the construction costs related to Austin Oaks Hospital, a newly constructed, 80-bed behavioral health facility located in Austin, Texas, that was completed and opened during the second quarter of 2013, and; (iii) additional/renovated capacity at certain of our behavioral health facilities;

spent $34 million in connection with the purchase and implementation of electronic health records applications;

received $34 million in connection with the divestiture of Peak Behavioral Health Services and certain other real property including three previously closed behavioral health care facilities, and;

spent $1 million in for the purchase of real property located in Pennsylvania.

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During the first six months of 2012, we used $162 million of net cash in investing activities as follows:

- spent $182 million to finance capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities, including the construction costs related to Temecula Valley Hospital and additional capacity at certain of our behavioral health facilities;
- spent $28 million in connection with the purchase and implementation of electronic health records applications;
- received $53 million in connection with the divestiture of the Hospital San Juan Capestrano and the divestiture of the real property of a previously closed behavioral health care facility;
- spent $11 million in connection with the acquisition of a physician practice and various real property, and;
- received $7 million from a deposit returned to us in connection with the termination of an agreement to purchase an acute care hospital located in Texas.

Net cash provided by/used in financing activities

During the first six months of 2013, we used $240 million of net cash in financing activities as follows:

- spent $196 million on net repayments of debt due to repayments pursuant to our: (i) Term Loan A and A2 facilities ($36 million), revolving credit facility ($150 million) and various other debt facilities ($10 million);
- generated $11 million of proceeds from new borrowings pursuant to our accounts receivable securitization program;
- spent $27 million to pay profit distributions related to noncontrolling interests in majority owned businesses;
- spent $21 million to repurchase shares of our Class B Common Stock in connection with income tax withholding obligations related to employee stock-based compensation programs;
- spent $10 million to pay quarterly cash dividends of $.05 per share, and;
- generated $3 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

During the first six months of 2012, we used $219 million of net cash in financing activities as follows:

- spent $196 million on net repayments of debt due to repayments pursuant to our Term Loan A ($36 million), Term Loan B ($13 million), revolving credit ($126 million), accounts receivable securitization ($10 million), short-term, on demand ($9 million)

facilities, and; various other debt facilities ($2 million);

spent $14 million to pay profit distributions related to noncontrolling interests in majority owned businesses;

spent $3 million to repurchase shares of our Class B Common Stock in connection with income tax withholding obligations related to employee stock-based compensation programs;

spent $10 million to pay quarterly cash dividends of $.05 per share, and;

generated $3 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

Expected Capital Expenditures During the Remainder of 2013:

During the remaining six months of 2013, we expect to spend approximately $175 million to $200 million on capital expenditures. We believe that our capital expenditure program is adequate to expand, improve and equip our existing hospitals. We expect to finance all capital expenditures and acquisitions with internally generated funds and/or additional funds, as discussed below.

Capital Resources

Credit Facilities and Outstanding Debt Securities

On May 16, 2013, we entered into a third amendment (the Third Amendment) to the credit agreement, dated as of November 15, 2010 (as amended from time to time, the Credit Agreement), among UHS, the several banks and other financial institutions from time to time parties thereto, JPMorgan Chase Bank, N.A., as administrative agent and the other agents party thereto. The Third Amendment was effective on May 16, 2013. The Third Amendment provides for a reduction in the interest rates payable in connection with certain borrowings under the Credit Agreement. Upon the effectiveness of the Third Amendment, UHS replaced its existing $745.9 million senior secured Tranche B term loan with a new senior secured Tranche B-1 term loan in the same amount on substantially the same terms as the Tranche B term loan, other than lower interest rates. Borrowings under the Tranche B-1 term loan

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bear interest at a rate per annum equal to, at our election, one, two, three or six month LIBOR, plus an applicable margin of 2.25% or ABR plus an applicable margin of 1.25%. The minimum ABR and LIBOR rates for the Tranche B term loan of 2.0% and 1.0%, respectively, were eliminated.

In September, 2012, we entered into a second amendment (Second Amendment) to our Credit Agreement which provided for: (i) a new $900 million Term Loan-A (Term Loan A2) at the same interest rates as our existing Term Loan A and a final maturity date of August 15, 2016; (ii) the extension of the maturity date on a substantial portion of our $800 million revolving credit facility commitment with $777 million of the commitment extended to mature on August 15, 2016 and the remaining $23 million commitment scheduled to mature on November 15, 2015 (there were no borrowings outstanding pursuant to our revolving credit facility as of June 30, 2013), and; (iii) the extension of the maturity date on a substantial portion of our Term Loan-A borrowings which, based upon the outstanding Term Loan-A borrowings as of June 30, 2013, $919 million is scheduled to mature on August 15, 2016 and the remaining $44 million is scheduled to mature on November 15, 2015. The Second Amendment also provides for increased flexibility for refinancing and certain other modifications but substantially all other terms of the Credit Agreement remain unchanged.

