COPY
-Application
Lakeside Behavioral Health System

CN1505-019

LAKESIDE
BEHAVIORAL HEALTH SYSTEM

MAY 14 '15 PM2:38

May 14, 2015

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

RE: CON Application Submittal
Lakeside Behavioral Health System –New Construction- 48-bed Geriatric Building
Memphis, Shelby County Tennessee

Dear Ms. Hill:

This letter transmits an original and two copies of the subject application. The affidavit and filing fee are enclosed.

I am the contact person for this project. Bryon Trauger, with Trauger and Tuke, Attorneys at Law, is the legal counsel.

Please advise me of any additional information you may need. We look forward to working with the Agency on this project.

Respectfully,

Anna Joy Golden, MSN, RN
CEO/Managing Director
Lakeside Behavioral Health System
2911 Brunswick Road
Memphis, TN 38133
901-377-4774

Lakeside Behavioral Health System

INVOICE NUMBER	INVOICE DATE	P.O. NUMBER	INVOICE AMOUNT	DISCOUNT	NET AMOUNT
CON FILING FEE	05/13/15		21,089.00	.00	21,089.00

VENDOR NO.	VENDOR NAME	CHECK NUMBER	CHECK DATE	TOTAL AMOUNT
257-5420	STATE OF TENNESSEE	257056584	5/13/2015	$21,089.00

BORDER CONTAINS MICROPRINTING - PANTOGRAPH IS BLUE/GREEN/BLUE - REVERSE SIDE HAS FDIC ENDORSEMENT BACKER

SUPER SAFETY™ ANTI-FRAUD PROTECT

Lakeside Behavioral Health System
2911 Brunswick Road
Memphis, TN 38133

Bank Of America
Commercial Disbursement Account
Northbrook, IL
70-2328/719

70-2328
719

CHECK NO. **257056584**

GENERAL DISBURSEMENT ACCOUNT

DATE	PAY EXACTLY
5/13/2015	$******21,089.00

PAY Twenty-One Thousand Eighty-Nine And No/100 Dollars

To The Order Of
STATE OF TENNESSEE
HEALTH SERVICES & DEVELOPMENT
ANDRE JACKSON BUILDING, 9TH FL
502 DEADERICK ST
NASHVILLE, TN 37243
USA

Lori Dixson
TWO SIGNATURES REQUIRED FOR CHECKS OVER $5,000.00
NOT NEGOTIABLE FOR AMOUNT OVER $100,000.00
CHECK NON-NEGOTIABLE AFTER 180 DAYS
Anna Jay Golden

⑈257056584⑈ ⑆071923284⑆ ⑈8765216704⑈

LAKESIDE
BEHAVIORAL HEALTH SYSTEM

CERTIFICATE OF NEED APPLICATION
TO CONSTRUCT
A NEW 48-BED GERIATRIC BUILDING
MEMPHIS, SHELBY COUNTY, TN

Submitted May 2015

SECTION A: APPLICANT PROFILE

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

UHS of Lakeside, LLC d/b/a Lakeside Behavioral Health System
Name

2911 Brunswick Road — Shelby
Street or Route — County

Memphis — TN — 38133
City — State — Zip Code

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

Anna Joy Golden — CEO and Managing Director
Name — Title

UHS of Lakeside, LLC d/b/a Lakeside Behavioral Health System — anna.golden@uhsinc.com
Company Name — Email address

2911 Brunswick Road — Memphis — TN — 38133
Street or Route — City — State — Zip Code

CEO/Managing Director — 901-377-4774 — 901-373-0987
Association with Owner — Phone Number — Fax Number

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

Universal Health Systems, Inc. — 610-768-3300
Name — Phone Number

367 South Gulp Road — Montgomery
Street or Route — County

King of Prussia — PA — 19406
City — State — Zip Code

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

A. Sole Proprietorship _____

B. Partnership _____

C. Limited Partnership ____

D. Corporation (For Profit) ____

E. Corporation (Not for Profit) _____

F. Government (State of TN or Political Subdivision) _____

G. Joint Venture _____

H. Limited Liability Company XX

I. Other (Specify) _____

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

5. ***Name of Management/Operating Entity (If Applicable)*** ***Not Applicable***

_____
Name

_____ _____ Street
or Route County

_____ _____ _____ City
State Zip Code

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

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

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

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

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

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

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

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

9. Bed Complement Data

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

	Current Beds Licensed	*CON	Staffed Beds	Beds Proposed	TOTAL Beds at Completion
A. Medical					
B. Surgical					
C. Long-Term Care Hospital					
D. Obstetrical					
E. ICU/CCU					
F. Neonatal					
G. Pediatric					
H. Adult Psychiatric	158	158	158		158
I. Geriatric Psychiatric	48	48	48		48
J. Child/Adolescent Psychiatric	55	55	55		55
K. Rehabilitation (CSU)	8				8
L. Nursing Facility (non-Medicaid Certified)					
M. Nursing Facility Level 1 (Medicaid only)					
N. Nursing Facility Level 2 (Medicare only)					
O. Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P. ICF/MR					
Q. Adult Chemical Dependency	15		15		15
R. Child and Adolescent Chemical Dependency	5		5		5
S. Swing Beds					
T. Mental Health Residential Treatment	30		30		30
U. Residential Hospice					
TOTAL	319	261	311		319

NO ADDITIONAL CON BEDS REQUESTED. NEW CONSTRUCTION ONLY ON EXISTING LAND OWNED BY THE FACILITY.

10. Medicaid Provider Number **#444004**

Certification Type: **Psychiatric Hospital**

11. Medicaid Provider Number **#044-4004**

Certification Type: **Psychiatric Hospital**

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

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

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

ADDITIONAL RESPONSE to Section A. Item 3. See Attachment A.4.

ADDITIONAL RESPONSE to Section A. Item 4: The Applicant, UHS of Lakeside, LLC, d/b/a/ Lakeside Behavioral Health System is a direct, wholly-owned subsidiary of Universal Health Services, Inc. The Applicant is a Medicare-certified psychiatric and residential treatment facility located at 2911 Brunswick Road, Memphis, Tennessee 38133.

ADDITIONAL RESPONSE to Section A. Item 5: The Applicant does not operate pursuant to a management agreement. All Universal Health Services, Inc. affiliated hospitals operate autonomously in accordance with the parent company's philosophy on decentralized managerial control. The parent company, Universal Health Services, Inc. provides direction, information technology services, and legal services support to the Applicant. However, the Applicant manages the facility with its own administrative team with oversight by its own governing body.

ADDITIONAL RESPONSE to Section A. Item 6: See Attachment A.4.

ADDITIONAL RESPONSE to Section A. Item 13: Lakeside Behavioral Health System is contracted with all three (3) TennCare providers in West TN: United Community HealthCare Plan (UHCP), Blue Care and Amerigroup.

Table One: Contractual Relationships with Service Areas MCO's:	
Available TennCare MCO's	**Applicant Relationship**
BlueCare	Contracted
United Community HealthCare Plan (UHCP)	Contracted
Amerigroup	Contracted

The facility provides acute care and residential psychiatric care services. The Applicant has contracts with the following Behavioral Health Organizations:

- Aetna Behavioral health
- BHSG
- Humana/Lifesynch
- Cigna
- Coventry
- Health Choice
- Health Partners
- Magellan HMO
- Magellan State of Tennessee
- Magellan-PPO
- Medicaid-AR and MS
- Health Spring
- Wellcare
- PHCS
- UBH
- Value Options

For any out of network plans, the Applicant negotiates such plans under a single case agreement, thus allowing the member to receive in-network benefit coverage. The Applicant also participates as a Certified Application Counselor (CAC) under the Healthcare Insurance Marketplace assisting uninsured persons with enrollment processes.

SECTION B: PROJECT DESCRIPTION

B. I

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

RESPONSE:

Proposed Services and Equipment

Lakeside requests approval for construction of a new 48-bed geriatric psychiatric building. The new geriatric building will replace the current 31-bed unit which cannot accommodate the increasing geriatric census. The current geriatric unit was built in 1988 as a residential adolescent unit. The 11,000-square-foot 16-patient room building is not designed to care for patients needing assistance with ambulation and assisted hygiene. The current building has limited space for wheelchairs, walkers, and other assistive devices. The new building will be located on the northeast section of the campus on existing property owned by the Facility. No new CON beds are requested. Lakeside is licensed for 261 beds with an average daily census of 228 in 2014.

The Applicant also offers two very effective treatment options for patients suffering from major depressive disorder along with other co-morbidity issues, Electroconvulsive Therapy (ECT) and Transcranial Magnetic Stimulation (TMS). These procedures have had a substantial increase in the past two years. ECT procedures have increased 85% and TMS procedures have increased 123% since it became a covered treatment option for Medicare patients in April 2013. Blue Cross and Blue Shield added TMS as a covered treatment in January 2015. The Applicant plans to reconfigure some existing space to increase efficiency and better serve all patient populations. This includes relocation of the procedure areas for ECT and TMS to the new building.

In 2013 the geriatric census exceeded 31 patients requiring geriatric admissions to be accommodated on the West Adult unit. Renovations were made to have capacity for 17 geriatric beds on this unit as a designated overflow wing. This allows geriatric patients to be admitted and cared for on this wing until a bed is available in the geriatric building. However, this overflow wing also is not designed to care for patients needing assistance with ambulation and assisted hygiene. Census has been as high as 48 geriatric patients. The proposed construction of a new building will not increase the number of licensed hospital beds for the facility or in Shelby County.

Ownership Structure

The Applicant, Lakeside Behavioral Health System, is a wholly owned by Universal Health Systems, Inc. (UHS, Inc.). Lakeside is a Tennessee-based psychiatric hospital that currently operates 261 CON beds in an acute care facility in Memphis, TN. Attachment A.4 contains information on all facilities owned by facility's parent organization, UHS, Inc.

Service Area

Lakeside provides mental healthcare to residents of 53 counties in three states. The primary service area from which 95% of admissions will come consists of 21 Tennessee counties, 22 Mississippi counties, and 10 Arkansas counties. See Attachment C. Need-3.

Need

Lakeside has strong relationships with nursing homes and assisted living facilities in Shelby County, West Tennessee and Northern, MS. The geriatric unit serves older adult male and female patients who are in need of acute psychiatric stabilization. However, as is the current practice patients are also admitted to this unit who are under the age of 50 who need assistance with their Activities of Daily Living (ADLs). Patients conduct all programming on the unit along with their daily meals being delivered and served in the dining room on the unit. The proposed construction will relocate all of the geriatric patients to one building that will be designed to accommodate adult patients needing assistance with ADL's. The programming has been revised to provide active treatment for both the higher and lower functioning geriatric patients. Patient satisfaction is strong with an average score of 4.50 on a 1-5 scale.

In July 2014, Lakeside joined the University of Tennessee (UT) College Of Medicine in a Graduate Medical Education (GME) Affiliation Agreement as a clinical training site for four residents/fellows under the direction of Lakeside attending psychiatrists who are also credentialed UT faculty. The agreement includes staffing one geriatric Psychiatry Fellow, which UT is actively recruiting to fill. Once UT has filled this geriatric Fellow position, Lakeside will attain additional growth in geriatric admissions. In addition to the UT agreement, Lakeside also has 25 other clinical site agreements for education and training which compliment this proposal.

Existing Resources

Shelby County has three general hospitals with licensed psychiatric bed units, and two free-standing hospitals. Lakeside is the only facility located in the north Shelby County service area. A 60-bed free-standing facility was approved in April 2014 to replace existing beds in two general hospitals; however, construction has not started. This 60-bed facility will be located in southeast Shelby County. Also an approved 16-bed Gero-Psychiatric hospital has not been implemented in seven years after the initial approval of the CON. This facility was approved in March 2015 for a third extension and modification to relocate as a unit in a nursing home located in downtown Memphis.

Project Cost, Funding, Financial Feasibility, and Staffing

The project cost is estimated to be $9,393,796, (including CON filing fee of $21,089). The project's cash requirements will be funded entirely by a cash transfer from Universal Health Services, Inc., the parent company of the Applicant. See Attachment C. Economic Feasibility-2. The Applicant projects the 48-bed new construction will have a positive operating margin within year two of the construction.

Lakeside, a free-standing behavioral health facility, is known for providing care for medically compromised patients. An Intravenous team was formed in 2010 and since that time the medical exclusion criteria has been revised to safely and successfully care for patients with additional co-morbidities. Staffing on the geriatric unit uses a primary nursing model; and in 2014 the Registered Nurses were trained to perform Phlebotomy duties for stat lab tests. The new building will be staffed with a total of 43.0 FTEs.

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

A. Describe the construction, modification, and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. §68-11-1601et seq.) Including square footage, major operational area, room configuration, etc. Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the Square Footage and cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above, describe the development of the proposal.

RESPONSE: See Below

Table Two: Construction Costs	
Square Feet	24,205 SF
Construction Cost	$6,644,547
Construction Cost PSF	$275 PSF

Table Three: Geriatric Building Size	
1. Building Area	24,205 SF
2. Building Type	Single story, central services and two patient wings; ECT and TMS procedure areas
3. Size of the Site	2.0 acres
4. Licensed Beds	48-all current CON beds in operation. No additional beds requested.

Physical Description of the Facility

The geriatric building will be constructed on the northeast section of the existing 37 acre Lakeside Behavioral Health System campus. The address will remain the same as the facility at 2911 Brunswick Road, Memphis, TN 38133. A separate address for the building will be assigned after construction. The main hospital entrance off Brunswick Road will not be altered by the construction of the new building. A

location and site map are attached after this section to illustrate the position on the proposed site. See Attachment B. III.

In order to address the growing need for geriatric psychiatric services within the community, Lakeside Behavioral Health System proposes to construct a new 24,205 sf, 48-bed geriatric psychiatric building on the existing Lakeside campus in Memphis, TN. The new building will also include an Electroconvulsive Therapy (ECT) and Transcranial Magnetic Stimulation (TMS) Clinic. TMS is a MRI strength, non-invasive, non-systemic, outpatient, FDA cleared treatment option for depression that does not involve any surgery, anesthesia or sedation. Lakeside is the only psychiatric hospital in the area that provides the TMS outpatient treatment option.

The building will provide two distinct 24-bed inpatient wings with a centralized nursing station. Both wings will provide a variety of group therapy and activity spaces as well as exam, consult, and treatment facilities. Safety and security features are based on current best practices within the behavioral health industry.

Additionally, the facility will provide ample natural light, open circulation and way finding, and a residential and therapeutic atmosphere throughout. Select patient rooms will be larger than required by the Tennessee State Building Code in order to better accommodate the needs of the geriatric patient population.

The ECT and TMS Clinic will replace the existing ECT/TMS Unit on the Lakeside campus and will offer updated, state-of-the-art inpatient and outpatient treatment services to the community.

The entire facility will be designed to meet the most current requirements of the Facility Guidelines Institute for the Design and Construction of Healthcare Facilities and all other applicable code requirements.

An overall floor plan is included as Attachment B. IV.

Table Four: Proposed Changes in Assignment of Facility's Licensed CON Hospital Beds
NONE

Unit	Current Beds	Proposed Beds	Difference	Total
Adult Psychiatric	158	158	0	158
Geriatric Psychiatric	48	48	0	48
Child/Adolescent Psychiatric	55	55	0	55
TOTAL ACUTE CON BEDS	**261**	**261**	**0**	**261**

Source: Lakeside Management. Beds are currently in-service to care for geriatric patients on two units, and will be relocated to the new geriatric building. No change in total licensed CON beds.

Operation of the Facility
As a licensed inpatient acute care facility, Lakeside will operate 24 hours daily throughout the year. If granted final CON approval during CY 2015, the new building is expected to be completed during the second quarter of 2016.

Ownership of the Facility
The CON Applicant is UHS of Lakeside, LLC, d/b/a/ as Lakeside Behavioral Health System. Lakeside is wholly owned by Universal Health Services, Inc. Universal Health Services Inc. is a Delaware based healthcare company that currently operates 216 psychiatric facilities in 37 states and the UK. Attachment A.4 contains information on all facilities owned by Lakeside's parent organization.

Financing of the Project
The cost of the project is approximately $9,393,796 and will be funded by the Applicant's parent company, Universal Health Services, Inc. The attachments contain the Universal Health Services Inc. funding commitment letter and the facility's income statement and balance sheet. See Attachment C. Economic Feasibility-2 and C. Economic Feasibility-10.

Applicants with Hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the square footage and costs per square footage chart.

RESPONSE:
See Table Two below and cost per square footage chart.

Please also discuss and justify the cost per square foot for this project.

RESPONSE: Hospital construction projects approved by HSDA in 2011-2013 have the following average construction cost per Square Foot as shown on Table Five below.

Table Five: Hospital Construction Cost PSF-Years: 2011-2013			
	Renovated Construction	**New Construction**	**Total Construction**
1st Quartile	$107.15/sq ft	$235.00/sq ft	$151.56/sq ft
Median	**$179.00/sq ft**	**$274.63/sq ft**	**$227.88/sq ft**
3rd Quartile	$249.00/sq ft	$324.00/sq ft	$274.63/sq ft

SOURCE: CON approval applications for years 2011 through 2013

The Lakeside geriatric building will be cost-effective and consistent with similar projects recently approved by the HSDA. The project's estimated construction cost is approximately $275 PSF, consistent with the HSDA's published Median quartile cost PSF in those years.

Table Two: Construction Costs	
Square Feet	24,205 SF
Construction Cost	$6,644,547
Construction Cost PSF	$275 PSF

If the project involves none of the above, describe the development of the proposal.

RESPONSE: N/A

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

RESPONSE: The project is limited to construction of a new geriatric building to allow all geriatric patients to be treated on one unit. The ECT/TMS procedure areas will also be relocated to the new building. No additional CON beds are requested. Currently 17 beds in the West adult building are used as an overflow hall for geriatric patients. These beds will be relocated to the new building along with the 31 beds from the current geriatric unit.

Although there will be no new beds added as a result of this project, and the number of geriatric psych beds will remain at 48, as noted in the Table Four below, the services offered will improve. The new building will contain superior functionality and because of consolidation of services into one location Lakeside will increase efficiencies.

Table Four: Proposed Changes in Assignment of Facility's Licensed CON Hospital Beds NONE				
Unit	**Current Beds**	**Proposed Beds**	**Difference**	**Total**
Adult Psychiatric	158	158	0	158
Geriatric Psychiatric	48	48	0	48
Child/Adolescent Psychiatric	55	55	0	55
TOTAL ACUTE CON BEDS	**261**	**261**	**0**	**261**

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
Geriatric Unit										
Building Support		500				830	830			
ECT.TMS Clinic		1,584				2,440	2,440			
Admin/Intake		300				1,570	1,570			
IP Wings		10,610				13,940	13,940			
B. Unit/Depart. GSF Sub-Total		12,994				18,780	18,780			
C. Mechanical/ Electrical GSF		250				415	415			
D. Circulation /Structure GSF		2,390				5,010	5,010			
E. Total GSF		15,634				24,205	24,205			

C. **As the Applicant, describe your need to provide the following health care services (if applicable to this application):**

1. **Adult Psychiatric Services (Geriatric)**
2. Alcohol and Drug Treatment for Adolescents (exceeding 28 days)
3. Birthing Center
4. Burn Units
5. Cardiac Catheterization Services
6. Child and Adolescent Psychiatric Services
7. Extracorporeal Lithotripsy
8. Home Health Services
9. Hospice Services
10. Residential Hospice
11. ICF/MR Services
12. Long-term Care Services
13. Magnetic Resonance Imaging (MRI)
14. Mental Health Residential Treatment
15. Neonatal Intensive Care Unit
16. Non-Residential Methadone Treatment Centers
17. Open Heart Surgery
18. Positron Emission Tomography
19. Radiation Therapy/Linear Accelerator
20. Rehabilitation Services
21. Swing Beds

RESPONSE: Given the increased demand for mental health treatment in the Applicant's service area for older adults, the Applicant has managed two geriatric units for the past 24 months on two units at the facility. The existing size, configuration, and the current process of operating in two buildings create challenges. Efficiencies of geriatric patient care, supplies and staff will be realized by having one unit provide all the care.

The 48-bed building will replace the current 31-bed building which cannot accommodate the increasing geriatric census. The current geriatric unit was built in 1988, and designed as a residential adolescent unit. That 11,000-square-foot 16-patient-room building is not designed to care for patients needing assistance with ambulation and assisted hygiene. The current building does not have adequate space for wheelchairs, walkers, and other assistive devices.

The ECT/TMS procedure areas will be relocated to the new building. Currently the procedure areas are in 1584 square feet. They will be relocated in the new building and allocated 2440 square feet due to the significant increase in procedures in the last twelve months.

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

RESPONSE: Although we are not proposing to replace an entire facility, we will relocate the two units where geriatric psychiatric services are offered with a single building. This will result in overall improved facilities, space, and services for our patients.

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

1. For fixed-site major medical equipment (not replacing existing equipment):

a. Describe the new equipment, including:

1. Total cost (As defined by Agency Rule);

2. Expected useful life;

3. List of clinical applications to be provided; and

4. Documentation of FDA approval.

b. Provide current and proposed schedules of operations.

2. For mobile major medical equipment:

a. List all sites that will be served;

b. Provide current and/or proposed schedule of operations;

c. Provide the lease or contract cost.

d. Provide the fair market value of the equipment; and

e. List the owner for the equipment.

3. Indicate Applicant's legal interest in equipment (*i.e.*, purchase, lease, etc.) In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

RESPONSE: Not applicable. The project does not involve acquisition of any additional major medical equipment.

B. III

A. Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which <u>must</u> include:

1. **Size of site (*in acres*);**
2. **Location of structure on the site; and**
3. **Location of the proposed construction.**
4. **Names of streets, roads or highway that cross or border the site.**

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

<u>RESPONSE:</u> See Attachments B.III A.

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

<u>RESPONSE:</u> The Applicant's facility, located at 2911 Brunswick Road, is less than one-fourth mile from the intersections of Highway 64 and I-40. The location provides easy access for patients/clients and caregivers from the north and south of the facility by using I-55 or I-51 to I-240 to I-40 to Highway 64. It also provides easy access for patients/clients and caregivers from the east and west by using I-40 to Highway 64. The map noted as Attachment C. Need-3 details the excellent access this location will provide to all patients and clients in the surrounding counties. Lakeside is accessible to all areas of Memphis/Shelby County through our local Memphis Area Transit Authority. A MATA bus stop is conveniently located at New Brunswick Road and Stage Road, which is less than a quarter mile from Lakeside's campus. With 28 Inbound/Outbound trips per day, Lakeside is accessible to all areas of Shelby County at convenient times.

Table Six A below provides drive times and distances from communities within our primary service area.

Table Six B below outlines distances and drive times from referral sources to acute geriatric beds.

Table Six-A: Mileage and Drive Times Between Project and Major Communities in the Primary Service Area Ranked in Order of Patient Admissions			
Community	**County/State (Patient Origin Ranking)**	**Distance in Miles**	**Drive time in Minutes**
Memphis	Shelby, TN (1)	0	0
Jackson	Madison, TN (2)	65.4	62
Covington	Tipton, TN (3)	38	45
Dyersburg	Dyer, TN (4)	74.4	83
Milan,Trenton,Humboldt	Gibson, TN (5)	80	84
Somerville	Fayette, TN (6)	24.7	30
Union City	Obion, TN (7)	115.2	119
Selmer	McNairy, TN (8)	72	85
Lexington	Henderson, TN (9)	91	86
Southaven, Olive Branch, Hernando	Desoto, MS (10)	25.1	32
Huntingdon	Carroll, TN (11)	98.4	97
Bolivar	Hardeman, TN (12)	49	58
Savannah	Hardin, TN (13)	96	112
Ripley	Lauderdale, TN (14)	52	62
Tiptonville	Lake, TN (15)	101	116
Dresden, Martin	Weakley, TN (16)	115	120
Alamo	Crockett, TN (17)	60.7	65
Camden	Benton, TN (18)	124.6	117
Jonesboro	Craighead, AR (19)	91.5	90
Paris	Henry, TN (20)	125	125

Table Six-B: Distances and Drive Times From Referral Sources to Acute Geriatric Psychiatric Care Beds				
Provider	**Type of Facility**	**County/State**	**Distance**	**Drive Time**
Baptist Hospital-Huntingdon, TN	Unit of M/S Hospital	Carroll, TN	98.46 miles	97 mins
Delta Medical Center	Unit of M/S Hospital	Shelby, TN	18.16 miles	20 mins
Methodist Univ. Healthcare	Unit of M/S Hospital	Shelby, TN	16.65 miles	21 mins
St. Francis Hospital	Unit of M/S Hospital	Shelby, TN	12.77 miles	15 mins
Oak Hills Behavioral Ctr	Psychiatric Facility	Madison, TN	65.48 miles	62 mins
Martin Behavioral Health	Psychiatric Facility	Weakley, TN	115.23 miles	1hr/59 mins
Parkwood Behavioral Health	Psychiatric Hospital	Desoto, MS	25.11 miles	32 mins
Forrest City Medical Center	Unit of M/S Hospital	St. Francis, AR	65.82 miles	64 mins

Source: MapQuest, 04-29-2015

Addresses of Providers in Table Above	
Baptist Hospital-Huntingdon	631 R.B. Wilson Drive, Huntingdon, TN 38344
Delta Medical Center	3000 Getwell Road, Memphis, TN 38118
Methodist University Healthcare	1265 Union Avenue, Memphis, TN 38104
St. Francis Hospital	5959 Park Avenue, Memphis, TN 38119
Oak Hills Behavioral Health Center	49 Old Hickory Blvd., Jackson, TN 38305
Martin Behavioral Health	458 Hannings Lane, Martin, TN 38237
Parkwood Behavioral Health	8135 Goodman Road, Olive Branch, MS 38654
Forrest City Medical Center	1601 New Castle Road, Forrest City, AR 72335

Source: MapQuest 05-04-15

B. IV.
Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc.

RESPONSE: See Attachment B.IV.

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

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

RESPONSE: Not applicable. The application is not for a home-care organization.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

NEED

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

RESPONSE: The Applicant's mission encompasses the philosophy of the Guidelines for Growth and the Five Principles to Achieve Better Health outlined in the State Health Plan. Lakeside's mission is to provide quality psychiatric and addiction healthcare services that patients will recommend to families and friends, physicians will prefer for their patients, payers will select for their members, and for which employees are proud. Lakeside has by far the widest referral base of any acute psychiatric provider in West Tennessee, providing services to a socio-economical diverse population. This project mirrors the Applicant's mission and aspects of the State Health Plan and Guidelines for Growth.

The following Five Principles for Achieving Better Health serve as the basic framework for the State Health Plan. After each principle, the Applicant states how this application supports the principle if applicable.

1. **Healthy Lives**
The purpose of the State Health Plan is to improve the health of Tennesseans. Every person's health is the result of the interaction of an individual's behaviors, society, the environment, economic factors, and our genetic

endowment. The State Health Plan serves to facilitate the collaboration of organizations and their ideas to help address health at these many levels.

RESPONSE: The Healthy Lives Principle is promoted through the expansion to modernize healthcare for older adults seeking mental health treatment. This will have a positive impact on older adults who may also have medical co-morbidities requiring assistance with ambulation and hygiene care. Instead of the current two units, neither of which were designed for older adults, patients will be treated in an adequately sized unit. Lakeside has a patient/family centered culture. Employees partner with patients and families for their input in mental healthcare decisions. This benefits the patient/caregiver in planning better care and delivery of services. The Applicant's core principles and values include respect and dignity, service excellence, culture of safety and individualized treatment for all patients served. The new geriatric building design coupled with employment of these principles provides an opportunity to meet the patient's needs and overall care.

2. **Access to Care**
Every citizen should have reasonable access to healthcare. Many elements impact one's access to health care, including existing health status, employment, income, geography, and culture. The State Health Plan can provide standards for reasonable access, offer policy direction to improve access, and serve a coordinating role to expand health access.

RESPONSE: Lakeside is a premier provider of mental health and addiction healthcare services. This includes providing vital mental healthcare needs for the vulnerable older adult population. In keeping with the mission, access to these mental health services is not restricted by an individual's health status, income, geography or culture. Lakeside is a free-standing for-profit facility; however, it is committed to serving elderly and low-income patients in Medicare and TennCare programs and to provide a limited amount of indigent care. Lakeside accepts both voluntary and involuntary admissions.

3. **Economic Efficiencies**
The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system. The State Health Plan should work to identify opportunities to improve the efficiency of the state's health care system and to encourage innovation and competition.

RESPONSE: The new geriatric building will maintain the Applicant's scope of services for mental healthcare for older adults while also meeting the patient care needs in a more modernized facility. With the two geriatric units being relocated to one building, long-term cost reductions will be recognized by combining equipment and maintenance costs, minimal staffing level changes and the workspace being more efficient, thus improving work productivity. The project supports this goal by

ensuring adequate care for older adults in the 53 counties served and increases the competitiveness of the Memphis market for private hospital psychiatric services. It will provide psychiatric beds in areas currently underserved, and replace central county acute care beds that have been taken out of the market during the past two years.

4. **Quality of Care**
Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers. Health care providers are held to certain professional standards by the state's licensure system. Many health care stakeholders are working to improve their quality of care through adoption of best practices and data-driven evaluation.

RESPONSE: The current two geriatric units present challenges in providing efficient care due to inadequate space and barriers to optimal patient flow. Lakeside, like its parent company, UHS, Inc, works to ensure the facility's and staff's patient care practices are continuously measured, evaluated, and focused on quality and efficiency. The new building design creates adequate clinical space, and flexible room configuration, for all acuity levels of the older populations served. Lakeside's goal is to keep pace with evolving public standards and evidenced-based practices by providing state of the art equipment thus allowing better functionality.

5. **Health Care Workforce**
The state should support the development, recruitment, and retention of a sufficient and quality health care workforce. The state should consider developing a comprehensive approach to ensure the existence of a sufficient, quality health care workforce, taking into account issues regarding the number of providers at all levels and in all specialty and focus areas, the number of professionals in teaching positions, and the capacity of medical, nursing, allied health and other educational institutions, state and federal health laws and regulations impacting capacity programs, and funding.

RESPONSE: This project includes clinical staff and physicians dedicated to providing high quality service to older adults served. The proposed new geriatric building will provide a more effective, efficient, treatment option. Lakeside fills a need for mental healthcare in communities served. The hospital has a strong reputation as a premier healthcare provider which attracts physicians and healthcare clinicians as partners in care. The project will expand employment opportunities for a professional workforce with clinical expertise and experience. It will enhance the current Graduate Medical Education Affiliation Agreement with the UT College of Medicine in recruiting a geriatric Fellow for clinical training. Nationally there are over 100 geriatric fellowships available with currently only 50 slots filled.

a. **Please provide a response to each criterion and standard in Certificate**

of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

Project-Specific Review Criteria: Construction, Renovation, Expansion, and Replacement of Health Care Institutions.

1. **Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.**

   RESPONSE: Not applicable; no beds, services or major medical equipment are being added to the applicant's licensed organization.

2. **For relocation or replacement of an existing licensed healthcare institution:**

   a. **The applicant should provide plans, which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.**
   b. **The applicant should demonstrate that there is acceptable existing and projected future demand for the proposed project.**

   RESPONSE: Neither a. nor b. are applicable. This project is a new construction for existing beds.

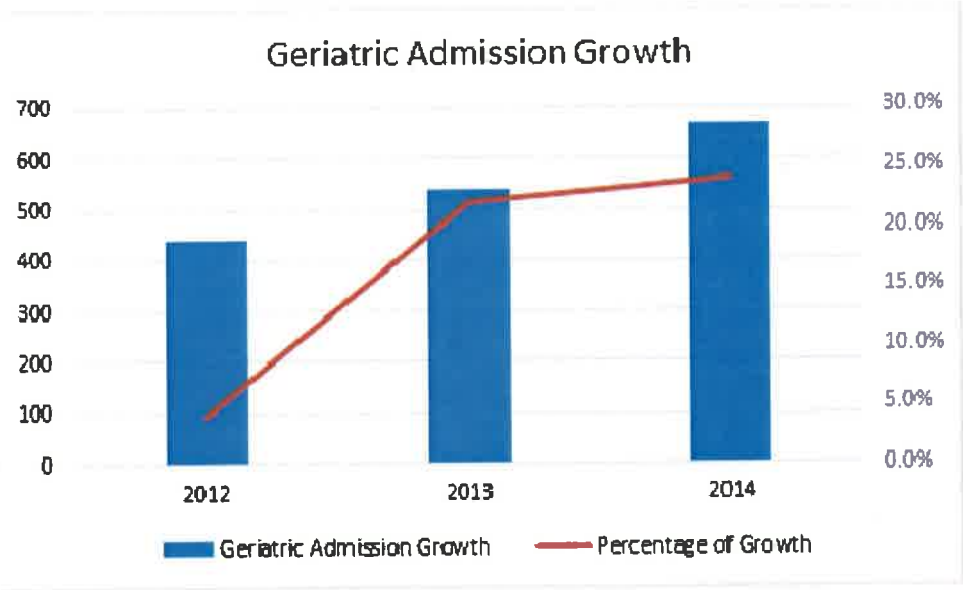
3. **For renovation or expansions of an existing licensed healthcare institution:**

   a. **The applicant should demonstrate that there is an acceptable existing demand for the proposed project.**
   b. **The Applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.**

   RESPONSE: The applicant is presenting the detailed justification for the project in this section of the application. Both a. and b. are responded to in the narrative and exhibits beginning below.

DEMAND FOR THE PROJECT

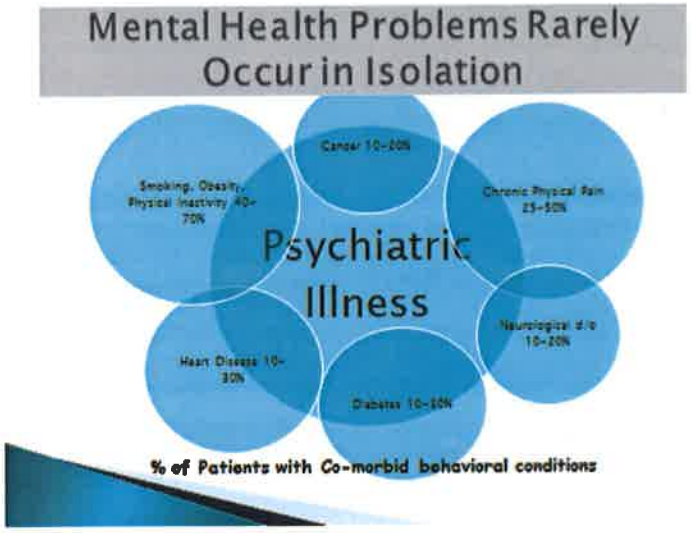
The current geriatric building was built in 1988 as a residential adolescent unit. The 11,000-square-foot 16-patient room building is not designed to care for patients needing assistance with ambulation and assisted hygiene. The current building has limited space for wheelchairs, walkers, and other assistive devices. In 2013 the geriatric census exceeded 31 patients requiring geriatric admissions to be accommodated on an adult unit in a separate building. Renovations were completed to provide capacity for 17 geriatric beds on this designated overflow space. To the best of its ability, Lakeside modified existing spaces; however, there continue to be challenges due to space constraints. Patient volumes have increased and the constraints of the current two units are a barrier to operational efficiencies to deliver patient care. The best alternative is construction of a new 48-bed building on property owned by the facility to treat older adults on one unit.



This new geriatric building will provide modernized healthcare options to the growing older population. The need for mental health resources for the aging population is acute. In fact in their September 2013 factsheet, the World Health Organization stated older adults, those aged 60 or above, increased from 9.2 percent in 1990 to 11.7 percent in 2013, and will continue to grow to an estimated 21.1 percent by 2050. While many have good mental health, over 20% of adults aged 60 and over suffer from a mental or neurological disorder. The most common neuropsychiatric disorders in this age group include depression along with anxiety disorders and some substance use problems. Unfortunately around a quarter of deaths are from self-harm from those aged 60 or above.

Evidenced-based data reflects about one-fifth of all successful suicides are committed by persons over age 65. The geriatric patient most likely to commit suicide is a widowed or

divorced white male suffering from a masked depression with high anxiety who has been ill for an extended period of time; is living in a nursing home, has co-morbid medical or neurologic illness, and has a heightened fear of losing control and loss of dignity. Older women have similar risk factors. Senior years are often reportedly less satisfying with 17-37% of individuals over age 60 suffering from minor depression. Lakeside has both the psychiatric and medical expertise and solid reputation to care for this growing vulnerable population. Reference: Hall, R., Hall, R., & Chapman, M.J. (2003). Identifying Geriatric Patients at Risk for Suicide and Depression. *Clinical Geriatrics*, 11 (10) 36-44.



Several studies identified that many older adults who commit suicide have visited their PCP in close proximity to the time of suicide. Reports include 20% visited the PCP on the same day and 40% have been seen within one week of the suicide. These reports are alarming considering Tennessee has one of the highest rates of suicide per 100,000 people for age groups in older adults.

Suicides Per 100,00 by Age in TN
1.9 for 10 to 14 years
9.5 for 15 to 17 years
14.3 for 20 to 24 years
14.5 for 25 to 29 years
19.5 for 30 to 34 years
22.0 for 35 to 44 years
22.6 for 45 to 54 years
22.4 for 55 to 64 years
19.2 for 65 to 74 years
20.6 for 75 to 84 years

http://news.tn.gov/node/13442

Tennessee's overall suicide rate of 15.7 in 2013 compares with 12.6 for the United States that same year.

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

RESPONSE: No change in site for the facility.

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

RESPONSE: The Applicant is currently licensed for 261 acute care beds and is a Medicare certified mental health hospital located in Shelby County, Memphis, Tennessee. The facility has been in the greater Memphis market for over 45 years providing mental health and substance abuse services. As stated earlier in the application, due to the facility's configuration, there are significant issues impacting the Applicant's ability to provide specialized psychiatric care to older adults and adults needing assistance with ambulation and hygiene while receiving mental health care treatment. The optimal solution to meet the service area needs of the growing older adult population is to provide modernized capacity in one building designed to care for individuals who may need assistance with ambulation and hygiene. The larger rooms and work space will allow Lakeside to offer management of the medical co-morbidities.

The Applicant has experienced a steady increase in occupancy on the existing geriatric unit requiring use of the designated overflow unit. More specifically over the past 12 months the Applicant has been at a maximum occupancy for a total of 242 days on the primary geriatric unit. This proposed project will allow the Applicant to better serve the older adults through access to mental health care and to work alongside mental health providers to ensure placement and safety of individuals experiencing a mental health crisis.

3. **Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).**

RESPONSE: Lakeside is not a new facility and has been operated as an established mental Healthcare facility in the area for over 45 years. Lakeside provides mental healthcare to residents of 53 counties in three states. The primary service area from which 95% of admissions will come will consist of 21 Tennessee counties, 22 Mississippi counties, and 10 Arkansas counties. Attachment C. Need-3 contains a map of the counties served.

4. A. **Describe the demographics of the population to be served by this proposal.**

RESPONSE: Lakeside has the reputation and experience to treat older adults experiencing mental health problems. Depression is not a normal part of aging, and is often undiagnosed and undertreated in older adults. The Surgeon General's Report estimates that 20% of persons age 55 and older experiences specific mental disorders that are not part of "normal" aging. The National Association of State Mental Health Program Director's (NASMHPD's) Presidential Task Force of Mental Health and Aging notes that the elderly remain the most under-served and inappropriately served population in mental health services. Often symptoms go unrecognized in the context of multiple physical problems. Accurate diagnosis is the key to effective treatment for older adults that can prevent suffering for patients and families. Our goal is to provide outstanding customer service to patients and families through increased responsiveness for mental health needs of older adults (i.e., age 50 and above). The demographic data required by the HSDA staff for primary service area (PSA) counties is shown in the tables on the next pages. Data has been provided for total population and also for ages 50+. Sources are footnoted.

Tennessee PSA Counties Compared to State of Tennessee:

- In 11 PSA counties the 50+ population percentage is greater than the state percentage of the same age group.
- From 2012 to 2014 total population loss in the PSA counties was -1.1%
- The total percentage of 50+ in the PSA counties is 34.1% compared to 32.38% of state 50+ population.

In terms of percentage growth, the most rapidly growing segment of the population through 2025 will be the 65 to 69 age group for both males and females. In terms of *numbers* of people, the most rapidly growing segment of the population is the 75 and over age group. Wide variation in growth rates is expected for Tennessee cities and counties over the next 22 years, although all counties will experience some positive growth.
http://tn.gov/tacir/PDF_FILES/Other_Issues/pop%20project.pdf

Arkansas PSA Counties Compared to State of Arkansas:

- In 6 PSA counties the 50+ population percentage is greater than the state percentage of the same age group.
- From 2012 to 2014 total population loss in the PSA counties was -2.3%
- The total percentage of 50+ in the PSA counties is 33.4% compared to 32.5% of state's 50+ populations.

Mississippi PSA Counties Compared to State of Mississippi:

- In 14 PSA counties the 50+ population percentage is greater than the state percentage of same age group.
- From 2012 to 2014 total population gain in the PSA counties was 13.2%
- The total percentage of 50+ in the PSA counties is 32% compared to 30% of state 50+ populations.