In September, 2012, we used $700 million of the proceeds from the new Term Loan A2 facility to extinguish a portion of our higher priced, Term Loan-B facility. Pricing under the new Term Loan A2 facility was 1% lower than the Term Loan-B facility and did not include a LIBOR Floor whereas, at that time, the Term Loan-B facility had a 1% LIBOR Floor (which has since been eliminated as part of the above-mentioned Third Amendment in May, 2013). During the third quarter of 2012, in connection with the extinguishment of a portion of our Term Loan-B facility, we recorded a pre-tax charge of $29 million to write-off the related portion of the Term Loan-B deferred financing costs.

The Credit Agreement, as amended, is a senior secured facility which provided for an initial aggregate commitment amount of $3.43 billion, comprised of an $800 million revolving credit facility, a $988 million Term Loan-A facility, a $746 million Term Loan-B facility and a $900 million Term Loan-A2 facility. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Credit Agreement is secured by substantially all of the assets of the Company and our material subsidiaries and guaranteed by our material subsidiaries.

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, Term Loan-A and Term Loan-A2 borrowings and 1.25% for Term Loan B 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, Term Loan-A and Term Loan-A2 borrowings and 2.25% for Term Loan-B borrowings. The current applicable margins are 0.75% for ABR-based loans, 1.75% for LIBOR-based loans under the revolving credit, Term Loan-A and Term Loan-A2 facilities and 2.25% under the Term Loan-B facility.

As of June 30, 2013, we had no borrowings outstanding pursuant to the terms of our $800 million revolving credit facility and we had $769 million of available borrowing capacity, net of $10 million of outstanding borrowings pursuant to a short-term, on-demand credit facility and $21 million of outstanding letters of credit. The $10 million of outstanding borrowings under a short-term, on-demand credit facility as of June 30, 2013 are classified as long-term on our Consolidated Balance Sheet since we have the intent and ability to refinance through available borrowings under the terms of our Credit Agreement.

During the first six months of 2013, we made scheduled principal payments of $36 million on the Term Loan-A and Term Loan A2 facilities. Quarterly installment payments (Installment Payments) are due on the Term Loan-A and Term Loan-A2 facilities which, during 2013 and 2014, approximate $36 million during the remaining six months of 2013 and $72 million in 2014. No Installment Payments are due on the Term Loan-B facility. The Installment Payments due on the Term Loan-A and Term Loan-A2 facilities during the remainder of 2013 and the first six months of 2014 are classified as current maturities of long-term debt on our Consolidated Balance Sheet as of June 30, 2013.

Our accounts receivable securitization program (Securitization) with a group of conduit lenders and liquidity banks was amended in October, 2010. We increased the size of the Securitization from $200 million to $240 million (the Commitments), and extended the maturity date to October 25, 2013. In May, 2012, we further increased the size of the securitization by $35 million to $275 million. Substantially all of the patient-related accounts receivable of our acute care hospitals (Receivables) serve as collateral for the outstanding borrowings. The interest rate on the borrowings is based on the commercial paper rate plus a spread of 0.475% and there is a facility fee of 0.375% required on 102% on the Commitments. 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

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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, 2013, we had $260 million of outstanding borrowings and $15 million of additional capacity pursuant to the terms of our accounts receivable securitization program. In the event we do not either enter into a new financing agreement, or an agreement to extend the scheduled maturity date of the Securitization, we expect to have the borrowing capacity and intend to refinance the Securitization upon its scheduled maturity utilizing borrowings under our Credit Agreement. Therefore, outstanding borrowings as of June 30, 2013 under the Securitization are classified as long-term on our Consolidated Balance Sheet.

Our $250 million, 7.00% senior unsecured notes (the Unsecured Notes) are scheduled to mature on October 1, 2018. The Unsecured Notes were issued on September 29, 2010 and registered in April, 2011. Interest on the Unsecured Note is payable semiannually in arrears on April 1st and October 1st of each year. The Unsecured Notes can be redeemed in whole at anytime subject to a make-whole call at treasury rate plus 50 basis points prior to October 1, 2014. They are also redeemable in whole or in part at a price of: (i) 103.5% on or after October 1, 2014; (ii) 101.75% on or after October 1, 2015, and; (iii) 100% on or after October 1, 2016. These Unsecured Notes are guaranteed by a group of subsidiaries (each of which is a 100% directly or indirectly owned subsidiary of Universal Health Services, Inc.) which fully and unconditionally guarantee the Unsecured Notes on a joint and several basis, subject to certain customary automatic release provisions.