Demograhic characteristics of Tennessee Primary Service area - Ages 50 and up
Lakeside Behavioral Health System
2014

Demographic	Benton County	Carroll County	Chester County	Crockett County	Decater County	Dyer County	Fayette County	Gibson County	Hardeman County
STATE OF TENNESSEE									
Total Population - 2014	16,489	28,522	17,131	14,586	11,757	37,935	38,413	49,683	27,253
Total Population - 2012	16,362	28,579	17,190	14,614	11,640	38,253	38,561	49,672	26,549
Population % Growth/Loss	-0.8%	0.2%	0.3%	0.2%	-1.0%	0.8%	0.4%	0.0%	-2.6%
Population Age 50+ (2014)	7,019	10,670	5,437	4,987	4,785	12,970	14,637	17,122	8,551
% of Total Population age 50+	42.57%	37.41%	31.74%	34.19%	40.70%	34.19%	38.10%	34.46%	31.38%

Demgraphic	Henry County	McNairy County	Madison County	Lake County	Lauderdale County	Obion County	Shelby County	Tipton County	Weakley County
Total Population - 2014	32,330	26,075	98,294	7,832	27,815	31,807	927,644	61,081	35,021
Total Population - 2012	32,338	26,167	98,511	7,729	27,780	31,373	939,877	61,629	34,726
Population % Growth/Loss	0.0%	-0.4%	-0.2%	1.3%	0.1%	1.4%	-1.3%	-0.9%	0.8%
Population Age 50+ (2014)	13,245	9,750	31,008	2,060	8,136	11,847	262,565	17,947	11,516
% of Total Population age 50+	40.97%	37.39%	31.55%	26.30%	29.25%	37.25%	28.30%	29.38%	32.88%
Total TN Population	6,346,000								
Total TN Pop. Age 50+	2,055,000								
% of State Total Pop. Age 50+	32.38%								

Source: 1) Surburban Stats.org/Tennessee Population by County/Age 2) US-Places.com

Demographic Characteristics of Mississippi Primary Service Area - Ages 50 and up
Lakeside Behavioral Health System
2014

Demographic	Alcorn County	Benton County	Calhoun County	Chickasaw County	Coahoma County	Desoto County	Itawamba County	Lafayette County	Monroe County	Lee County	Marshall County
STATE OF MISSISSIPPI											
Total Population - 2014	37,057	8,729	14,962	17,392	26,151	161,252	23,401	47,351	36,989	82,910	37144
Total Population - 2012	37,228	8,713	14,842	17,443	25,667	166,317	23,353	50,502	36,422	84,960	36,545
Population % Growth/Loss	-0.5%	0.2%	0.8%	-0.3%	1.9%	-3.1%	0.2%	-6.7%	1.5%	-2.5%	1.6%
Population Age 50+ (2014)	12,829	2,992	5,246	5,747	7,640	43,075	7,794	11,420	12,952	25,080	12,206
% of Total Population age 50+	34.62%	34.28%	35.06%	33.04%	29.21%	26.71%	33.31%	24.12%	35.02%	30.25%	32.86%
Demgraphic	**Panola County**	**Pontotoc County**	**Prentiss County**	**Quitman County**	**Tallahatchie County**	**Tate County**	**Tippah County**	**Tishomingo County**	**Tunica County**	**Union County**	**Yalobusha County**
Total Population - 2014	37,707	29,957	25,276	8,223	15,378	28,886	22,232	19,593	10,778	27,134	12,678
Total Population - 2012	34,427	30,498	25,306	7,798	15,106	28,499	21,925	19,615	10,510	27,398	12,402
Population % Growth/Loss	8.7%	-1.8%	-0.1%	5.2%	1.8%	1.3%	1.4%	-0.1%	2.5%	-1.0%	2.2%
Population Age 50+ (2014)	11,002	9,064	8,591	2,728	4,279	8,917	7,310	7,336	2,864	8,787	4724
% of Total Population Age 50+	29.18%	30.26%	33.99%	33.18%	27.83%	30.87%	32.88%	37.44%	26.57%	32.38%	37.26%
Total MS Population	2,967,000										
Total MS Pop. Age 50+	913,000										
% of State Total Pop. Age 50+	30.77%										

Source: 1) Surburban Stats.org/Mississippi Population by County/Age 2) US-Places.com

Demographic Characteristics of Arkansas Primary Service Area - Ages 50 and up
Lakeside Behavioral Health System
2014

Demographic	Clay County	Craighead County	Crittenden County	Cross County	Greene County	Lawrence County	Mississippi County	Poinsett County	Randolph County	St. Francis County
STATE OF ARKANSAS										
Total Population - 2014	16,083	96,443	50,902	17,870	42,090	17,414	42,480	24,583	17,969	28,258
Total Population - 2012	15,592	99,920	50,088	17,686	43,165	17,028	45,529	24,270	17,885	27,859
Population % Growth/Loss	3.1%	-3.6%	1.6%	1.0%	-2.6%	2.2%	-7.2%	1.3%	0.5%	1.4%
Population Age 50+ (2014)	6,492	26,735	14,306	6,200	13,531	6,322	14,058	8,624	6,769	8,259
% of Total Population age 50+	40.37%	27.72%	28.10%	34.70%	32.15%	36.30%	33.09%	35.08%	37.67%	29.23%
Total AR Population	2,915,000									
Total AR Pop. Age 50+	948,000									
% of State Total Pop. Age 50+	32.52%									

Source: 1) Surburban Stats.org/Arkansas Population by County/Age 2) US-Places.com

PERCENTAGE OF MEDICARE BENEFICIARIES BY STATE 2012		
TENNESSEE	MISSISSIPPI	ARKANSAS
POPULATION: 6,500,00 BENEFICIARIES: 1,130,000 PERCENTAGE: 17% TENNCARE: 1,200,000 PERCENTAGE: 18%	POPULATION: 3,000,000 BENEFICIARIES: 525,000 PERCENTAGE: 18%	POPULATION: 3,000,000 BENEFICIARIES: 561,000 PERCENTAGE: 19%

Source:http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/Downloads/12All.pdf

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

RESPONSE: With this project Lakeside is making a strong commitment to financial accessibility to acute mental healthcare for older adults. Lakeside does not discriminate in its admission decisions based on age, race, ethnicity, gender, or handicapped status; and it will be broadly accessible to low-income and underinsured persons. In addition, the facility currently accepts involuntary patients.

In an effort to increase the number of insured individuals in Tennessee who have access to quality healthcare, Lakeside serves as an enrollment location for the Affordable Care Act. Lakeside has three Certified Application Counselors who are able to meet with individuals around the clock to assist with enrollment in the Insurance Marketplace. In an effort to reach a wider population of Shelby County and the surrounding areas, Lakeside coordinated with local grassroots efforts, Enroll America, to funnel more uninsured Americans to our facility to obtain application assistance. To date, Lakeside has assisted more than 100 individuals in Shelby and the surrounding counties with their enrollment in the Healthcare Marketplace. Within the facility, Lakeside coordinates with the various units on campus to ensure that all patients, both adults and children, have access to the application and have assisted patients with the process. Lakeside seeks ways to give back to the community and help to improve the overall mental and physical well-being. Moving forward, plans are to expand efforts by increasing community awareness of services and to create more partnerships with additional agencies to better ensure all Tennesseans have access to affordable healthcare.

Lakeside is located right off I-40 providing easy access to patients with limited access to private transportation. The Memphis Area Transport Authority has a number of scheduled routes as outlined in Attachment titled Miscellaneous Information. Lakeside plans to keep the geriatric unit at a 95% or higher capacity which provides service to a relatively disadvantaged sector of the areas served, including TennCare/Medicaid and Medicare participants.

Medicare and TennCare/Medicaid Revenues, Year One		
	Medicare	TennCare/Medicaid
Gross Revenue	$877,090	$1,267,680
Percent of Gross Revenue	13%	22%

Source: Lakeside corporate management

5. **Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.**

RESPONSE: TDH JAR data, 2011-2013, as outlined on the next pages provide utilization of Tennessee primary service area hospitals for inpatient psychiatric care. The majority of inpatient psychiatric care in the service area is provided by Shelby County facilities. In 2013, acute psychiatric care providers in Shelby County averaged 67.3% occupancy on 606 licensed psychiatric beds, and provided 4,364 more days of care than in the prior year.

Shelby County has three general hospitals with licensed psychiatric bed units, and two free-standing hospitals. Since 2013 two psychiatric facilities in Shelby County have reduced the number of beds available. Community Behavioral Health closed a 50-bed hospital in downtown Memphis when the building was sold and the facility lost the lease. Additionally, Memphis Mental Health Institute, a State hospital, closed 25 beds in 2013. These two actions reduced the bed inpatient psychiatric capacity by 65 beds.

Approved but Unimplemented CONs include:

- CN0711-089AE granted to Behavioral HealthCare to build a 16-bed gero-psychiatric hospital in central Shelby County. It was issued seven years ago, and was approved March 25, 2015 for a third extension until April 1, 2016 with modification. Behavioral Healthcare Center was approved to relocate from a planned free-standing building to a newly constructed addition in Harbor View, Inc. nursing home at 1513 North Second Street in Memphis, TN.

- CN1310-040, Crestwyn Behavioral Health approved in April 2014 to establish a 60-bed mental health psychiatric hospital to provide psychiatric care for: adolescents (15) beds; adults of all ages (30) beds, and adult chemical dependency care (15) beds. The CON application represented that Delta Medical Center and Saint Francis Memphis, a Tenet facility, will reduce 60 beds in the service area. Construction has not started on this facility. However, construction of this new facility will not offset the 65 psychiatric hospital beds that have closed in central Shelby County in the past two years.

According to the HSDA, there are no other unimplemented acute care bed projects in the primary service area with final uncontested approval involving psychiatric beds.

Psychiatric Bed Utilization in Tennessee Primary Service Area
2011-2013

2011 Joint Annual Reports of Hospitals

State	Facility Name	County		Assigned / Licensed Psychiatric Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
TN	Community Behavioral Health-psych beds	Shelby		50	694	6,011	9	16	32.9%
TN	Lakeside Behavioral health System-psych beds	Shelby		290	6,247	59,671	10	163	56.4%
TN	Lakeside Behavioral health System-CD beds	Shelby		15	565	3,466	6	9	63.3%
TN	Memphis mental Health Institute	Shelby		75	1,853	20,615	11	56	75.3%
TN	Delta Medical Center	Shelby		90	1,574	20,834	13	57	63.4%
TN	Methodist University Healthcare-psych beds	Shelby		34	630	9,385	15	26	75.6%
TN	St. Francis Hospital-psych beds	Shelby		102	2,043	16,199	8	44	43.5%
	Shelby County Subtotal			**656**	**13,606**	**136,181**	**10**	**373**	**56.9%**
TN	Western Mental Health Institute	Hardeman		200	1,386	43,427	31	119	59.5%
TN	Pathways of Tennessee	Madison		25	691	3,085	4	8	33.8%
	TN PRIMARY SERVICE AREA TOTALS			**881**	**15,683**	**182,693**	**12**	**501**	**56.8%**

2012 Joint Annual Reports of Hospitals

State	Facility Name	County	Staffed Psychiatric Beds	Assigned / Licensed Psychiatric Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
TN	Community Behavioral Health-psych beds	Shelby	19	50	772	6,655	9	18	36.5%
TN	Lakeside Behavioral health System-psych beds	Shelby	290	290	6,806	63,508	9	174	60.0%
TN	Lakeside Behavioral health System-CD beds	Shelby	15	15	536	3,903	7	11	71.3%
TN	Memphis mental Health Institute	Shelby	75	75	1,440	21,630	15	59	79.0%
TN	Delta Medical Center	Shelby	90	90	1,500	22,304	15	61	67.9%
TN	Methodist University Healthcare-psych beds	Shelby	34	34	619	9,748	16	27	78.5%
TN	St. Francis Hospital-psych beds	Shelby	102	102	2,008	16,843	8	46	45.2%
	Shelby County Subtotal		**625**	**656**	**13,681**	**144,591**	**11**	**396**	**60.4%**

TN	Western Mental Health Institute	Hardeman	162	187	1,211	41,617	34	114	61.0%
TN	Pathways of Tennessee	Madison	25	25	490	2,846	6	8	31.2%
	TN PRIMARY SERVICE AREA TOTALS		**812**	**868**	**15,382**	**189,054**	**12**	**518**	**59.7%**
	2013 Joint Annual Reports of Hospitals								
State	Facility Name	County	Staffed Psychiatric Beds	Assigned / Licensed Psychiatric Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
TN	Community Behavioral Health-psych beds	Shelby							
TN	Lakeside Behavioral health System-psych beds	Shelby	290	290	6,941	71,143	10	195	67.2%
TN	Lakeside Behavioral health System-CD beds	Shelby	15	15	570	3,715	7	10	67.9%
TN	Memphis mental Health Institute	Shelby	75	75	1,213	18,207	15	50	66.5%
TN	Delta Medical Center	Shelby	90	90	2,116	30,897	15	85	94.1%
TN	Methodist University Healthcare-psych beds	Shelby	34	34	525	9,146	17	25	73.7%
TN	St. Francis Hospital-psych beds	Shelby	102	102	1,875	15,847	8	43	42.6%
	Shelby County Subtotal		**606**	**606**	**13,240**	**148,955**	**11**	**408**	**67.3%**
TN	Western Mental Health Institute	Hardeman	150	150	975	47,895	49	131	87.5%
TN	Pathways of Tennessee	Madison	25	25	607	2,959	5	8	32.4%
	TN PRIMARY SERVICE AREA TOTALS		**781**	**781**	**14,822**	**199,809**	**13**	**547**	**70.1%**

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

Table Eight: Lakeside Behavioral Health Systems Current Utilization & Years One and Two Projected Utilization

Lakeside Behavioral Health Systems Utilization

2012-2014

Hospital			
	2012	**2013**	**2014**
Admission	6,687	7,629	8,456
Patient Day	63,526	74,858	83,256
Average Daily Census	174.0	205.1	228.1
Average Annual Occupancy	66.7%	78.6%	87.4%
Geriatric			
	2012	**2013**	**2014**
Admission	494	446	506
Patient Day	8,892	10,147	10,535
Average Daily Census	24.4	27.8	28.9
Average Annual Occupancy	78.6%	89.7%	93.1%

Source: Lakeside corporate management

Hospital Projection		
	Year One	**Year Two**
Admission Growth	524	751
Patient Day Growth	4,142	6,205
Average Daily Census Growth	11.3	17.0
Average Annual Occupancy	91.7%	93.9%

Source: Lakeside corporate management

ECONOMIC FEASIBILITY

1. **Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.**
   - **All projects should have a project cost of at least $3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line**

D. (See Application Instructions for Filing Fee)

- **The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.**

- **The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.**

- **For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.**

RESPONSE:

A letter from Charles A. Hill, AIA, Leed AP, Stengel Hill Architecture, is included supporting the construction cost estimate and is provided in Attachment C. Economic Feasibility-1.

On the Project Costs Chart, A & E fees were estimated by the architect. Legal, administrative, consultant fees, and site preparation, construction cost, contingency and moveable equipment costs were estimated by John Bennett, P.E. Senior Director with UHS Design and Construction Department.

PROJECT COSTS CHART

A	**Construction and equipment acquired by purchase:**	
1	Architectural and Engineering Fees	599,460
2	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	342,000
3	Acquisition of Site	0
4	Preparation of Site	630,450
5	Construction Costs	6,644,547
6	Contingency Fund	218,250
7	Fixed Equipment (Not included in Construction Contract)	938,000
8	Moveable Equipment (List all equipment over $50,000)	
9	Other (Specify)	
	TOTAL A	9,372,707
B	**Acquisition by gift, donation, or lease:**	
1	Facility (inclusive of building and land)	0
2	Building only	0
3	Land only	0
4	Equipment (Specify)	0
5	Other (Specify)	0
	TOTAL B	0
C	**Financing Costs and Fees:**	
1	Interim Financing	
2	Underwriting Costs	
3	Reserve for One Year's Debt Service	
4	Other (Specify)	
	TOTAL C	0
D	**Estimated Project Cost (A+B+C)**	9,372,707
E	**CON Filing Fee**	21,089
F	**Total Estimated Project Cost (D+E)**	9,393,796
	TOTAL	9,393,796

2. **Identify the funding sources for this project.**

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

__ A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

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

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

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

X E. **Cash Reserves--Appropriate documentation from Chief Financial Officer.**

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

RESPONSE: All project costs will be provided through cash transfers from Universal Health Services, Inc., the Applicant's parent company. Documentation of intention to provide the funding is included in Attachment C. Economic Feasibility-2, along with the Income Statement and Balance Sheet of Lakeside Behavioral Health System included in Attachment C. Economic Feacibility-10.

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

RESPONSE: The Lakeside new building will be cost-effective and consistent with similar projects approved by the HSDA. The project's estimated construction cost is approximately $275 PSF, consistent with the HSDA's median quartile cost PSF in years 2011-2013.

Table Two: (Repeated from Prior Section) Construction Costs	
Square Feet	24,205 SF
Construction Cost	$6,644,547
Construction Cost PSF	$275 PSF

Table Five: (Repeated from Prior Section) Hospital Construction Cost PSF-Years: 2011-2013			
	Renovated Construction	**New Construction**	**Total Construction**
1st Quartile	$107.15/sq ft	$235.00/sq ft	$151.56/sq ft
Median	**$179.00/sq ft**	**$274.63/sq ft**	**$227.88/sq ft**
3rd Quartile	$249.00/sq ft	$324.00/sq ft	$274.63/sq ft

SOURCE: CON approval applications for years 2011 through 2013

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

See attached Historical Data Charts on following page.

HISTORICAL DATA CHART

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

Financial Data in Thousands		Year 2014	Year 2013	Year 2012
A. Utilization Data (Specify unit of measure) Pt Days		83,256	74,860	63,489
B. Revenue from Services to Patients				
1 Inpatient Services		$115,723	$106,625	$90,085
2 Outpatient Services		$947	$642	$550
3 Emergency Services				
4 Other Operating Revenue (Specify)				
	Gross Operating Revenue	$116,670	$107,267	$90,635
C. Deductions from Gross Operating Revenue				
1 Contractual Adjustments		$59,484	$54,900	$46,615
2 Provision for Charity Care		$1,221	$1,580	$981
3 Provisions for Bad Debt		$2,187	$2,186	$2,080
	Total Deductions	$62,892	$58,666	$49,676
NET OPERATING REVENUE		$53,778	$48,601	$40,959
D. Operating Expenses				
1 Salaries and Wages		$23,447	$20,608	$18,086
2 Physician's Salaries and Wages				
3 Supplies		$3,311	$2,954	$2,531
4 Taxes				
5 Depreciation		$963	$967	$960
6 Rent		$251	$179	$126
7 Interest, other than Capital				
8 Management Fees:				
a.	Fees to Affiliates	$1,211	$857	$972
b.	Fees to Non-Affiliates			
9 Other Expenses (Specify) Professional Fees, Purchased Services, Maintenance, Travel, Insurance		$8,709	$7,794	$7,052
	Total Operating Expenses	$37,892	$33,359	$29,727
E. Other Revenue (Expenses) – Net (Specify)		$1,318	$1,189	$1,487
NET OPERATING INCOME (LOSS)		$17,204	$16,431	$12,719
F. Capital Expenditures				
1 Retirement of Principal				
2 Interest				
	Total Capital Expenditures	$0	$0	$0
NET OPERATING INCOME (LOSS)		$17,204	$16,431	$12,719

PROJECTED DATA CHART

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

Financial Data in Thousands			Year One	Year Two
A. Utilization Data (Specify unit of measure) Pt Days		Pt Days	730	2,190
B. Revenue from Services to Patients				
1 Inpatient Services			$1,009	$3,060
2 Outpatient Services			$0	$0
3 Emergency Services				
4 Other Operating Revenue (Specify)				
	Gross Operating Revenue		$1,009	$3,060
C. Deductions from Gross Operating Revenue				
1 Contractual Adjustments			$504	$1,528
2 Provision for Charity Care			$0	$0
3 Provisions for Bad Debt			$5	$18
	Total Deductions		$509	$1,545
NET OPERATING REVENUE			$499	$1,514
D. Operating Expenses				
1 Salaries and Wages			$75	$151
2 Physician's Salaries and Wages				
3 Supplies			$28	$83
4 Taxes				
5 Depreciation			$493	$493
6 Rent			$6	$6
7 Interest, other than Capital				
8 Management Fees:				
a.	Fees to Affiliates		$0	$0
b.	Fees to Non-Affiliates			
9 Other Expenses (Specify) Professional Fees, Purchased Services, Maintenance, Travel, Insurance			$327	$378
	Total Operating Expenses		$929	$1,111
E. Other Revenue (Expenses) – Net (Specify)			$0	$0
NET OPERATING INCOME (LOSS)			($430)	$403
F. Capital Expenditures				
1 Retirement of Principal				
2 Interest				
	Total Capital Expenditures		$0	$0
NET OPERATING INCOME (LOSS)			($430)	$403

5. **Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.**

RESPONSE: See Data Below

Average Charges, Deductions, Net Charges, Net Operating Income		
	2016	**2017**
Patient Days	4,142	6,205
Admissions or Discharges	524	751
Average Gross IP Charge Per Day	$1,390	$1,390
Average Gross IP Charge Per Admission	$10,987	$11,485
Average Deduction from Operating Revenue per day	$740	$741
Average Deduction from Operating Revenue per Admission	$5,853	$6,123
Average Net Charge (Net Operating Revenue) Per Day	$646	$647
Average Net Charge (Net Operating Revenue) Per Admission	$5,107	$5,342
Average Net Operating Income after Expenses, Per Day	$197	$308
Average Net Operating Income after Expenses, Per Admission	$1,555	$2,547

Source: Lakeside Corporate Management

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

RESPONSE: The current average adult inpatient billable rate (i.e. Gross Charge) at the Applicant's facility is $1,390 per patient day. The Applicant does not anticipate any adjustments to the current charge schedules as a result of the construction of the new geriatric building.

Item	Davidson County	Williamson County	Rutherford County	Applicant - Shelby County
Average Gross Charge per Patient	$3,397	$1,534	$1,106	$1,390
Average Deduction per Patient	$1,739	$847	$608	$740
Average Net Charge per Patient	$1,658	$687	$498	$646
GSF of Hospital Expansion	9,872	29,045	N/A	24,205
Cost of Hospital Expansion	$3,485,811	$9,796,910	$165,000	9,393,796*
Total Cost per GSF	$228	$337	N/A	$275
Total Cost per Bed	$151,217	$244,923	$10,313	$176,745

*Includes $21,089 CON filing fee

Source: Recent CON Applications filed by Select Specialty Hospital Nashville (CN1210-053); Rolling Hills (CN131251) Williamson County; Senior Health of Rutherford (CN1207-031)

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

RESPONSE: The Applicant is reimbursed according to a prospective payment system that is calculated using a based rate per diem adjusted for DRG (diagnosis), wage rate, co-morbidity add-ons, and a variable cost component. Most of the Applicant's geriatric patients fall into DRG categories of 885, 884, 881 and 880. These are the predominant diagnoses for mental health and chemical dependency as published in the Federal Register.

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

RESPONSE: Lakeside is an experienced mental health provider in the area with over 45 years-experience. Lakeside is assured that the projected occupancy rates for these psychiatric beds for older adults will generate a positive operating margin by Year Two.

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

RESPONSE: Lakeside's financial statements document the ability to sustain the hospital with a positive cash flow. See Attachment C. Economic Feasitility-10.

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

RESPONSE: Lakeside will participate in all available TennCare MCO's. Indigent and self-pay care is 1% of the facility's gross revenue, consisting of underinsured, uninsured and indigent. This is a minimum commitment. Current TennCare/Medicaid is 40% of applicant's payer mix.

Medicare and TennCare/Medicaid Revenues 2014		
	Medicare	TennCare/Medicaid
Gross Revenue	$39,588,590	$36,516,690
Percent of Gross Revenue	38%	35%

Medicare and TennCare/Medicaid Revenues, Year One Growth		
	Medicare	TennCare/Medicaid
Gross Revenue	$877,090	$1,267,680
Percent of Gross Revenue	13%	22%

Source: Lakeside corporate management

10. **Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Economic Feasibility.**

RESPONSE: See Attachments C. Economic Feasibility-10.

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

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

RESPONSE: Both units have maximized all available patient care space. The current geriatric building was built in 1988 for residential adolescents, and is not designed for adults needing assistance with ambulatory devices. Patients and staff have difficulty navigating in a building originally designed for adolescents. If no changes are made, patient safety and satisfaction could be negatively impacted. Further renovations to these areas are cost prohibitive and would not be effective to care for these older adults. Design and construction of a building specifically outlined to care for older adults will modernize the treatment received. The new geriatric building will increase square footage by 8,571 square feet to provide additional space for patients using ambulatory assisted devices. The proposed construction of a new building will not increase the number of licensed hospital beds for the facility or in Shelby County.

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

RESPONSE: In 2013 the geriatric census exceeded 31 patients requiring geriatric admissions to be accommodated on the West Adult unit. Renovations were made to have capacity for 17 geriatric beds on this unit as a designated overflow wing. This allows geriatric patients to be admitted and cared for on this wing until a bed is available in the geriatric building. However, this overflow wing also is not designed to care for patients needing assistance with ambulation and assisted hygiene. For example, shower stalls in both the current geriatric and overflow units have a raised shower entrance making entry/exit difficult for older adults. Additionally rooms are not large enough to easily navigate for patients with ambulation assistance devices. Neither building has other viable renovation options. Patient care space has been maximized on both current units. The Applicant believes that the new construction for a larger designated geriatric building will allow greater access to and create a higher quality of psychiatric care for older adults. Both will have a positive impact on the health care system for Shelby County and counties served.

Alternatives: One alternative considered was to continue with the current process of caring for older adults on two units with no changes. This alternative was rejected because of the market demands adequate space and services to treat this increasing older adult population. There is no advantage, but rather a significant disadvantage to patients being unable to receive the care they need. The older adult patient requiring mental health care is a fragile population, and it is imperative they receive necessary services in a timely, safe manner.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. **List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks**

with which the Applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.

RESPONSE: In addition to the MCO's noted at Section A Item 13, above, the applicant currently has affiliations with the following health care providers, suppliers, institutions and educators.

- Mobile Crisis in all Tennessee counties served
- Memphis Police Department
- Collierville Police Department
- Bartlett Police Department
- Germantown Police Department
- Shelby County Police Department
- Tipton County Sheriff Department
- Fayette County Sheriff Department
- Saint Francis Bartlett Hospital
- Regional One Medical Center
- NAMI
- Tennessee Suicide Prevention Network
- TDMHSAS
- University of Tennessee College of Medicine

Saint Francis Bartlett Hospital, a Tenet facility, is less than three (3) miles from the Applicant. Saint Francis is a large acute care medical hospital currently licensed for 196 beds. The Applicant has a current transfer agreement with this facility, as well as a transfer agreement with Regional One Medical Center.

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

RESPONSE: Over the past 12 months a total of 242 days required geriatric patients to be admitted to the West adult unit for care pending a bed available in the geriatric building. This requires duplication of all equipment required to treat the older adults such as Hoyer lifts, etc.

Design and construction of a building specifically outlined to care for older adults will modernize the treatment received. The current geriatric building was built in 1988 for residential children and is not designed for adults needing assistance with ambulation and assisted hygiene. The new geriatric building will increase square footage by 8,571 square feet to provide additional space for patients using ambulatory assisted devices.

The following table depicts the positive effects of the proposal:

	CURRENT BUILDING	PROPOSED BUILDING
1	6' corridors	8' corridors – **will help with patient flow in wheelchairs, walkers, etc.**
2	2 ADA complaint patient rooms	12 ADA compliant patient – **larger rooms will provide better access.**
3	Central dining area cannot be directly viewed from the nursing station.	The central dining room is directly across from the nursing station – **Will provide staff a direct view of the dining area.**
4	2 current patient wings have a combined square footage of 10,610.	New patient wings will have 13,940 square feet. **The building will have larger group rooms, new comfort rooms and a larger, staff-assist shower room.**
5	The ECT/TMS clinic is 1,584 square feet. The current space has 1 consult/exam room.	The ECT/TMS clinic will be 2,440 square feet. **The new space will have a separate, centralized nursing station. The new space will also have 4 exam/consult rooms for staff and physicians to meet with patients and families prior to their procedures.**
6	Current geriatric unit has 1 medication window.	New building will have 2 medication windows – **Will improve staff efficiency in medication distribution.**
7	Current geriatric unit does not have a beauty shop.	New building will have a beauty shop – **Patients will be able to have their hair styled.**
8	Current geriatric building has a small fenced outdoor space.	New building will have a large fenced backyard – **Patients will be able to enjoy a walking path and covered outdoor area.**
9	Patients coming to the current geriatric building via ambulance must enter through the front lobby.	New building will have a separate side entrance for ambulance delivery – **Patients will have more privacy.**

Applicant is not aware of any negative effects and there will be no duplication of services from the proposal. The Applicant does not anticipate any material shifting of patients or patient days from other providers in our service area. The basis for this application is to serve the older adult population in a single building designed to care for this population. Many of these patients currently do not seek needed inpatient treatment but rather see their PCP for all health care needs including severe depression.

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

RESPONSE: Lakeside has current staffing of 43.0 FTEs in place to care for the 48 geriatric patients. Currently the geriatric patients are cared for on two units. With approval all 48 geriatric patients will be cared for on one unit in the new building. No additional FTEs will be required with this proposal.

Lakeside does not have any difficulty staffing existing FTEs. With the enhancements provided in the new building, working at the facility will be more attractive. Turnover is lower than other facilities at an average of 30% annually. Facility vacancy rates average =<3.5%.

Geriatric Staffing Plan		
	Daily FTE	**Weekly FTE**
DIR - NURSING	1.0	1.0
CHARGE NURSE	5.2	7.3
RN	9.1	12.8
LPN/LVN	1.6	2.3
NURSING ASST (CEF	5.7	7.9
TECH - MH/BH	8.7	12.2
Grand Total	**31.3**	**43.4**

Position	**Applicant's Average Pay Rate**	**Market Range of Pay**
MHT	$12.70	$9.50-$14.26
Registered Nurse	$31.03	$21.26-$31.89
LPNS	$19.74	$14.36-$21.56
Social Workers	$22.75	$18.51-$27.76

Sources of Market Range Pay: Bureaus of Labor Statistic; Applicant's Compensation Data; Economic Research Institute, I.H.S. Mercer Healthcare Survey.

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

RESPONSE: In addition to the existing staff, the Applicant will recruit additional professional support staff if needed due to turnover, including specialty staff for geriatric services and a complement of psychiatric nurses, psychiatric social workers, family therapists and support technicians. The Applicant's parent organization, Universal Health Services Inc. has the ability to survey areas for available staff and will assist if needed in locating human resources.

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

RESPONSE: Applicant has reviewed and understands the aforementioned requirements.

6. **Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (*e.g.,* internships, residencies, etc.).**

RESPONSE: The following list outlines academic programs affiliated with the facility. Nursing clinical agreements include a maximum of 12 nursing students per clinical rotation, and Therapy/Social Work include 10-12 students per year.

Concorde Career Institute	Nursing Program
Dyersburg State Community College	Clinical Training Program
Freed Hardeman University	Counseling
Harding Graduate School of Religion	Counseling
High Tech Institute	Pharmacy
Memphis Fire Dept.	Paramedic Clinical Training
Methodist Hospital	Nursing
Union University	Nursing
Union University	Social Work
University of Arkansas	Nursing
University of Memphis	Social Work
University of Memphis	Nursing
University of Memphis	Psychology & Counseling
University of Memphis	Recreational Therapist
University of Mississippi	Nursing
University of Tennessee	Nursing University of Tennessee
University of Tennessee	Social Work
University of Tennessee	Medicine
University of Tennessee	Recreational & Occupational Therapists
Vanderbilt University	Nursing (Nurse Practitioners)
Victory University	Counseling
Walden University	Nursing

University of Tennessee College of Medicine Graduate Medical Education Agreement
Lakeside and the University of Tennessee College of Medicine Department of Psychiatry entered into a Graduate Medical Affiliation Agreement for general and child/adolescent Residents and Fellows effective July 2014. While at Lakeside, Fellows and Residents participate in patient care activities, in addition to learning the basics of acute inpatient and outpatient psychiatry. Currently one Fellow and two Residents are on campus each month. Medical Students will also be included in an elective rotation effective July 1, 2015. Active recruitment for a geriatric Fellow is ongoing.

Health Information Management- approximately 10 students per year.
National College of Business and Technology for Health Information
Delta Technical College
University of Tennessee Health Science Center-Health Information Management

7. **(a) Please verify, as applicable, that the Applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.**

RESPONSE: The Applicant is familiar with all licensure requirements of the Tennessee regulatory agencies and relevant Medicare requirements.

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

RESPONSE:

Licensure:	Tennessee Department of Mental Health Substance Abuse Services
Certification:	Medicare Certification from CMS
Accreditation:	The Joint Commission

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

RESPONSE: Facility is currently licensed in good standing with all regulatory agencies. See Attachment C. Orderly Development 7(c).

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

RESPONSE: The Applicant has no outstanding deficiencies.

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

RESPONSE: Not Applicable.

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

RESPONSE: Not Applicable.

10. **If the proposal is approved, please discuss whether the Applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.**

RESPONSE: If the proposal is approved, the Applicant will promptly provide Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.

PROOF OF PUBLICATION

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

RESPONSE: See Attachment – Miscellaneous Information

DEVELOPMENT SCHEDULE

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

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

   The Project Completion Forecast Chart is provided with this page.

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

   Not applicable. The Applicant anticipates completing the project within the period of validity.

PROJECT COMPLETION FORECAST CHART

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

Assuming the CON approval becomes the final agency action on 08/26/15; indicate the number of days from the above agency decision date to each phase of the completion forecast.

Phase	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed	5	August 2015
2. Construction documents approved by the Tennessee Department of Health	90	November 2015
3. Construction contract signed	1	August 2015
4. Building permit secured	45	October 2015
5. Site preparation completed	30	November 2015
6. Building construction commenced	1	November 2015
7. Construction 40% complete	70	January 2016
8. Construction 80% complete	70	March 2016
9. Construction 100% complete (approval for occupancy)	30	April 2016
10. *Issuance of license	10	May 2016
11. *Initiation of service	15	May 2016
12. Final Architectural Certification of Payment	30	June 2016
13. Final Project Report Form (HF0055)	30	July 2016

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

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

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF SHELBY

ANNA JOY GOLDEN, being first duly sworn, says that he/she is the Applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the Applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68- 11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

Anna Joy Golden CEO/Managing Director
SIGNATURE/TITLE

Sworn to and subscribed before me this 14th day of May, 2015, a Notary Public in and for the County of Shelby/State of Tennessee.

GAIL OUTLAND
STATE OF TENNESSEE NOTARY PUBLIC
SHELBY COUNTY

Gail Outland
NOTARY PUBLIC

My commission expires **My Commission Expires: September 21, 2015**
(Month/Day) (Year).

INDEX OF ATTACHMENTS

A.4	Ownership-Legal Entity
B. II. A	Square Footage and Costs Per Square Footage Chart
B. III.A	Plot Plan
B. IV.	Floor Plan
C. Need-3	Service Area Maps
C. Economic Feasiblity-1	Documentation of Construction Cost Estimate
C. Economic Feasiblity-2	Documentation of Availability of Funding
C. Economic Feasibility-10	Financial Statements
C. Orderly Development 7(c)	Licensing and Accreditation Inspections
Miscellaneous Information	
Support Letters	

A. 4

Ownership-Legal Entity

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

Filing Information

Name: **UHS OF LAKESIDE, LLC**

General Information

SOS Control #	**000601571**	Formation Locale:	DELAWARE
Filing Type:	Limited Liability Company - Foreign	Date Formed:	06/02/2000
	04/30/2009 12:30 PM	Fiscal Year Close	12
Status:	Active	Member Count:	2
Duration Term:	Perpetual		
Managed By:	Director Managed		

Registered Agent Address
C T CORPORATION SYSTEM
STE 2021
800 S GAY ST
KNOXVILLE, TN 37929-9710

Principal Address
2911 BRUNSWICK RD
MEMPHIS, TN 38133-4105

The following document(s) was/were filed in this office on the date(s) indicated below:

Date Filed	Filing Description	Image #
03/23/2015	2014 Annual Report	B0073-8162
	Member Count Changed From: 3 To: 2	
03/19/2014	Assumed Name Renewal	7304-2158
	Assumed Name Changed From: LAKESIDE BEHAVIORAL HEALTH SYSTEM To: LAKESIDE BEHAVIORAL HEALTH SYSTEM	
	Expiration Date Changed From: 04/30/2014 To: 03/19/2019	
03/14/2014	Assumed Name Renewal	7299-2672
	Assumed Name Changed From: LAKESIDE CLINICS To: LAKESIDE CLINICS	
	Expiration Date Changed From: 04/30/2014 To: 03/14/2019	
02/25/2014	2013 Annual Report	A0216-2890
02/19/2013	2012 Annual Report	A0156-1249
	Member Count Changed From: 1 To: 3	
	Managed By Changed From: Member Managed To: Director Managed	
06/26/2012	2011 Annual Report	A0134-2414
	Principal Address 1 Changed From: 2911 BRUNSWICK ROAD To: 2911 BRUNSWICK RD	
	Principal Postal Code Changed From: 38133 To: 38133-4105	
	Principal County Changed From: No value To: SHELBY COUNTY	

Filing Information

Name: **UHS OF LAKESIDE, LLC**

06/02/2012	Notice of Determination	A0127-0619
02/18/2011	2010 Annual Report	6834-2950
03/03/2010	2009 Annual Report	6666-0445
04/30/2009	Initial Filing	6529-0768
04/30/2009	Common Amendment	6529-0770
04/30/2009	Assumed Name	6529-0775
04/30/2009	Assumed Name	6529-0776
04/30/2009	Assumed Name	6529-0777
04/30/2009	Assumed Name	6529-0778

Active Assumed Names (if any)	Date	Expires
LAKESIDE CLINICS	04/30/2009	03/14/2019
LAKESIDE BEHAVIORAL HEALTH SYSTEM	04/30/2009	03/19/2019

Tom Leatherwood

Shelby County Register / Archives

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

14089782

09/03/2014 - 09:54 AM

4 PGS	
ERICA	1246888 - 14089782
VALUE	0.00
MORTGAGE TAX	0.00
TRANSFER TAX	0.00
RECORDING FEE	20.00
DP FEE	2.00
REGISTER'S FEE	0.00
WALK THRU FEE	0.00
TOTAL AMOUNT	22.00

TOM LEATHERWOOD

REGISTER OF DEEDS SHELBY COUNTY TENNESSEE

1075 Mullins Station, Suite W165 ~ Memphis, Tennessee 38134 (901) 222-8100
Website: http://register.shelby.tn.us Email: Tom.Leatherwood@shelbycountytn.gov
Join us on Facebook

This instrument was prepared by: Jarret S. Stephens, Esq.

RECORD AND RETURN TO:
Norton Rose Fulbright
666 Fifth Avenue
New York, NY 10103
Attn.: Jarret S. Stephens, Esq.

TRUST DEED RELEASE

WHEREAS, by that certain Deed of Trust, Assignment of Leases and Rents, Financing Statement, Fixture Filing and Security Agreement (**"Trust Deed"**) heretofore recorded in the Register's Office of Shelby County, Tennessee, certain real property was conveyed by the hereinafter named Grantor to Frank Alvstad, as Trustee, for the purpose of securing the indebtedness described in such Trust Deed; and

WHEREAS, all of the indebtedness has been satisfied in full; and

WHEREAS, said Trust Deed is briefly described as follows, to-wit:

GRANTOR:	UHS OF LAKESIDE, LLC
BENEFICIARY:	JPMORGAN CHASE BANK, N.A., as Collateral Agent
DATE:	December 30, 2010
RECORDED:	January 13, 2011
INSTRUMENT NO.:	11005122

As such Trust Deed was amended by that certain First Amendment to Deed of Trust, Assignment of Leases and Rents, Financing Statement, Fixture Filing and Security Agreement, dated December 31, 2012, by and between Grantor and Beneficiary, and recorded in the records of Shelby County on January 17, 2013 as Instrument No. 13008397.

NOW, THEREFORE, in consideration of the premises, the undersigned, Beneficiary, as legal owner and holder of the Trust Deed and the indebtedness secured thereby, acknowledges full satisfaction thereof, and hereby releases and discharges the lien of said Trust Deed, and to this end, quit claims and conveys unto said Grantor, all of Beneficiary's right, title and interest in and to the real estate described in said Trust Deed, to which reference is made for a particular description of said property.

The undersigned covenants with Grantor that it is the legal owner of the indebtedness described in and secured by said Trust Deed and that it has the lawful right to release and

discharge the lien thereof.

IN WITNESS WHEREOF Beneficiary has caused its corporate name to be signed hereto by and through its proper officers duly authorized so to do, this the 26 day of August, 2014.

JPMorgan Chase Bank, N.A., as Collateral Agent

By: _____

Name: **Dawn L. LeeLum**

Title: **Executive Director**

STATE OF New York)

COUNTY OF New York)

Before me, Margarita Torres, a Notary Public of said State and County aforesaid, personally appeared Dawn Lee LUM, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself (or herself) to be Executive Director of JPMorgan Chase Bank, N.A., as Collateral Agent, the within named Beneficiary, a corporation, and that she as such _____, executed the foregoing instrument for the purpose therein contained, by signing the name of the corporation by himself (or herself) as _____.

WITNESS my hand and seal, at office in _____, this the 26 day of August, 2014

_____
Notary Public

My Commission Expires 1 day of May, 2018.

Margarita Torres
Notary Public, State of New York
Qualified in Bronx County
Certificate Filed In New York County
Commission #: 01TO6041062
My Commission Expires: May 1, 2018

I, Seth Schlusberg, do hereby make oath that I am a licensed attorney and/or the custodian of the electronic version of the attached document tendered for registration herewith and that this is a true and correct copy of the original document executed and authenticated according to law.

X_____
Seth Schlusberg

State of New York :
: SS
County of New York :

On this 2nd day of Sept. 2014, Damariz, Valentin personally appeared before me, Angela Fletcher, a notary public for this county and state who acknowledged that this certification of an electronic document is true and correct and whose signature I have witnessed.