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

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

Our Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens and indebtedness, transactions with affiliates and dividends; 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, 2013.

As of June 30, 2013, the carrying value of our debt was $3.55 billion and the fair-value of our debt was $3.60 billion. The fair value of our debt was computed based upon quotes received from financial institutions and we consider these to be level 2 in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with debt instruments.

Our total debt as a percentage of total capitalization was 54% at June 30, 2013 and 58% at December 31, 2012.

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

Off-Balance Sheet Arrangements

During the three months ended June 30, 2013, there have been no material changes in the off-balance sheet arrangements consisting of operating leases and standby letters of credit and surety bonds. Reference is made to *Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations Contractual Obligations and Off-Balance Sheet Arrangements,* in our Annual Report on Form 10-K for the year ended December 31, 2012.

We have various obligations under operating leases or master leases for real property and under operating leases for equipment. The real property master leases are leases for buildings on or near hospital property for which we guarantee a certain level of rental income. We sublease

space in these buildings and any amounts received from these subleases are offset against the expense. In addition, we lease four hospital facilities from Universal Health Realty Income Trust with terms scheduled to expire in 2014 and 2016. These leases contain up to four, 5-year renewal options.

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As of June 30, 2013 we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds which totaled $91 million consisting of: (i) $70 million related to our self-insurance programs, and; (ii) $21 million of other debt and public utility guarantees.

Item 3. Quantitative and Qualitative Disclosures About Market Risk

There have been no material changes in the quantitative and qualitative disclosures during the three months ended June 30, 2013. Reference is made to *Item 7A. Quantitative and Qualitative Disclosures About Market Risk* in our Annual Report on Form 10-K for the year ended December 31, 2012.

Item 4. Controls and Procedures

As of June 30, 2013, under the supervision and with the participation of our management, including our Chief Executive Officer (CEO) and Chief Financial Officer (CFO), we performed an evaluation of the effectiveness of our disclosure controls and procedures, as defined in Rule 13a-15(e) or Rule 15d-15(e) under the Securities Exchange Act of 1934, as amended (the 1934 Act). Based on this evaluation, the CEO and CFO have concluded that our disclosure controls and procedures are effective to ensure that material information is recorded, processed, summarized and reported by management on a timely basis in order to comply with our disclosure obligations under the 1934 Act and the SEC rules thereunder.

Changes in Internal Control Over Financial Reporting

There have been no changes in our internal control over financial reporting or in other factors during the second quarter of 2013 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II. OTHER INFORMATION

Item 1. Legal Proceedings

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

Office of Inspector General (OIG) and Other Government Investigations

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

In July, 2012, one of our subsidiaries, Peachford Behavioral Health System of Atlanta located in Atlanta, Georgia, received a subpoena from the OIG for the Department of Health and Human Services requesting various documents from 2004 to the present. We have provided all requested documents. 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.

In February, 2013, the OIG served a subpoena requesting various documents from January 2008 to the present directed at Universal Health Services, Inc. (UHS) concerning it and UHS of Delaware, Inc., and several UHS owned 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 United States Department of Justice of its intent to proceed with an investigation following requests for documents from January, 2007 to the present 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 present, and; (iii) The Meadows Psychiatric Center received a subpoena from the OIG in February, 2013 requesting certain documents from 2008 to the present. 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 present. In June, 2013, the OIG served a subpoena on Coastal Harbor Health System in Savannah, Georgia requesting documents from January, 2009 to the present. In July 2013, another subpoena was issued to Wekiva Springs and River Point requesting additional records. At present, we are uncertain as to the focus, scope or extent of the investigations, liability of the facilities and/or potential financial exposure, if any, in connection with these matters. Unrelated to these matters, the Keys of Carolina was closed and the real property was sold in January, 2013.

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Matters Relating to PSI:

The following matters pertain to PSI or former PSI facilities (owned by subsidiaries of Psychiatric Solutions, Inc.) 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:

Garden City Employees Retirement System v. PSI:

This is a purported shareholder class action lawsuit filed in the United States District Court for the Middle District of Tennessee against PSI and the former directors in 2009 alleging violations of federal securities laws. We intend to defend the case vigorously. Should we be deemed liable in this matter, we believe we would be entitled to commercial insurance recoveries for amounts paid by us, subject to certain limitations and deductibles. Included in our consolidated balance sheets as of December 31, 2012 and 2011, is an estimated reserve (current liability) and corresponding commercial insurance recovery (current asset) which did not have a material impact on our financial statements. Although we believe the commercial insurance recoveries are adequate to satisfy potential liability and related legal fees in connection with this matter, we can provide no assurance that the ultimate liability will not exceed the commercial insurance recoveries which would make us liable for the excess.