X_____
Damariz Valentin, Notary Public

DAMARIZ VALENTIN
NOTARY PUBLIC, STATE OF N.Y.
REG. #01VA6033427
QUALIFIED IN BRONX COUNTY
MY COMMISSION EXPIRES 11/15/2017

ATTACHMENT "A"

UNIVERSAL HEALTH SERVICES, INC.
FACILITIES

Last Updated: April 24, 2015 - HMG

ACUTE CARE HOSPITALS

HOSPITAL	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Aiken Regional Medical Centers 302 University Parkway P.O. Box 117 Aiken, SC 29802-6302 Tax ID: 23-2791808	42-0082 42-S082 1680 7577-CRNAs	1467448498 1124014931 1407988637 1083663553 1295743631 1952433948 1447437157 1316955875-EKGs 1942610928-Neuro Science	SC: 226374 SC: 340420
Centennial Hills Hospital Medical Center 6900 N. Durango Drive Las Vegas, NV 89149-4409 Tax ID: 23-2937646	29-0054	1487771812	N/A
Corona Regional Medical Center 800 S. Main Street Corona, CA 92882-3420 Tax ID: 52-1247839	05-0329 55-5390-skilled Nursing 05-T329 05-S329 55-7106 (Home Health) 05-1574 (Hospice) LTC70008G FS187 – Part B (Nutritionist)	1457347239 1437145109 1255327920 1346236015 1063408730 1881680569 1932476769	CA: HSC303291 CA: ZZT403291
Desert Springs Hospital 2075 East Flamingo Rd. Las Vegas, NV 89119 Tax ID: 23-2937646 23-2947273 tax ID	29-0022 29-S022 GA778A – Part B (Atkinson)	1154317964 1154623569 1790073575 1801152855	NV: 1102847 WV: 0104874000
Doctors' Hospital of Laredo 10700 McPherson Rd Laredo, TX 78045 Tax ID: 23-2995413 23-3001904 -use this tax ID	45-0643 45-T643 45-S643-deactivated 45-5890-deactivated	1396731105 1497942098 1588650295 1497942098	TX: H045063
Fort Duncan Regional Medical	45-0092	1770579591	TX: 110803703

ATTACHMENT "A"

UNIVERSAL HEALTH SERVICES, INC.
FACILITIES

Last Updated: April 24, 2015 - HMG

ACUTE CARE HOSPITALS

HOSPITAL	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Center 3333 N. Foster Maldonado Road Eagle Pass, TX 78852 Tax ID: 23-3046675	45-1197 45-8603 ETSDT22754 45-8834 45-T092	1477544047 1083799514 1134454366 1386635951	TX: Z04511979 TX: R04586030 TX: Z000120R5 TX: CR00129R5
The George Washington University Hospital 901 23rd Street, N.W. Suite 2500 N Washington, DC 20037-2327 Tax ID: 23-2896725	09-0001 09-T001 09-S001 104320 6624014400 220680 – Part B	1487640207 1548257082 1568458297 1487640207	DC: 10404320 DC: 304320
Lakewood Ranch Medical Center 8330 Lakewood Ranch Blvd. Lakewood Ranch, FL 34202 Tax ID: 23-2798290	10-0299 74565 –Part B(Imaging Center)	1730179714 1104839737	N/A
Manatee Memorial Hospital 206 Second Street East Bradenton, FL 34208-1000 Tax ID: 23-2798290	10-0035 10-S035-term'd 40463	1760472799 1235129149 1770505687	FL: 0101168-00
McAllen Heart Hospital / Medical Center 1900 South D Street McAllen, TX 78503 Tax ID: 23-3069260	45-0119 45-T119 45-S119 45-0811-old Edinburg 45-T811-old Edinburg 675193 94113001 11276402	1770573586 1962492660 1053301754 1508856337 1831226521	TX: 94217902 TX: 94113001
Northern Nevada Medical Center 2375 E. Prater Way Sparks, NV 89434 Tax ID: 88-0159958	29-0032 29-T032 – Rehab 29-S032 – Psych	1548250582 1477543171 1851381768	NV: 11-16400 NV: 12-16400
Northwest Texas Healthcare System	45-0209 45-S209	1467442418 1740347087	TX: 1372450-09 TX: 1372450-07

ATTACHMENT "A"

UNIVERSAL HEALTH SERVICES, INC.
FACILITIES

Last Updated: April 24, 2015 - HMG

ACUTE CARE HOSPITALS

HOSPITAL	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
1501 S. Coulter Road Amarillo, TX 79106-1770 Tax ID: 23-2238976	45-T209 29-T032 00U51Q 50-7333 AMB019 00U55Q 590012690 1305380001	1356777502 1477543171 1770509507 1962434860 1295751022 1346266186 1851305007 1336213545 1154347987	TX: 1372450-01 TX: 3172450-10 TX:1372450-005 TX: 0175655-01 TX: 0189763-01 TX: 0217713-01 TX: 1372450-04 TX: 0882557-02 TX: 0882557-01 TX: 0001679-01 TX: 0871923-01
Palmdale Regional Medical Center 38600 Medical Center Drive Palmdale, CA 93551 Tax ID: 95-3565954	05-0204 05-T204-term'd 08/01/2010	1508856535 1033109947	CA: HSP30204G CA: UGS- HHA07446G
St. Mary's Regional Medical Center 305 South 5th Street Enid, OK 73701-5832 Tax ID: 23-3041933	37-0026 37-T026 37-5080 – SNF	1417947466 1659361475 1215927918	OK: H7306146556
South Texas Health System - Edinburg 1102 W. Trenton Road PO Box 2000 Edinburg, TX 78539 Tax ID: 23-3069260	45-0119 45-T119 45-S119 67-5919 - SNF	1770573586 1962492660 1053301754 1144210840	TX: H04501195
Southwest Healthcare System Inland Valley Campus 36485 Inland Valley Drive Wildomar, CA 92595 Rancho Springs Campus 25500 Medical Center Drive Murrieta, CA 92562 Tax ID: 23-3059262	05-0701	1245221050	CA: HSC30701H CA: HSP40701H CA: HSP30701H
Spring Valley Hospital	29-0046	1346230323	N/A

ATTACHMENT "A"

UNIVERSAL HEALTH SERVICES, INC.
FACILITIES

Last Updated: April 24, 2015 - HMG

ACUTE CARE HOSPITALS

HOSPITAL	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Medical Center 1635 Village Center Circle Suite 220 Las Vegas, NV 89134 Tax ID: 23-2937646	29-T046 29-T045	1568439693	
Summerlin Hospital Medical Center 657 Town Center Drive Las Vegas, NV 89134-6367 Tax ID: 23-2939047	29-0041 29-T041 29-T026	18311896Fcu38 1043200736	NV: 1102008 NV: 1202008
Temecula Valley Hospital 31700 Temecula Parkway Temecula, CA 92592-5896 Tax ID 46-1246570	05-0775	1679816201	
Texoma Medical Center 5016 U.S. 75 Denison, TX 75020 Tax ID: 20-5908627	45-0324 67-5227 45-S324 45-T324 45-7655-HH 5877180002 5877180001	1851390967 1467452094 1720087729 1073512000 1497754527 1306142927 1487654133	AZ: 553175 CA: 1851390967 AL: Pending AR: Pending CO: 55538347 DE: Pending FL: 003585700 GA: Pending IL: 205908627001 IN: 200339060A KS: 201095350A MI: 1851390967 MT: 1851390967 MS: Pending MN: 1851390967 NV: Pending NM: Pending NY: Pending OK: 200014270A OR: 500630030 TN: 1524664 TX: 1949976 TX: 1949976-01 TX: 1949976-02

ATTACHMENT "A"

UNIVERSAL HEALTH SERVICES, INC.
FACILITIES

Last Updated: April 24, 2015 - HMG

ACUTE CARE HOSPITALS

HOSPITAL	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
			UT: Pending VA: 1851390967 WA: Pending WI: 1851390967
Valley Hospital Medical Center 620 Shadow Lane Las Vegas, NV 89106 Tax ID: 23-2937646 23-2973511-Valley Health Med Ctr	29-0021 29-S021 29-T021 29-7074	1417947490 1205820297 1104114925	NV: 11-02881 NV: 12-02881
Wellington Regional Medical Center 10101 Forest Hill Blvd. West Palm Beach, FL 33414-6103 Tax ID: 23-2306491	10-0275 U5817-part B	1720078702 1275566838-Diagnostic center	FL: 10213000

ATTACHMENT "A"

UNIVERSAL HEALTH SERVICES, INC.
FACILITIES

Last Updated: April 24, 2015 - HMG

PHYSICIAN PRACTICES

GROUP NAME	MEDICARE PROVIDER #	NPI#	MEDICAID PROVIDER #
Aiken Professional Association LLC 302 University Parkway Aiken SC 29801-6302 Tax ID: 27-3493136	SC: 9636 GA: 202G708978	1639479801	SC: GP5588 GA: Pending
Desert Spring Medical Group - Atkinson PC DBA Surgical Weight Control Center 3802 Meadows Lane Las Vegas, NV 89107-3112 Tax ID: 45-4721804	NV: GA778A	1801152855	NV: 1801152855
Heart Clinic PLLC 1801 South 5th St Suite 215 McAllen, TX 78503-2927 Tax ID: 74-2793592	TX: 00909Y	1437153244	TX: 085475403
HMHM Group Horizon Mental Health Management, LLC 1965 Lakepointe Dr #100 Lewisville, Texas 75057-6424 Tax ID: 36-3709746	70064 MI3533 000013192 C02158 6893 CH4994 DP1738 DS0895 DN8357 DO1307 CH4631 I0550 70064001 MI3533001 MI3533002 131920003 512I260075 302i267095 AA06186893	1255391363 1609024652 1710188529 1043517188 1619190162 1235194960 1992789309 1831115419 1487708079 1770681280 1255304705 1255380176	IA: 1255380176 MI: 1255380176 MO: 1255380176 MS: 09014277 SC: GP2127 TN: 1527956 AL: 1255380176

ATTACHMENT "A"

UNIVERSAL HEALTH SERVICES, INC.
FACILITIES

Last Updated: April 24, 2015 - HMG

PHYSICIAN PRACTICES

GROUP NAME	MEDICARE PROVIDER #	NPI#	MEDICAID PROVIDER #
Laredo Physicians Group 6801 McPherson Rd Suite 101 Laredo, TX 78041-6403 Tax ID: 46-1122577	TX: 294109	1659619260	TX: Pending
Manatee Cardiology Associates, LLC 316 Manatee Avenue West Bradenton, FL 34205-8805 Tax ID: 45-5367757	FL: GL096A	1720341068	FL: 006518100
Manatee Physician Alliance 206 Second Street East Bradenton, FL 34208 Tax ID: 27-3276948	FL: EG436A	1588970446	FL: 002733000
McAllen Hospitalist Group PLLC 1400 W Trenton Road Edinburg, TX 78539- 3413 Tax ID: 65-1255384	TX: 00W044	1356361976	TX: 178762401
Northern Nevada Medical Group LLC 2345 E. Prater Way, # 104 Sparks, NV 89434-9664 Tax ID: 26-3303591	NV: BK009	1975751618	NV: 1972751618
Regional Medical Clinic of Boney Lake 21220 SR 410E Bonney Lake, WA 98391 Regional Medical "Clinic at WalMart" 34520 16th Ave. S Federal Way, WA 98003 Regional Medical Clinic Kent 6719 S 211th Street Suite 102	G8885440 G8889145 *please note that: according to Noridian G8885440 changed location and they assigned a new PTAN number.	1255664827 1063737096	N/A

ATTACHMENT "A"

UNIVERSAL HEALTH SERVICES, INC.
FACILITIES

Last Updated: April 24, 2015 - HMG

PHYSICIAN PRACTICES

GROUP NAME	MEDICARE PROVIDER #	NPI#	MEDICAID PROVIDER #
Kent, WA 98032 Regional Medical Orthopedic Clinic 121 North Division, Suite 310 Auburn, WA 98001 Regional Medical General Surgery 121 North Division, Suite 210 Auburn, WA 98001 Regional Medical Internal Medicine 202 N. Division, Suite 400 Auburn, WA 98001 *Tax ID: 26-4756827*			
St. Mary's Physician Associates LLC 407 E CHEROKEE AVE Enid, OK 737001-5814 Tax ID: 20-8630863	OK: 600522368	1740302751	OK: 200111620A
1500 Billing (UHS of Texoma, Inc.) 5016 S.HWY 75 Denison Texas 75020-4587 Tax ID: 20-5908627	TX: 00A0028	1760529812	TX: 194997605 OK: 200014270E
TexomaCare 5012 S. US Hwy 75 Denison, TX 75020-4584 Tax ID: 75-2617462	TX: 00T72W	1740233592	TX: 127350004
TexomaCare Bonham Clinic 2201 N. Hwy 121 Bonham TX 75418-2345 Tax ID: 75-2617462	TX: OOU21M	1770536518	TX: 127350002

ATTACHMENT "A"

UNIVERSAL HEALTH SERVICES, INC.
FACILITIES

Last Updated: April 24, 2015 - HMG

PHYSICIAN PRACTICES

GROUP NAME	MEDICARE PROVIDER #	NPI#	MEDICAID PROVIDER #
TexomaCare Madill Clinic 500 Brookside Drive Madill,Ok 73446-0847 Tax ID: 75-2617462	OK: 752617462	1407800857	OK: 100754740A
TexomaCare Specialty Physicians 5012 S US Hwy, Suite 100 Denison, TX 75020-4587 Tax ID: 36-4705614	TX: B152730	1548541733	TX: 200424690A
Wellington Physician Alliances Inc Wellington Location: 1397 Medical Park Blvd. Suite 100 Wellington, FL 33414-3187 Atlantis Location: 160 JFK Drive, Suite 204 Atlantis, FL 33462-6633 Tax ID: 26-2782140	BL077	1275798472	FL: 000591200

ATTACHMENT "A"

UNIVERSAL HEALTH SERVICES, INC.
FACILITIES

Last Updated: April 24, 2015 - HMG

BEHAVIORAL HEALTH CENTERS AND NON-PUBLIC SCHOOLS

FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Alabama Clinical Schools 1221 Alton Drive Birmingham, AL 35210 Tax ID: 62-1715236	N/A	1174541957	WV: 5501007000 AL: RTF0008H DC: 7100164850 NV: 100511717 WY: 1257331-01
Alhambra Hospital 4619 N. Rosemead Blvd. Rosemead, CA 91770 Tax ID: 62-1658521	05-4032	1194758623	CA: 1194758623
Alliance Health Center 5000 Highway 39 North Meridian, MS 39301 Tax ID: 64-0777521	25-0151 25-S151 302g701360-Part B	1831184951 1811156326 1679850150	MS: 00020237 (Psych & Detox) MS: 09306871 (RTC) MS: 04100801 (Prof Fee) MS: 07100531 (Pharm)
Anchor Hospital 5454 Yorktown Drive Atlanta, GA 30349 Tax ID: 23-3044975	11-4032 HOSP226-Part B	1023095429 1023095429	GA: 291416659A GA: 003146241A
Arbour-Fuller Hospital 200 May Street South Attleboro, MA 02703-5520 Tax ID: 23-2801395	22-4021 M20142-Part B	1316917222 1316917222	MA: 110027429A MA: 110027429B
Arbour-HRI Hospital 227 Babcock Street Brookline, MA 02446-6773 Tax ID: 23-2238958	22-4018 M21427-Part B	1518938174 1518938174	MA: 110027416A MA: 110027416C
The Arbour Hospital 49 Robinwood Avenue P. O. Box 9 Boston, MA 02130-9101 Tax ID: 23-2238962	22-4013- Part A 0005196- Part B 1770766529-NPI	1821068818 1770766529	MA: 11002084E MA: 11002084D MA: 11002084B

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UNIVERSAL HEALTH SERVICES, INC.
FACILITIES

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BEHAVIORAL HEALTH CENTERS AND NON-PUBLIC SCHOOLS

FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Arbour Counseling Services 227 Babcock Street Brookline, MA 02446-6773 Tax ID: 23-2542973	Y10309-Part B 22-4625-HRI Clinic Inc. 22-4615 22-4627	1598707002	MA: 110028020/N MA: 110028020/B MA: 110028020/C MA: 110028020/D MA: 110028020/E MA: 110028020/F MA: 110028020/A MA: 110028020/I MA: 110028020/O MA: 110028020H
Arbour Senior Care 384 Washington St. Norwell, MA 02061-2010 Tax ID: 23-2868192	M20535-Part B M15606 – 22-4623	1720034705 1922123199	MA: 110027781/A MA: 110027781/B
Arrowhead Behavioral Health Arrowhead Park 1725 Timber Line Rd. Maumee, OH 43537-4015 Tax ID: 27-0608044	36-4036 H256760-Part B	1336370196	OH: 3003494
Atlantic Shores Hospital 4545 North Federal Highway Ft. Lauderdale, FL 33308 Tax ID: 20-3788069	10-4065	1427002070	FL: 10358600
Austin Lakes Hospital 1025 East 32nd Street at St. David's Pavilion, 2nd & 3rd Floors Austin, TX 78705 Tax ID: 20-8706107	45-4069	1962614834	TX: 192996002
Austin Oaks Hospital 1407 W Stassney Lane Austin TX 78745-2947 Tax ID 84-1618661	45-4121	1578809505 1366442550	TX: 3330862-01

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BEHAVIORAL HEALTH CENTERS AND NON-PUBLIC SCHOOLS

FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Aurora BH Pavilion at Aiken (A) 655 Medical Park Drive Aiken, SC 29801 Tax ID: 23-2791808	42-S082	1124014931	SC: 226374 SC: 340420
Behavioral Hospital of Bellaire 5314 Dashwood Drive Houston, TX 77081 Tax ID: 27-2849780	45-4107	1093021719	TX: 217547301 TX: 2175473
Belmont Pines Hospital 615 Churchill-Hubbard Road Youngstown, OH 44505 Tax ID: 62-1658523	36-4038	1275582306	OH: 331519 (Hospital) OH: 2065974 (Physician Group) OH: 2864388 (Hospital Outpatient) PA: 100769266003 (Hospital) PA: 100769266001 (Hospital Partial) PA: 100769266002 (Residential Treatment Facility) PA: 100769266004 (Physician Group) WV: 3810002280
Benchmark Behavioral Health Systems 592 West 1350 South Woods Cross, UT 84087 Tax ID: 93-0893928	46-4007	1598772618	AK: 1006629 IA: 0014688 KY: 7100174800 MT: 4101301 NE: 10026029000 NV: 006102400 ND: 55520 OK: 100705870A PA: 0016453130001 SD: 5168010 WY: 100053502

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Bloomington Meadows Hospital 3600 North Prow Road Bloomington, IN 47404 Tax ID: 35-1858510	15-4041 (Part A) 54-9200 (Part B)	1417968595 1891796108(A#) 1033298120	IN: 100273680 IN: 200075480 IN: 200457070 IN: 200951230 IL: 351858510402 IL: 351858510002
Boulder Creek Academy 378 Emerson Lane Bonners Ferry, ID 83805 Tax ID: 20-3171102	N/A	1104998202	N/A
Brentwood Behavioral Healthcare of Mississippi 3531 Lakeland Drive Flowood, MS 39232 Tax ID: 20-0773985	25-4007 C03108	1487638441	MS: 220625
Brentwood Hospital 1006 Highland Avenue Shreveport, LA 71101 Tax ID: 20-0474854	19-4020(A) 5D465 – Part B	1417979204 1164725701	LA: 1749826 TX: 1915373-03 AR: 159162125
The Bridgeway 21 Bridgeway Road North Little Rock, AR 72113 Tax ID: 23-2238973	04-4005 57226- Part B	1962473306	AR: 105312125 (Hospital) AR: 160542526 (outpatient)
Brighton Behavioral Health Center 301 Fort Lane Portsmouth, VA 23704 Tax ID: 54-1465094	N/A	1093740482	VA: 1093740482 DC: 031456601 NC: 3404545 MD: 500037801 PA: 1007298230006
Bristol Youth Academy 12422 NW Revell Dr Bristol, FL 32321 Tax ID: 71-0902725	N/A	1134309438	FL: 076916900

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Brooke Glen Behavioral Hospital 7170 Lafayette Avenue Fort Washington, PA 19034-2301 Tax ID: 20-0085660	39-4049 07-2885 194930R2C 054722R2C 012351R2C 026028R2C 901333R2C 056999R2C 098444R2C 405854R2C 029098R2C 116310R2C 047333R2C 118027R2C 134836R2C 212224R2C	1588603872 1972662625 1144394859 1639121270 1184705360 1184650475 1831115559 1164453775 1013957091 1457424319 1306830658 1730371154 1891815775 1063595411 1285831693 1689839862 1528214426	NJ: 0123111 NY: 02949099 PA: 001965180-0002 (Psych- Inpatient) PA: 001965180-0003 (Psych- Physicians) PA: 001965180-0002 (Psych- Specialty (EAC))
Brynn Marr Hospital 192 Village Drive Jacksonville, NC 28546 Tax ID: 56-1317433	34-4016 2351452A-Part B	1992701486 1144207804	NC: 3404016 NC: 3404500
Calvary Center 720 East Montebello Ave. Phoenix, AZ 85014 Tax ID: 20-0380961	N/A	1013134667	N/A
Canyon Ridge Hospital 5353 G Street Chino, CA 91710 Tax ID: 20-2935031	05-4111	1902825128	CA: 1902825128
The Carolina Center for Behavioral Health 2700 E. Phillips Road Greer, SC 29650 Tax ID: 23-3044427	42-4010 7085-Part B	1881664407	SC: A00806 NC: 4204010 NC: 4204010

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Cedar Grove Residential Treatment Center 1640 Lascassas Pike Murfreesboro, TN 37130 Tax ID: 48-1274107	N/A	1396763199	TennCare: 4121518
Cedar Hills Hospital 10300 SW Eastridge Street Beaverton, OR 97225 Tax ID: 26-2343447	38-4012 R149041	1528231826	N/A
Cedar Ridge Hospital 6501 NE 50th Street Oklahoma City, OK 73141-9118 Tax ID: 20-2901605	37-4023 Part B-pending	1598716490 1083985600	OK: 200085660B
Cedar Ridge Residential Treatment Center 6501 NE 50th Street Oklahoma City, OK 73141 Tax ID: 20-2901605	N/A	1588836779	OK: 200085660A
Cedar Springs Behavioral Health System 2135 Southgate Road Colorado Springs, CO 80906 Tax ID: 74-3081810	06-4009 COA101248-Part B	1992752133 1992752133 1770707739	AK: 1006290 (Acute) AK: 1006496 (RTC) AZ: 893231 (Acute) AZ: 918360 (Acute) CO: 24174203 (Acute) CO: 05123313 (RTC) MT: 4104021 (Acute) MT: 410845 (RTC) NV: 001388325 (Acute) NV: 006388325 (RTC) WY: 119874200 (Acute) WY: 119874201 (RTC)

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Centennial Peaks Hospital 2255 South 88th Street Louisville, CO 80027 Tax ID: 26-3973154	06-4007 COB5031-Part B	1760623888 1760623888	CO: 10886753
Center for Change 1790 North State Street Orem, UT 84057 Tax ID: 20-3687800	N/A	1184689580 1184689581 1184689582 1184689583 1184689584	NV: 100506796 IA: 20-3687800 AK: 1006030 AK: 1006028 NJ: 326143 SC: 11377A ID: 1184689580 NV: 1184699580 OR: 500647517 TN: Pending
Clarion Psychiatric Center Two Hospital Drive RD #3, Box 188 Clarion, PA 16214-9424 Tax ID: 23-2842434	39-4043 060148qut- Part B	1821068750 1134217706	PA: 1007285950022 PA: 1007285950045 IL: 232842434001 MD: 422670400 NJ: 0178195 NY: 02654108 NC: 3944043 OH: 2170716 WV: 3810000177 CA: 1821068750
Central Florida Behavioral Health 6601 Central Florida Parkway Orlando, FL 32821-8064 Tax ID: 58-1791069	10-4072 AT702	1235252602 1235252602	FL: 009129600 FL: 008135700 FL: 010822500

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Chicago Children's Center for Behavioral Health Saints Mary & Elizabeth Medical Center-Chicago 1431 N. Claremont Avenue – 3rd Floor Chicago, IL 60622 Tax ID: 62-1843658	N/A	N/A	N/A
Coastal Behavioral Health 633 Stephenson Avenue Savannah, GA 31405-5970 Tax ID: 20-0931196	11-4008 202G708241	1427292333	GA: 081389116C Amerigroup: 1000064 Peach State: 103475 Wellcare Adult: 785777
Coastal Harbor Treatment Center 1150 Cornell Avenue Savannah, GA 31406 Tax ID: 20-0931196	11-4008	1679543672 1427292333	DC: 037056100 GA: 081389116A GA: 081389116B KY: 45002292 MT: 4103800 SC: A02559 SC: RTF022 SD: 5168170 WV: 3810000037 FL: 008411700 NV: 100511464 PA: 101554721-0001 WY: 125500201 Amerigroup: 1000064 Peach State: 103475 Wellcare Adult: 785777 Wellcare Child: 635089
Columbus Behavioral Center for Children and Adolescents 2223 Poshard Drive Columbus, IN 47203 Tax ID: 62-1740367	15-4048	1275580003	IN: 200492270A

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Community Cornerstones Valencia 1, Bldg 17, 5th Floor, Metro Office Park Guaynabo, PR 00968 Tax ID: 54-1959829	N/A	1578658647	N/A
Compass Intervention Center 7900 Lowrance Road Memphis, TN 38125 Tax ID: 62-1837606	N/A	1063431294	AR: 142682125 TennCare: 5441352
Copper Hills Youth Center 5899 W. Rivendell Drive West Jordan, UT 84081 Tax ID: 62-1681825	N/A	1649380593	AK: 1006504 MT: 4100570 (NPI:1649380593) WY: 117906303 NV: 006388500 CO: 68073046 ND: 55513 SD: 12172629
Cottonwood Treatment Center 1144 West 3300 South South Salt Lake, UT 84119 Tax ID: 26-0464201	N/A	1851590533	AK: 1006038 NV: 1851590533 MT: 222651 WY: 125131701 IA: 1851590533 NM: 38031906 AZ: 273362 DC: 36499800 MD: 27323430
Crescent Pines Hospital 1000 Eagles Landing Parkway Stockbridge, GA 30281 Tax ID: 23-3044975	11-4032	1952537920	GA: 272374380A GA: 003146287A
Cumberland Hall Hopkinsville 270 Walton Way Hopkinsville, KY 42240	18-4014 K045760-Part B	1750392502 1720353501	KY: 2021301 KY: 45024536 TN: 1518330

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Tax ID: 61-1267294			TN: 1071650 IN: 201153550 A
Cumberland Hospital 9407 Cumberland Road New Kent, VA 23124 Tax ID: 02-0567575	49-3300 All children-no Medicare	1871507699	VA: 00493301 AL: AHS3300N AZ: 367451 CT: 00317398 DC: 03415220 FL: 914049200 GA: 000938605X IA: 0586446 NC: 4903300 NJ: 8885001 NY: 01682806 VT: 0493300 WV: 0002782000 OK:100355600A MD: 402001400 TN: 049330 SC: 1871507699
Cypress Creek Hospital 17750 Cali Drive Houston, TX 77090 Tax ID: 62-1864266	45-4108	1730187568	TX: 0212037-01 TX: 0212417-01
Del Amo Hospital 23700 Camino del Sol Torrance, CA 90505 Tax ID: 23-2646424	05-4053	1245203447	CA: 1245203447
Diamond Grove Center P.O. Box 848 2311 Hwy 15, S Louisville, MS 39339 Tax ID: 20-4537541	N/A	1447350160 1659404572 1801967674 1619000593	MS: 00220411 (Acute) MS: 00220801 (RTC) MS: 09014508 (Prof Fees) MS: 00330450 (Pharmacy)
Dover Behavioral Health System 725 Horsepond Road Dover, DE 19901	08-4004	1083708689 1740316488 1295996809	DE: 1083708689 MD: 595504

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Tax ID: 20-5093162		1649318403 1902868268	
Emerald Coast Behavioral Hospital 1940 Harrison Ave. Panama City, FL 32405-4542 Tax ID: 27-0720873	10-4073 CP438B-Part B	1578795332 1578795332	FL: 008135300
Fairfax Hospital 10200 NE 132nd St. Kirkland, WA 98034 Tax ID: 62-1658528	50-4002 GAB20892-Part B G8928133-Part B-Everett	1053327890 1104959097	WA: 3300001
Fairmount Behavioral Health System 561 Fairthorne Avenue Philadelphia, PA 19128-2412 Tax ID: 23-3044432	39-4027 051193	1215902168 1215902168 1134161938 1013009216 1215902168	NJ: 0090093 PA: 1007720100003 PA: 1007720100004 PA: 1007720100001 PA: 1500586
First Hospital Panamericano Rd. 787, Km.1.5 Cidra, PR 00739 Tax ID: 66-0490148	40-4004 CU600A-part B	1346357225 1396022349	N/A
FHCHS of Puerto Rico Valencia 1, Bldg 17, 5th Floor, Metro Office Park, Guaynabo, PR 00968 Tax ID: 66-0584821	N/A	N/A	N/A
First Home Care/Oyster Point 1634 London Blvd. Portsmouth, VA 23704 Tax ID: 54-1782162	N/A	1083794093 1639205560	VA: 1083794093 DC: 36523100
Forest View Hospital 1055 Medical Park Drive, S.E. Grand Rapids, MI 49546-3671	23-4030 OP41930	1740251313 1902808272	MI: 1902808272 MI: 1740251313

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Tax ID: 23-2285657			
Fort Lauderdale Hospital 1601 E. Las Olas Blvd. Fort Lauderdale, FL 33301 Tax ID: 20-1021229	10-4026 Pending-part B	1649224320	FL: 10357800
Foundations Behavioral Health System 833 East Butler Avenue Doylestown, PA 18901-2280 Tax ID: 20-8179692	39-4038	1346441722	PA: 1019219380001 PA: 1019219380002 PA: 1019219380003 PA: 1019219380004 PA: 1019219380005 PA: 1019219380010 PA: 1019219380011 PA: 1019219380012 NJ: 0176818 NJ: 0158950 NY: 00592796 MD: 4204263 00
Foundations for Living 1451 Lucas Road P.O. Box 2226 Mansfield, OH 44903 Tax ID: 48-1274207	N/A	1518986777	NJ: 176818 NY: 592796 PA: 101921938-0001 INPT PA: 101921938-0002 RTF PA: 101921938-0003 RTF PA: 101921938-0004 RTF PA: 101921938-0005 RTF PA: 101921938-0012 RTF PA: 101921938-0012 BHRS / WRAP
Fox Run Center for Children and Adolescents 67670 Traco Dr. St. Clairsville, OH 43950 Tax ID: 62-1658531	N/A	1992760334	WV: 2457001 DC: 40378800 OH: 2847487
Fremont Hospital 39001 Sundale Drive Fremont, CA 94538-2005	05-4110	1245346741	CA: 1245346741

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Tax ID: 62-1658532			
Friends Hospital 4641 Roosevelt Blvd. Philadelphia, PA 19124-2399 Tax ID: 20-2523648	39-4008 Part A 10-3698 Part B 022634VP2 110417VP2 110578VP2 100517VP2 52788 182226VP2 119526VP2 429994VP2 769107VP2 054722VP2 141225VP2 89-4162 076612VP2 096127VP2 163894VP2 085015VP2 095833VP2 169929VP2 221585VP2 091949VP2 107828VP2 118532VP2 216132VP2 179190VP2 185551VP2 501014VP2 478967VP2 221247VP2 055284VP2 110072VP2 076458VP2	1023099405 1326131699 1033256235 1124071428 1598975617 1902075872 1770630691 1124141379 1497743470 1639121270 1427182013 1265433726 1467426247 1942292313 1295996643 1881894889 1609900455 1396983532 1538325634 1508801010 1518907914 1215074489 1679516546 1689887515 1114032786 1629066626 1447299680 1154582377 1134211253 1770620478 1639122740	PA: 1012776950001 NJ: 6667104 GA: 003125666A
Garfield Park Hospital 520 North Ridgeway Avenue Chicago, IL 60624	14-4039	1629328604	IL: 232983574003

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Tax ID: 46-0775763			
Glen Oaks Hospital 301 E. Division Greenville, TX 75402-4199 Tax ID: 23-2357811	45-4050 00U69Z-part B	1922078815	TX: 1127466-02
Good Samaritan Counseling Center 3230 C St., 2nd FL Anchorage, AK 99503 Tax ID: 68-0565408	N/A	1629013065	AK: 1021119 AK: 1029393
Gulf Coast Treatment Center 1015 Mar Walt Drive Fort Walton Beach, FL 32547 Tax ID: 56-1341134	N/A	1457580276 1700985462 1659597995 1841418332 1013131507 1568576098 1346355930 1093919284 1831237460	FL: 070424500 FL: 070424504 FL: 070424501 FL: 070424503 FL: 070424506 FL: 076163900 FL: 260981901
Gulf Coast Youth Services RTC 1015 Mar Walt Drive Fort Walton Beach, FL 32547 Tax ID: 56-1341134	N/A	1700985462	KY: 1700985462 DC: 32305400 NV: 1700985462
Hampton Behavioral Health Center Hampton Hospital 650 Rancocas Road PO Box 7000 Westhampton, NJ 08060 Tax ID: 23-2985430	02-9034 Part B 31-4021A	1285822858 1457324196	NJ: 5446406 NJ: 0225941
Harbor Point Behavioral Health Center 301 Fort Lane Portsmouth, VA 23704	N/A	1275564361	VA: 1275564361 VA: 0000701

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Tax ID: 54-1465094			MD: 500037800-02 and 19714500 DC: 031456600
Hartgrove Hospital 5730 West Roosevelt Road Chicago, IL 60644 Tax ID: 23-2983574	14-4026 IL7341 -Part B	1043280936 1396012951	IL: 232983574001
Havenwyck Hospital 1525 University Drive Auburn Hills, MI 48326-2673 Tax ID: 38-2409580	23-4023	1053342220 1053342220	MI: 1536284
Heartland Behavioral Health Services 1500 West Ashland Street Nevada, MO 64772 Tax ID: 43-1328523	N/A	1528069101 1942528047 1801114814 1992023907 1629380597	MO: 11960101 MO: 508321304 KS: 100004550B KS: 100004550A KS: 100004550C OK: 100693500A OK: 100693500E OK: 100693500F OK: 100693500G
Heritage Oaks Hospital 4250 Auburn Blvd. Sacramento, CA 95841-4100 Tax ID: 62-1658494	05-4104	1083709653	CA: 1083709653
Hermitage Hall 1220 8th Avenue South Nashville, TN 37203 Tax ID: 62-1715237	N/A	1215956446	DC: 040031100 KY: 7100169690 NV: 100517929 TennCare: 5441249 WY: 137551200
Hickory Trail Hospital 2000 N. Old Hickory Trail DeSoto, TX 75115 Tax ID: 20-4976326	45-4065	1205999232	TX: 184076102

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Highlands Behavioral Health System 8565 S. Poplar Way Littleton, CO 80130-3602 Tax ID: 20-5227927	06-4024 COAAA2762 – Part B	1326133216 1326133216	CO: 51328534 WY: 126907100
Hill Crest Behavioral Health Care 6869 Fifth Avenue South Birmingham, AL 35212 Tax ID: 63-0862148	01-4000 C905 – Part B	1760439590 1447287800 1760439590	AL: PSY4000H AL: RTF0023H AL: RTF0003H AL: 142709 AL: 142761 (RISE) AL: 165555 (TEAM C) AL: 165450 (HIGDON GH) AL: 165101 (BESS GH)
Holly Hill Hospital 3019 Falstaff Road Raleigh, NC 27610-1812 Tax ID: 62-1692189	34-4014 2352734-Part B	1518037233 1518037233	NC: 3404014
Hughes Center for Exceptional Children 1601 Franklin Turnpike Danville, VA 24540 Tax ID: 20-8711062	N/A	1255526596	DC: 065547100 VA: 1255526596
The Horsham Clinic 722 E. Butler Pike Ambler, PA 19002-2398 215-643-7800 Tax ID: 23-2842434	39-4034 830401	1295708832 1295708832 1598801136 1457469702 1396845806 1306830658 1003841503 1437281318 1417054586 1891895322 1073512927	PA: 100728595-0065 NJ: 4206703

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
		1306945852 1588764153 1407144967 1528069697 1962502492 1366542862 1114063146 1467552034 1457469702 1073659611 1508966003 1467552943 1427246982	
Intermountain Hospital 303 North Allumbaugh Boise, ID 83704 Tax ID: 621658493	13-4002	1881707552	ID: 1881707552 OR: 000753
John Costigan Residential Center 1360 E. Irving Park Road Streamwood, IL 60107 Tax ID: 62-1658515	N/A	1639466915	IL: 621658515003
Jefferson Trail Treatment Center 2101 Arlington Blvd. Charlottesville, Virginia 22903 Tax ID: 62-1732340	N/A	1740245117	WV: 3810013751 VA: 1740245117
The Kempsville Center or Behavioral Health 860 Kempsville Road Norfolk, VA 23502 Tax ID: 54-1465094	N/A	1942231063	VA: 1942231063 VA: 000207021 MD: 197145000 (Old #: 500037802) DC: 031456602

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
KeyStone Center 2001 Providence Avenue Chester, PA 19013-5504 Tax ID: 23-2811119	N/A	1841263407 1205932100 1295820504	N/A
Kingwood Pines Hospital 2001 Ladbrook Dr. Kingwood, TX 77339 Tax ID: 73-1726290	45-4103 No B #	1861598633	TX: 175965601
La Amistad Residential Treatment Center 1650 North Park Avenue Maitland, FL 32751 Tax ID: 58-1791069	N/A	1811964737	N/A
Lake Bridge Behavioral Health 3500 Riverside Drive Macon, GA 31210 Tax ID: 35-2174803	N/A	1588861876	GA: 372803396B
Lakeside Behavioral Health System 2911 Brunswick Road Memphis, TN 38133 Tax ID: 23-3044425	44-4004	1083687651	TN: 044-4004 MS: 00220643 AR: 142103125
Laurel Heights Hospital 934 Briarcliff Road Northeast Atlanta, GA 30306 Tax ID: 23-3045288	N/A	1306913736	GA: 571149819A TN: 1507729 FL: 002567600 IA: 1306913736
Laurel Oaks Behavioral Health Center 700 E. Cottonwood Road Dothan, AL 36301 Tax ID: 52-2090040	01-4013	1326078023	AL: PSY4007H AL: RTF0002H

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Laurel Ridge Treatment Center 17720 Corporate Woods Drive San Antonio, TX 78259 Tax ID: 43-2002326	45-4060 TXB151917-Part B	1043280951 1235402504	TX: 0212409-02
Liberty Point Healthcare 1110 Montgomery Avenue Staunton, Virginia 24401 Tax ID: 20-1989730	N/A	1659333045	WV: 3810011533 DC: 095795900 VA: 010135435
Lighthouse Care Center of Augusta 3100 Perimeter Parkway Augusta, GA 30909 Tax ID: 20-3854156	N/A	1376633578	GA: 238497179A GA: 238497179B SC: 892MXH SC: RTF030 MT: 1376633578
Lincoln Prairie Behavioral Health Center 5230 S. Sixth Street Road Springfield, IL 62703 Tax ID: 26-0388272	00-5512	1033397138 1285803007	IL: 260388272001
Lighthouse Care Center of Conway 152 Waccamaw Medical Park Drive Conway, SC 29526 Tax ID: 20-3854241	42-4002 (Part A) 9083 (Part B)	1194826081 1194826081	SC: A00898 SC: RTF029 SC: GP4658 (inactive) NC: 3404573
Lincoln Trail Behavioral Health System 3909 South Wilson Road Radcliff, KY 40160 Tax ID: 62-1244469	18-4012 (Part A) 3598 (Part B)	1518964345 (Part A) 1851500466 (Part B)	KY: 02021244

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BEHAVIORAL HEALTH CENTERS AND NON-PUBLIC SCHOOLS

FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
McDowell Center for Children 711 Highway 51 Bypass South Dyersburg, TN 38024 Tax ID: 62-1837606	N/A	1083634596	TennCare: 5441352 AR: 142682125 DC: 54510800 (inactive) KY: 45048568 (inactive) WV: 0501033000 (Inactive) AK: 142682125 (inactive)
Mayhill Hospital 2809 S. Mayhill Road Denton, TX 76208 Tax ID: 27-4126263	67-0010 67-S010	1871898478 1316242910	TX: 283280003 (Psych) TX: 283280001 (Medical) TX: 283280002 (Surgery)
The Meadows Psychiatric Center 132 The Meadows Drive Centre Hall, PA 16828-9231 Tax ID: 23-2842434	39-4040 09-4082-Part B R1701253 MA153319 CH054130 781472NKA 160805NKA 229631NKA 153733NKA 09812L/054002	1124091715 1124091715 1780664524 1720068620 1154301901 1659377760 1497916720 1134141211 1871755249 1851398812	MD: 4098463 NJ: 0094731 FL: 9128450 00 PA: 1007285950051 PA: 1007285950075 PA: 0012795700013 PA: 1012302310001 PA: 0018775790001 PA: 0015286940018 PA: 1023664300001 PA: 1026654850001 PA: 1022220650003 PA: 0017250490001
Meridell Achievement Center 12550 West Highway 29 Liberty Hill, TX 78642 Tax ID: 74-1655289	N/A	1801863311	AK: 1005816
Mesilla Valley Hospital 3751 Del Rey Blvd. Las Cruces, New Mexico 88012-7710 Tax ID: 20-2612295	32-4010 400521232 – Part B	1841205671 1841205671	NM: 83930523

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Michiana Behavioral Health Center 1800 North Oak Drive Plymouth, IN 46563 Tax ID: 20-0768028	15-4047 217510 – Part B	1801822440 1801822440	IN: 200484350A (Inpatient) IN: 200484370A (Residential) IN: 200483830A (Group) IL: 200768028001
Midwest Center for Youth and Families 1012 West Indiana Street Kouts, IN 46347 Tax ID: 23-2985289	N/A	1649243759 1548421100 1619280153	IN: 200465920A IN: 200900170A IN: 200218820A
Millwood Hospital 1011 North Cooper Street Arlington, TX 76011-5517 Tax ID: 20-1021264	45-4012 TXB148522-Part B	1023015120 1639454713	TX: 021189801 TX: 021189803 TX: 021226801
Mountain Youth Academy 332 Hospital Road P.O. Box 58 Mountain City, TN 37683 Tax ID: 48-1274107	N/A	1184823502 1750304044	WV: 3810000019 VA: 000207292 TennCare: 5441347 NV: 100513270 MT: 1750304044 WY: 125729300 DC: 040098500 NC: 1750304044
Natchez Trace Youth Academy 415 Seven Hawks Lane Waverly, TN 37185 Tax ID: 48-1274107	N/A	1902825151	NV: 100517918 SD: 5168220 TennCare: 5441259 MT: 1902825151
National Deaf Academy 19650 US Highway 441 Mount Dora, FL 32757 Tax ID: 59-3653865	N/A	1306858196	AK: 1006543 AZ: 552308 AR: 141554125 CO: 53987578 DC: 055550900 FL: 681196596