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 have been 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 been collected and delivered to the DOJ. 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. 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.

Virginia Department of Medical Assistance Services Recoupment Claims:

The Virginia Department of Medical Assistance Services (DMAS) has conducted audits at seven former PSI Residential Treatment Centers operated in the Commonwealth of Virginia to confirm compliance with provider rules under the state s Medicaid Provider Services Manual (Manual). As a result of those audits, DMAS claims the facilities failed to comply with the requirements of the Manual and has requested repayment of Medicaid payments to those facilities. PSI had previously filed appeals to repayment demands at each facility which are currently pending. We have recently reached a preliminary settlement of this matter which requires finalization of a definitive agreement and approval of Virginia state officials. The aggregate refund of Medicaid payments made to those facilities, as requested by DMAS, and the settlement amount is not material to our consolidated financial position or results of operations.

General:

The healthcare industry is subject to numerous laws and regulations which include, among other things, matters such as government healthcare participation requirements, various licensure, certifications, and accreditations, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government action has increased with respect to investigations and/or allegations concerning possible violations of fraud and abuse and false claims statutes and/or regulations by healthcare providers. Currently, and from time to time, some of our facilities are subjected to inquiries and/or actions and receive notices of potential non-compliance of laws and regulations from various federal and state agencies. Providers that are found to have violated these laws and regulations may be excluded from participating in government healthcare programs, subjected to potential licensure, certification, and/or accreditation revocation, subjected to fines or penalties or required to repay amounts received from the government for previously billed patient services. We monitor all aspects of our business and have developed a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards. Because the law in this area is complex and constantly evolving, governmental investigation or litigation may result in interpretations that are inconsistent with industry practices, including ours. Although we believe our policies, procedures and practices comply with governmental regulations, there is no assurance that we will not be faced with sanctions, fines or penalties in connection with such inquiries or actions, including with respect to the investigations and other matters discussed herein. Even if we were to ultimately prevail, such inquiries and/or actions could have a material adverse effect on us.

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

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

Item 1A. Risk Factors

Our Annual Report on Form 10-K for the year ended December 31, 2012 includes a listing of risk factors to be considered by investors in our securities. There have been no material changes in our risk factors from those set forth in our Annual Report on Form 10-K for the year ended December 31, 2012.

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

In various prior years, our Board of Directors has approved stock repurchase programs authorizing us to purchase shares of our outstanding Class B Common Stock on the open market at prevailing market prices or in negotiated transactions off the market. There is no expiration date for our stock repurchase programs. The most recent approval occurred during 2007 at which time our Board of Directors authorized the purchase of up to 10 million shares, a portion of which (as reflected below) remains available for purchase as of June 30, 2013. The following schedule provides information related to our stock repurchase programs for the three months ended June 30, 2013. All of the shares repurchased during the second quarter of 2013 related to income tax withholding obligations resulting from the exercise of stock options. No shares were repurchased pursuant to our publicly announced stock repurchase program.

	Additional Shares Authorized For Repurchase	Total number of shares purchased	Average price paid per share for forfeited restricted shares	Total Number of shares purchased as part of publicly announced programs	Average price paid per share for shares purchased as part of publicly announced program	Aggregate purchase price paid (in thousands)	Maximum number of shares that may yet be purchased under the program
April, 2013		7,563	N/A	0	N/A	N/A	767,702
May, 2013		90,364	N/A	0	N/A	N/A	767,702
June, 2013		11,638	N/A	0	N/A	N/A	767,702
Total April through June		109,565	N/A	0	N/A	N/A	

Dividends

During the quarter ended June 30, 2013, we declared and paid dividends of $.05 per share.

Item 6. Exhibits

(a) Exhibits:

11	Statement re computation of per share earnings is set forth in Note 7 of the Notes to Condensed Consolidated Financial Statements.
31.1	Certification of the Company s Chief Executive Officer pursuant to Rule 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934.

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31.2	Certification of the Company s Chief Financial Officer pursuant to Rule 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934.
32.1	Certification of the Company s Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of the Company s Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Instance Document
101.SCH	XBRL Taxonomy Extension Schema Document
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document
101.LAB	XBRL Taxonomy Extension Label Linkbase Document
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document

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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

Signatures

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

Universal Health Services, Inc.

(Registrant)

Date: August 8, 2013

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

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

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EXHIBIT INDEX

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