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
			KY: 45000593 LA: 1107191 MD: 525050100 MS: 01737068 MT: 1306858196 NC: 3404515 ND: 55510 NE: 10025578700 NJ: 8403805 NV: 100513589 OK: 100697040A PA: 0018330370001 VA: 000207187 WV: 0503713000 WY: 129943300
Newport News Behavioral Health Center 17579 Warwick Boulevard Newport News, VA 23603 Tax ID: 32-0066225	N/A	1174722599 1356360580	WV: 0505002-000 DC: 035597400 MD: 416531400 NC: 6603920 VA: 1356360580
North Spring Behavioral Healthcare 42009 Victory Lane Leesburg, VA 20176 Tax ID: 20-1215130	N/A	1932164308	VA: 10082137 DC: 0359684-0 MD: 413739600 (Inactive) WV: 3810000029 (Inactive)
North Star Bragaw - Bragaw Campus 1650 South Bragaw Street Anchorage, AK 99508 Tax ID: 72-1539530	02-4001	1841364957	AK: 1005826
North Star Hospital - DeBarr Campus 2530 DeBarr Road Anchorage, AK 99508 Tax ID: 72-1539530	02-4001A	1487629333	AK: 1005826

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
North Star DeBarr Residential Treatment Center 1500 DeBarr Circle Anchorage, AK 99508 Tax ID: 72-1539254	N/A	1356416101	AK: 1005758 AK: 1021319
North Star Palmer Residential Treatment Center 3647 N Clark Wolverine Rd Palmer, AK 99645 Tax ID: 72-1539254	N/A	1689749939	AK: 1005756
Northwest Academy 1 Ruby Creek Road P.O. Box 370 Naples, ID 83847 Tax ID: 20-3171102	N/A	1780759068	N/A
Oak Plains Academy 1751 Oak Plains Road Ashand City, TN 37015 Tax ID: 62-1725123	N/A	1891713624	WV: 0501046000 KY: 45049939 TennCare: 5441152
Okaloosa Youth Academy 4455 Straight Line Road Crestview, FL 32539 Tax ID: 56-1341134	N/A	1841418332	N/A
Old Vineyard Behavioral Health Services 3637 Old Vineyard Road Winston-Salem, NC 27104 Tax ID: 20-1943356	34-4007 2347810A-Part B	1922038082 1780817452	NC: 3404007
Palmetto Lowcountry Behavioral Health 2777 Speissegger Drive Charleston, SC 29405 Tax ID: 57-1101380	42-4006 8641-Part B-Palmetto BH Solutions EIN 20-4086208	1134232671 1104885516	SC: A00729

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
LTR_9.6.13__ Virginia Beach__PalmettoGBA_855A Revalidation Palmetto Pee Dee Behavioral Health 2777 Speissegger Drive Charleston, SC 29405 Tax ID: 57-1101381	N/A	1508979956	SC: RTF0024 PA:11018402400001 NC: 3404535 KY: 7100259710
Palmetto Summerville Behavioral Health 225 Midland Parkway Summerville, SC 29485 Tax ID: 57-0840074	N/A	1467485144	SC: RTF-0024 NC: 3404535
Palm Shores Behavioral Health Center 4480 51st Street West Bradenton, FL 34210 Tax ID: 65-0816927	N/A	1417094160	FL: 70565916
Palo Verde Behavioral Health 2695 N Craycroft Rd Tucson Arizona 85712-2243 Tax ID 46-3600310	03-4030 Z164170-part b	1659700086(A) 1700207651(B)	AZ: 946031
Parkwood Behavioral Health System 8135 Goodman Road Olive Branch, MS 38654 Tax ID: 23-3044435	25-4005 302G708365-Part B	1093785859	MS: 00220612 (Acute) MS: 00220615 (RTC) TN: 233044435 AR: 142135125
The Pavilion 809 West Church Street Champaign, IL 61820 Tax ID: 23-2800410	14-4029 IL2506-part B	1659511228 1518930619	IL: 232800410001 IL: 232800410002

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
The Pavilion at NWTX (A) 1501 S. Coulter Amarillo, TX 79106 Tax ID: 23-2238976	45-S209	1740347087	TX: 1372450-09 TX: 0217713-01
Peachford Behavioral Health System of Atlanta 2151 Peachford Road Atlanta, GA 30338 Tax ID: 23-3044978	11-4010 GRP3956-Part B 26BDHNC-Part B??	1093781544 1124207220 1467531806	GA: 1315599140 GA: 342365787A
Peak Behavioral Health Services 5055 McNutt Rd. Santa Teresa, NM 88008 Tax ID: 20-1124098	32-4012	1689654451	NM: 32122705 TX: 167438401
Pembroke Hospital 199 Oak Street Pembroke, MA 02359 Tax ID: 23-3061361	22-4023 (Part A) M20939 (Part B)	1760453328	MA: 110027393A MA: 110027393B ME: 1760453328
Pinnacle Pointe Hospital 11501 Financial Centre Parkway Little Rock, AR 72211 Tax ID: 62-1658502	04-4013 5F560(b)	1912962341 1184679060 1366477911 1154594380 1023275310 1568691301 1912136151 1154594380	AR: 1912962341
The Pointe Outpatient Behavioral Health Services 226411 I-30 S., Bldg 1000 Bryant, AR 72022 Tax ID: 62-1658502	N/A	1710259437 1831461532 1477825180 1326310038 1497027106 1477825198	AR - 140539726 (ALC) AR - 190132526 (Batesville) AR - 190130526 (Cabot) AR - 176991526 (Clinton) AR - 161378526 (Conway)

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
		1649542366 1932471646 1902178619 1932471638 1255603973 1750653440	AR - 190129526 (Fordyce) AR - 190128526 (FC) AR - 190127526 (Helena) AR - 190126526 (Hot Springs) AR - 190124526 (LR) AR - 190123526 (Marion) AR - 190121526 (Pine Bluff) AR - 190131526 (Saline) AR - 190119526 (Searcy) AR - 167345526 (Stuttgart) AR - 202112526 (Sheridan)
Poplar Springs Hospital 350 Poplar Drive Petersburg, VA 23805 Tax ID: 20-0959684	49-4022	1124051701	VA: 1124051701
Prairie St. John's 510 4th Street South Fargo, ND 58103-1914 Tax ID: 26-4314533	35-4004 B-N714530 B-C05341-MN	1679709802 1679709802 1679709802	ND: 11178 MN: 99725100 MT: 411655 ID: 1679709802-000 WA: 1679709802 WI: 81879600

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Provo Canyon School 4501 N University Ave Provo, UT 84604 Tax ID: 23-3044423	N/A	1609843523	NV: 1609843523-995 MT: 269750 WY: 117343003 NM: 00M00056 AK: 1006678 AZ: 702823 UT: 233044423 IA: 1609843523
Provo Canyon Behavioral Hospital 1350 East 750 North Orem, UT 84097-1182 Tax ID: 23-3044423	46-4014 U000077102-Part B	1598056053 1457617409	UT: 1598056053
Psychiatric Institute of Washington 4228 Wisconsin Ave., NW Washington, DC 20016 Tax ID: 52-1907007	09-4004 – Part A 56-9223 – Part B	1871549949 (Part A) 1871549949 (Part B) 1922398734 1871810366 1154760387 1003176371	DC: 026402100 DC: 26392500 DC: 89880400 MD: 075000600 MD: 208290000 MD: 292085900 SC: 11510A
Quail Run Behavioral Health 2645 West Quail Ave Phoenix AZ 85027-2412 Tax ID: 46-4207180	03-4031 Pending – Part B	1740604636	
The Recovery Center 2501 Taylor Street Wichita Falls, TX 76309 Tax ID: 26-0269878	N/A	1982897724	N/A
Ridge Behavioral Health System 3050 Rio Dosa Drive Lexington, KY 40509	18-4009	1316917198	KY: 02000016 (Acute) KY: 45000502 (EPSDT) KY: 65937526 (Physicians)

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Tax ID: 23-3044431			
Ridge Outpatient Counseling 3050 Rio Dosa Drive Lexington, KY 40509-1540 Tax ID: 25-1872645	00-6792 6792-Part B	1922214956 1922214956	KY: 65937526
Rivendell Behavioral Health Services of Arkansas 100 Rivendell Drive Benton, AR 72015 Tax ID: 20-0930981	04-4007 5F819-Part B	1063482735 1972673069 1063482735	AR: 154265125
Rivendell Behavioral Health Services of Kentucky 1035 Porter Pike Road Bowling Green, KY 42103 Tax ID: 20-0931121	18-4017 K112640- Part B	1396715967	KY: 45002284 (EPSDT) KY: 02000024
River Crest Hospital 1636 Hunter's Glenn San Angelo, TX 76901-5016 Tax ID: 23-2366041	45-4064 TXB109500-Part B	1518937218 1518937218	TX: 112745802
River Park Hospital 1230 6th Avenue Huntington, WV 25701 Tax ID: 20-2652863	51-4008 5140083-Part B BE7381881 HH5140083 HU7391731 BA7415131 7405961 7412021 7378261 NP85441 ME7415651 NP85751	1114096344 1477622603 1255360137 1205905437 1114096344 1568531796 1477622603 1497858740 1295778660 1376763144 1801095773 1003994450	WV: 3810001577 (Acute) WV: 3810002191 (PRFT) WV: 3810002013 (PRFT School) WV: 3810002756 (Group)

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
	WV0437A	1689635880 1578679049 1114944683 1689721474 1427059526 1376630384	
	5140083 – Part B	1114074002 1477622603	
River Point Behavioral Health 6300 Beach Blvd. Jacksonville, FL 33216 Tax ID: 20-4865566	10-4016 HZ285A-Part B	1568633683	FL: 160001000
River Oaks Hospital 1525 River Oaks Road West Harahan, LA 70123-2199 Tax ID: 72-0687735	19-4031 5D473-Part B	1851350862 1528230976	LA: 1761672
Riveredge Hospital, Inc. 8311 W. Roosevelt Forest Park, IL 60130 Tax ID: 22-3682760	14-4009 214395-part B	1710070701	IL: 223682760-001
Rock River Academy and Residential Day Center 3445 Elmwood Rockford, IL 61101 Tax ID: 26-0850668	N/A	1073743423	IL: 621658515005
Rockford Center 100 Rockford Drive Newark, DE 19713 Tax ID: 23-3044421	08-4002 G00531-Part B	1942273552 1740381334 1801945589 1073710687	DE: 1000016798 MD: 001669 NJ: 0190713 PA: 001962750001
Rolling Hills Hospital 2014 Quail Hollow Circle	44-4007 37360210-Part B	1942442710 1922240688	TN: 444007 MS: 444007

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Franklin, TN 37067 Tax ID: 20-5566098			
Roxbury Treatment Center 601 Roxbury Road, Box L Shippensburg, PA 17201-3802 Tax ID: 23-2842434 20-3782246-Roxbury Psychiatric Hospital	39-4050-Part A 135364-Part B 51193 111603LN7	1629118856 1629118856 1821021585 1386677029 1952598740 1518059724 1457302143 1245265099 1174598106	PA: 1016668350001 PA: 1016668350002 PA: 1007285950016 PA: 1007285950019 PA: 1007285950018 PA: 1007285950077 PA: 1007285950078
Salt Lake Behavioral Health 3802 South 700 East Salt Lake City, UT 84106-1182 Tax ID: 27-1365684	46-4013 U000075603-Part B	1295066116	UT: 1295066116 (inactive) AK: 1574935 AZ: 599670 ID: 1295066116 MT: Pending NV: 1295066116 WY: 1295066116 WY: 283Q0000X
San Marcos Treatment Center 120 Bert Brown Rd. San Marcos, TX 78666 Tax ID: 43-2002231	N/A	1942290267	AK: 1006536I AZ: 796089 AR: 149375125 DC: 442254-00 IA: 0012310 MS: 0020476 NV: 006388550 NM: 09276327
Sandy Pines Hospital 11301 S.E. Tequesta Terrace Tequesta, FL 33469 Tax ID: 20-5202539	N/A	1467514398	FL: 070694917
Schick Shadel Hospital	N/A	N/A	N/A

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
2101 Ambaum Blvd. S.W. Seattle, WA 98146 Tax ID: 45-2538281			
Schick Shadel of Florida 5960 SW 106th Avenue Cooper City, FL 33328 Tax ID: 20-3798265	N/A	1962522524	N/A
Shadow Mountain Behavioral Health System 6262 Sheridan Road Tulsa, OK 74133-4055 Tax ID: 43-2001465	Pending 355449-Part B	1003923442 1528089257 1659475952 1184941148 1841304250 1740384049 1982758538 1316091457 1821105263 1821105263 1285867713 1831304351 1316056534 1124037288	OK: 200006820A OK: 200006820C OK: 200006820E OK: 200006820F OK: 200006820G OK: 200006820H OK: 200006820J OK: 200006820L OK: 200006820Q OK: 200006820R OK: 200006820S OK: 200006820T
Sierra Vista Hospital 8001 Bruceville Road Sacramento, CA 95823-2329 Tax ID: 62-1658512	05-4087	1528066685	CA: 1528066685
South Texas Behavioral Health System (A) 2102 W. Trenton Road Edinburg, TX 78539 Tax ID: 233069260	45-0119 45-S119 TXB142112 – Part B	1053301754 1689965691	TX: 94113001
St. Louis Behavioral Medicine Institute 1129 Macklind Avenue St. Louis, MO 63110 Tax ID: 23-2812942	990001259	1487732335	MO: 1487732335

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
St. Simon's By-The-Sea 2927 Demere Road St. Simons, GA 31522 Tax ID: 20-3854107	11-4016 HOSP240-Part B	1972557916 1972557916	GA: 126525715C
Spring Mountain Sahara 5460 W. Sahara Avenue Las Vegas, NV 89146 Tax ID: 20-3955217	29-4010	1669408928	NV: 1669408928
Spring Mountain Treatment Center 7000 West Spring Mountain Road Las Vegas, NV 89117 Tax ID: 20-0930346	29-4011 FG613A-Part B	1255306270 1255306270	NV: 1255306270 NV: 1255306270
Springwoods Behavioral Health 1955 West Tuckers Drive Fayetteville, AR 72704-5637 Tax ID: 20-5395878	04-4019 5G437-Part B	1790925972 1790925972	AR: 182423125
Stonington Institute 75 Swantown Hill Road North Stonington, CT 06359 Tax ID: 20-0687971	N/A	1225097231	CT: 004245420 CT: 004260775 CT: 004260783 CT: 004245438
Streamwood Behavioral Health Systems 1400 East Irving Park Road Streamwood, IL 60107 Tax ID: 62-1658515	14-4034 F100125208-part B	1619916822	IL: 621658515001
SummitRidge Hospital 250 Scenic Highway Lawrenceville, GA 30046 Tax ID: 26-2203865	11-4004 511G701278	1407021546 1033359195	GA: 003145732A GA: 008210822A

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Summit Oaks Hospital 19 Prospect Street Summit, NJ 07902 Tax ID: 20-1021210	31-4001 096529	1205880200 1205880200	NJ: 4143906
Suncoast Behavioral Health Center 4480 51st St West Bradenton FL 34210-2855 TAX ID: 65-0816927	Part A-pending HV536A-Part B	1740600709 1740600709	FL: Pending
Talbott Recovery Campus 5448 Yorktowne Drive Atlanta, GA 30349 Tax ID: 23-3044968	N/A	1336114321 1275765307 1477835296	N/A
Texas NeuroRehab Center 1106 West Dittmar Rd Austin, TX 78745 Tax ID: 56-2274069	45-2038-long term care 45-4111-psych hosp	1760482939 1043221195	AK: 1006246 AK: 1006010 AZ: 785743 KY: 45001062 NV: 1760482939 NM: 000N1165 TX: 142276-01 TX: 142276-03
The Brook – Dupont 1405 Browns Lane Louisville, KY 40207 Tax ID: 20-5048087	18-4007 K142540 (part B)	1013188937 1275953754	KY: 7100165670 KY: 7100035410
The Brook – KMI 8521 LaGrange Road Louisville, KY 40242 Tax ID: 20-5048153	18-4008 00616-Part B	1104097021 1104097021	KY: 7100165570 IN: 200910090A

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
The Vines Hospital 3130 SW 27th Avenue Ocala, FL 34471 Tax ID: 32-0235544	10-4071 FT438A-Part B	1508037771 1548546864	FL: 160000100
Three Rivers Behavioral Health 2900 Sunset Boulevard West West Columbia, SC 29169-3422 Tax ID: 57-1106645	42-4008 (A) 9982 (B)	1427044957 1841586187(B)	SC: 1427044957 (A) SC: 1073509055 (A)
Three Rivers Residential Treatment / Midlands Campus 200 Ermine Road West Columbia, SC 29170 Tax ID: 57-0884924	N/A	1144253824	SC: RTF004 / NPI# 1144253824 SC: 172BHS / NPI#1891129797 NC: 3404527 / NPI# 1144253824
Timberlawn Mental Health System 4600 Samuell Blvd. Dallas, TX 75228 Tax ID: 23-2853139	45-4081 0073az-Part B	1871566018 1871566018	TX: 0943797-01
TMC Behavioral Health Center (A) 2601 Cornerstone Drive Sherman, TX 75092 Tax ID: 20-5908627	45-S324	1720087729	TX: 1965436-01 TX: 1949976-01 OK: 200014270C OK: 200014270A
Turning Point Hospital 3015 Veterans Parkway P. O. Box 1177 Moultrie, GA 31776 Tax ID: 58-1534607	11-0209 11-S209 HOSP169-Part B	1205809571 1699000273 1205809571	GA: 055003458B
Turning Point Youth Center 101 West Townsend Road St. Johns, MI 48879 Tax ID: 62-1681824	N/A	1578582672	N/A

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FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Two Rivers Behavioral Health System 5121 Raytown Road Kansas City, MO 64133 Tax ID: 23-2279129	26-4017 4600000-part B MA3250-Part B – TRBHS Physician Group-EIN 61-1636090	1548233802 1548233802 1407151608	MO: 12569505
Universal Community Behavioral Health 132 The Meadows Drive Centre Hall PA 16828 Tax ID: 23-2999939	030908 (Part B) 073752NKA 838625NKA 213837NKA 211979NKA 814289NKA 096261NKA 065060NKA 117371NKA CH054130 781472NKA 160805NKA 229631NKA 153733NKA	1235352634 1962437640 1366434466 1699072819 1689835704 1326070194 1962421206 1851316087 1518993823 1154301901 1659377760 1497916720 1134141211 1871755249 1568472801 1861430787 1659384436 1871506667 1053324848 1679584809 1972606960 1245240381 1467462572 1023136751 1922192608 1326133273 1760663793 1932328739 1821315276 1093977720	PA: 100003622-0018 PA: 100003622-0079 PA: 100003622-0084 PA: 100003622-0085 PA: 100003622-0086 PA: 100003622-0087 PA 100003622-0088 PA: 1000036220083 PA: 1000036220011 PA: 1000036220023 PA: 1000036220071 PA: 1000036220072 PA: 1000036220073 PA: 1000036220074 PA: 1000036220076 PA: 1000036220077 PA: 1000036220078 PA: 1000036220081 PA: 102222065-0002 PA: 102366430-0003
University Behavioral Center	10-4076	1851395263	FL: 360086616

ATTACHMENT "A"

UNIVERSAL HEALTH SERVICES, INC.
FACILITIES

Last Updated: April 24, 2015 - HMG

BEHAVIORAL HEALTH CENTERS AND NON-PUBLIC SCHOOLS

FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
2500 Discovery Drive Orlando, FL 32826 Tax ID: 20-5202458	HV381A-Part B		FL: 360086617
University Behavioral Health of Denton 2026 W. University Drive Denton, TX 76201 Tax ID: 20-3078922	45-4104	1851346407	TX: 177658501 OK: 200075470 A
El Paso Behavioral Health System 1900 Denver Avenue El Paso, TX 79902 Tax ID: 20-8364461	45-4109	1386779304	TX: 191968001 NM: 37580078
Upper East TN Juvenile Detention Center 307 Wesley Street Johnson City, TN 37601 Tax ID: 48-1274107	N/A	1326147331	N/A
Valle Vista Health System 898 East Main Street Greenwood, IN 46143-1407 Tax ID: 62-1740366	15-4024 264360-Part B	1699722405 1699722405	IN: 100273400A (Inpatient) IN: 200471150A (Pharmacy) IN: 200139010A (Outpatient)
Valley Hospital 3550 East Pinchot Ave Phoenix, AZ 85018 Tax ID: 27-0355566	03-4026 Z142625	1083942098	AZ: 616672
Virgin Islands Behavioral Services 6183 Anna's Hope, Christiansted, St Croix, US Virgin Islands 00820 Tax ID: 66-0502769	N/A	N/A	N/A

ATTACHMENT "A"

UNIVERSAL HEALTH SERVICES, INC.
FACILITIES

Last Updated: April 24, 2015 - HMG

BEHAVIORAL HEALTH CENTERS AND NON-PUBLIC SCHOOLS

FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Virginia Beach Psychiatric Center 1100 First Colonial Road Virginia Beach, VA 23454 Tax ID: 54-1414205	49-4025	1326071093	VA: 4940253
Wekiva Springs 3947 Salisbury Rd. Jacksonville, FL 32216 Tax ID: 20-4865588	10-4069 HV894A-Part B	1942471065	N/A
Wellstone Regional Hospital 2700 Vissing Park Rd. Jeffersonville, IN 47130 Tax ID: 20-3062075	15-4051 IN2219	1841215985 1841215985	IN: 200813230A KY: 7100146230
West Hills Hospital 1240 E 9th Street Reno, NV 89512 Tax ID: 88-0300031	29-4003 VT29400306-Part B	1730287319 1730287319	NV: 1730287319 (Facility) NV: 1740426956 (Facility MD Group) 1730287319 (Outpatient Services) 1740426956 (Outpatient Services)
West Oaks Hospital 6500 Hornwood Houston, TX 77074 Tax ID: 62-1864265	45-4026	1598764359	TX: 1218299-02 TX: 1218299-03
Westwood Lodge Hospital 45 Clapboardtree Street Westwood, MA 02090 Tax ID: 23-3061361	22-4023A M20939-Part B	1760453328 1760453328	MA: 110027393A MA: 110027393B ME: 1760453328
Willow Springs Center	N/A	1790883205	NV: 1790883205

ATTACHMENT "A"

UNIVERSAL HEALTH SERVICES, INC.
FACILITIES

Last Updated: April 24, 2015 - HMG

BEHAVIORAL HEALTH CENTERS AND NON-PUBLIC SCHOOLS

FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
690 Edison Way Reno, NV 89502 Tax ID: 62-1814471		1114128477	
Windmoor Healthcare of Clearwater 11300 US 19 No Clearwater, Fl 33764 Tax ID: 23-2922437	10-4017	1891888558	FL: 889400
Windsor – Laurelwood Center for Behavioral Medicine 35900 Euclid Ave Willoughby, Ohio 44094 Tax ID: 20-1870446 Laurelwood Associates Tax ID: 341658315	36-4029 9241583-Laurelwood Associates Inc	1386653541 1346282001	OH: 2006699 (Inpatient) OH: 0-943457 (LAI) OH: 2910747 (Outpatient MH) OH: 0066859 (Outpatient CD)
Wyoming Behavioral Institute 2521 East 15th Street Casper, WY 82609 Tax ID: 20-3367209	53-4004 W20638-Part B(Hospital B) 1295709822	1295709822 1295709822 1174702393-new	WY: 1295709822 WY: 122217101 (Acute) WY: 122217102 (Residential) WY: 125220800 (Out Patient)

ATTACHMENT "A"

UNIVERSAL HEALTH SERVICES, INC.
FACILITIES

Last Updated: April 24, 2015 - HMG

AMBULATORY SURGICAL CENTERS

FACILITY	MEDICARE PROVIDER #	NPI #	MEDICAID PROVIDER #
Cornerstone Regional Hospital 2302 Cornerstone Blvd. Edinburg, TX 78539-8471 Tax ID: 74-2829611	45-0825	1386652527	TX: 094221101 TX: 094221102
Eye Surgery Specialists of Puerto Rico 809 Hipodromo St., Stop 20 Santurce, PR 00909 Tax ID: 83-0337788	0011004 40-C0001004	1760437248	N/A
Northwest Texas Surgery Center 3501 Soncy, Suite 118 Amarillo, TX 79119-6405 Tax ID: 23-2984342	45-0796 00421R	1003842212 1750474516	TX: 94211201 OK: 200278730A CO: 141976 NM: 30605067 KS: 200639830A

OUTPATIENT RADIOLOGICAL CENTERS

FACILITY	MEDICARE PROVIDER #	NPI	MEDICAID PROVIDER #
Cancer Institute of Carolina 202 University Parkway P.O. Box 117 Aiken, SC 29802-1117 Tax ID: 27-1272954	420082	1922320399 1376502518 1417913070	SC: GP5411 SC: 214404 SC: G51336 GA: 346344805A
Chain Home Office UHS of Delaware, Inc. 367 South Gulph Road PO Box 61558 King of Prussia, PA 19406-0958	39-9001		

B. II. A

Square Footage and Costs Per Square Footage Chart

Summary & Worksheet

	PROJECT COST ESTIMATE				
	Lakeside Behavioral Health, Memphis TN				
Stage	Conceptual				
Date	5/4/2015				
By	Eric Brackin				
Item	**Description**				**Total Projected**
	48 Bed Addition				**Cost**
1000	**Professional Fees**				**$761,460**
2000	**Furniture, Fixture & Equipment**				**$674,000**
2100	**Information Systems**				**$264,000**
3000	**Construction**				**$7,493,247**
4000	**Permits Printing & Ins.**				**$140,000**
5000	**Testing & Inspection**				**$40,000**
	Total				**$9,372,707**
Items with no values are hidden refer to following Detail Estimate and Equipment Detail sheets.					
Bed Addition Worksheet				**Project Metrics**	
1	Core Bed Addition - No Other Upgrades			Number of beds	48
	Total Cost	$ 8,483,765		Number of existing beds	261
	Cost Per Bed	$ 176,745		New Building area in Square Feet	24,205
				Grand Total SF / Bed	504
2	Other Code Required Items			Building Construction Cost w/o Site	$6,644,547
	Total Cost	$ 97,255		Total $/bed	$195,265
	Cost Per Bed	$ 2,026.15		Building Cost / SF	$275
				Site Construction Costs	$630,450
	Itemized:			Site Construction Costs/Acre	$315,225
	Dining Area (15sf/patient)	*$ 97,255*		Parking Spaces Added	9
				Final Parking Total	508

SPACE ALLOCATION PROGRAM
(DRAFT 2)

LAKESIDE BEHAVIORAL HEALTH SYSTEM - NEW INPATIENT PSYCHIATRIC UNIT
Universal Health Services, Inc. / Memphis, Tennessee

NURSING UNIT - INPATIENT
BASE SCOPE - 48 GERIATRIC PSYCHIATRIC BEDS

Space Name	Units	NSF/Unit	Total NSF	2010 FGI Chapter 2.5	Comments
SUB-UNIT 1A - INPATIENT - SEMI-PRIVATE					**24 Bed Positions**
Patient Room, Semi-Private	6	200	1,200	2.4.2.1	
Patient Room, Semi-Private - Extended	4	250	1,000	2.4.2.1	Similar to ADA Patient Room
Patient Room, Semi-Private, ADA	2	250	500	2.4.2.1	
Toilet/Shower, Patient	6	40	240	2.2.2.6	
Toilet/Shower, Patient - Extended	4	60	240	2.2.2.6	Similar to ADA Paitent Toilet/Shower
Toilet/Shower, Patient, ADA	2	60	120	2.2.2.6	
Social Space, Noisy Activity / Dining	1	430	430	2.4.8.1	30 sf/patient Noisy+Quiet
Social Space, Quiet Activity	1	880	880	2.4.8.1	30 sf/patient Noisy+Quiet
Group Therapy	2	205	410	2.2.6.15	12 patients per typical Group Therapy Session
Consultation/Visitor Room	1	130	130	2.2.6.13/2.2.8.1	1:12 beds, windows in doors, panic buttons
Exam Room	1	140	140	3.1/4.1.2	exam table, blood-draw chair, UCR, EKG, scale(s)
Quiet (Comfort) Room	1	105	105	2.2.4.4	
Toilet, Patient, ADA	1	50	50		adjacent to Activity Rooms
Tub, Staff-Assist, Patient	1	80	80	2.4.2.2	walk-in tub
Patient Laundry	1	55	55	2.2.8.3	3 washer / 3 dryer
Beauty Shop	1	145	145		
Storage, Clean Linen / Patient Hygiene	2	15	30	2.2.6.11	
Electrical, Subpanel	1	15	15	8.3	
Subtotal			**5,770**		
SUB-UNIT 1B - INPATIENT - SEMI-PRIVATE					**24 Bed Positions**
Patient Room, Semi-Private	6	200	1,200	2.4.2.1	
Patient Room, Semi-Private - Extended	4	250	1,000	2.4.2.1	Similar to ADA Patient Room
Patient Room, Semi-Private, ADA	2	250	500	2.4.2.1	
Toilet/Shower, Patient	6	40	240	2.2.2.6	
Toilet/Shower, Patient - Extended	4	60	240	2.2.2.6	Similar to ADA Paitent Toilet/Shower
Toilet/Shower, Patient, ADA	2	60	120	2.2.2.6	
Social Space, Noisy Activity / Dining	1	430	430	2.4.8.1	30 sf/patient Noisy+Quiet
Social Space, Quiet Activity	1	880	880	2.4.8.1	30 sf/patient Noisy+Quiet
Group Therapy	2	205	410	2.2.6.15	12 patients per typical Group Therapy Session
Consultation/Visitor Room	1	130	130	2.2.6.13/2.2.8.1	1:12 beds, windows in doors, panic buttons
Receiving/Dishwash	1	140	140		
Quiet (Comfort) Room	1	105	105	2.2.4.4	
Toilet, Patient, ADA	1	50	50		adjacent to Activity Rooms
Shower, Staff-Assist, Patient	1	80	80	2.4.2.2	staff-assist shower with handheld wand

LAKESIDE BEHAVIORAL HEALTH SYSTEM - NEW INPATIENT PSYCHIATRIC UNIT
Universal Health Services, Inc. / Memphis, Tennessee

NURSING UNIT - INPATIENT
BASE SCOPE - 48 GERIATRIC PSYCHIATRIC BEDS

Space Name	Units	NSF/Unit	Total NSF	2010 FGI Chapter 2.5	Comments
Patient Laundry	1	55	55	2.2.8.3	3 washer / 3 dryer
Servery	1	145	145		
Storage, Clean Linen / Patient Hygiene	2	15	30	2.2.6.11	
Electrical, Subpanel	1	15	15	8.3	
Subtotal			**5,770**		
NURSING UNIT - INPATIENT ON-UNIT SUPPORT					
Nurse Station, Sub-Units 1/2	1	310	310	2.2.6.1	open concept
Documentation Area	1	80	80	2.2.6.2	
Office, Nurse Manager	1	100	100	2.2.6.3	
Office, Director of Social Services	1	100	100	2.2.6.3	
Workroom, Social Work	1	210	210	2.2.6.3	4-5 workstations
Conference/Treatment Planning	1	220	220	2.2.6.4/2.2.6.14	
Consultation Room, Discharge	1	100	100	2.2.6.13	1:12 beds, windows in doors, panic buttons
Consultation Room, Admit	3	100	300	2.2.6.13	1:12 beds, windows in doors, panic buttons
Seclusion Room	2	80	160	2.2.4.3	request Variance from State to omit Seclusion Suite
Anteroom, Seclusion	1	90	90	2.2.4.3	
Toilet, Seclusion	1	50	50	2.2.4.3	
Lounge/Locker, Staff	1	220	220	2.2.7.1/2.2.7.3	staff locker area
Toilet, Staff, ADA	1	50	50	2.2.7.2	
Medication Workroom	1	155	155	2.2.6.6	pass-through windows, accommodate future pyxis
Clean Supply	1	120	120	2.2.6.9	
Clean Linen	1	120	120	2.2.6.9	
Soiled Workroom	1	120	120	2.2.6.10	
Storage, Equipment/General	1	210	210	2.2.6.11/5.3.1.2	4 sf/patient
Storage, Patient Effects	1	120	120	2.2.8.4	bulk patient effects held in separate area on campus
Housekeeping	1	40	40	2.2.6.12	accommodate riding floor machine
Mechanical /Electrical, Main Panel	1	320	320	8.4	
Communications	1	40	40	8.5	
Subtotal			**3,235**		
OFF-UNIT SUPPORT					
Vestibule, Public Entrance	1	90	90		Aiphone to Nurse Station
Lobby / Waiting	1	190	190		capacity of 10, Aiphone to Nurse Station
Alcove, Locker, Visitor Effects / Visitor Search	1	50	50		

SPACE ALLOCATION PROGRAM
(DRAFT 2)

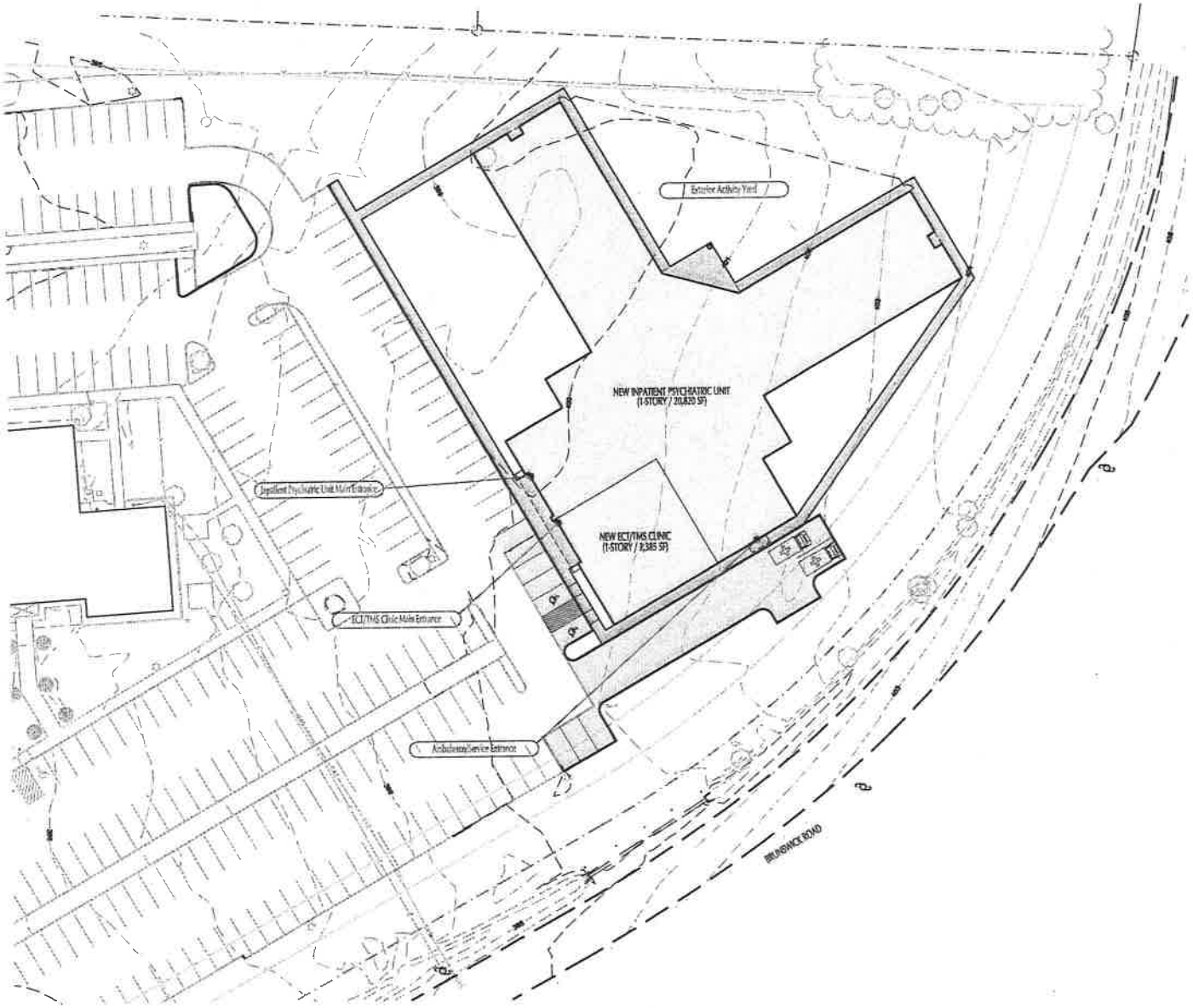
LAKESIDE BEHAVIORAL HEALTH SYSTEM - NEW INPATIENT PSYCHIATRIC UNIT
Universal Health Services, Inc. / Memphis, Tennessee

NURSING UNIT - INPATIENT
BASE SCOPE - 48 GERIATRIC PSYCHIATRIC BEDS

Space Name	Units	NSF/Unit	Total NSF	2010 FGI Chapter 2.5	Comments
Toilet, Public, ADA	1	50	50		
Vestibule, Ambulance Entrance	1	100	100		Aiphone to Nurse Station, covered drop-off
Subtotal			**480**		
Total Net Area			**15,255**		**FNSF**
Circulation (22% of FNSF)			3,356		
Structure and Walls (15% of FNSF)			2,288		
Total Gross Area			**20,899**		**FGSF**

Requirements per 2010 FGI Guidelines.

Approved By:
Date:
Title:



LEGEND	
New Building Area - Inpatient Psychiatric Unit	20,820 sf
New Building Area - ECT/TMS Clinic	3,385 sf
TOTAL NEW BUILDING AREA	24,205 sf
Circulation Area - Horizontal	

48 INPATIENT PSYCHIATRIC BEDS

GRAPHIC SCALE

0'	25'	50'	100'

NORTH

SCHEMATIC SITE PLAN

NEW GERIATRIC PSYCHIATRIC BUILDING
LAKESIDE BEHAVIORAL HEALTH SYSTEM
MEMPHIS, TENNESSEE

SD01-01

UH51507

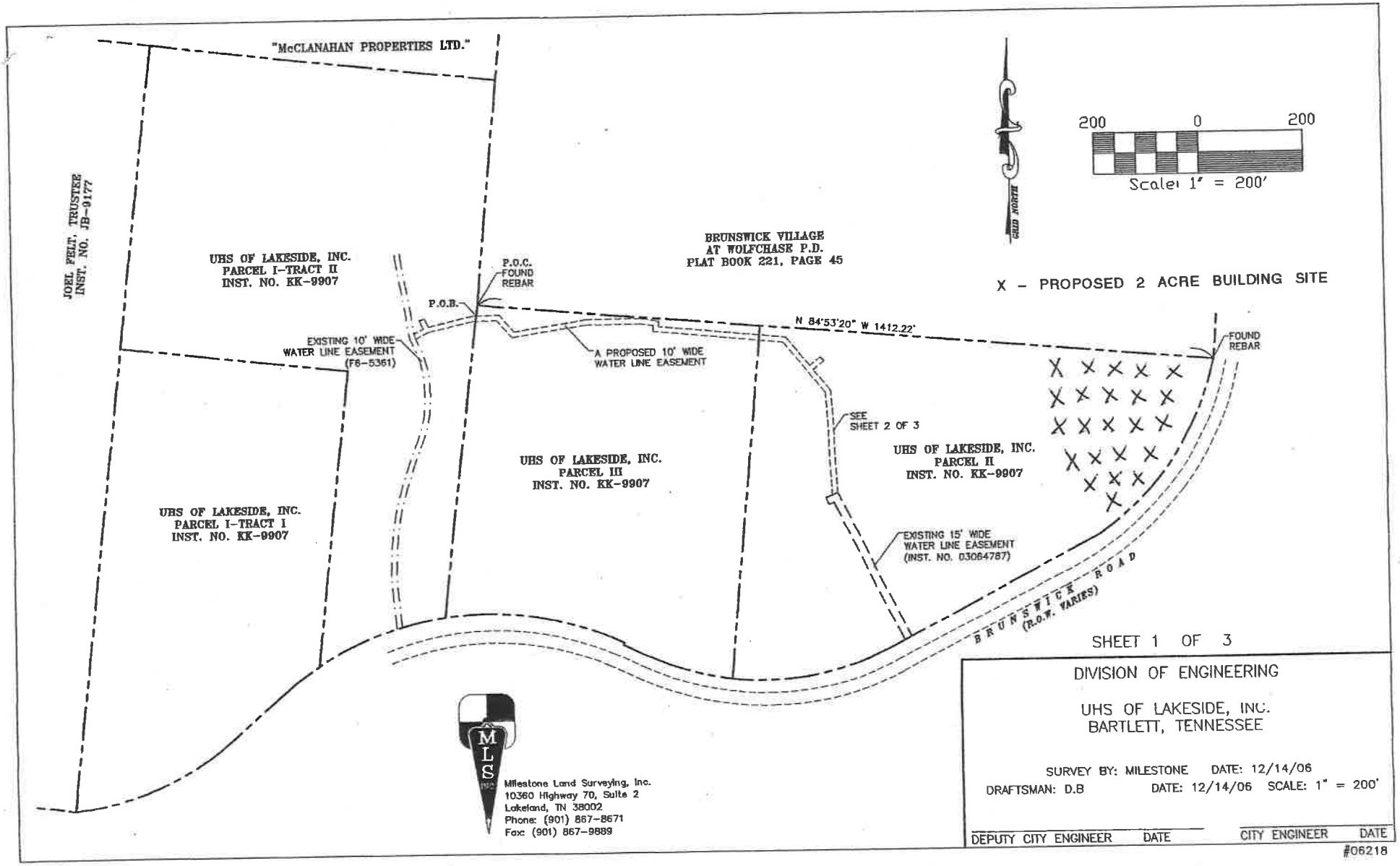
18 MARCH 2015

STENGEL-HILL ARCHITECTURE

REVISED 05.04.15

B. III. A

Plot Plan



SHEET 1 OF 3

DIVISION OF ENGINEERING

UHS OF LAKESIDE, INC.
BARTLETT, TENNESSEE

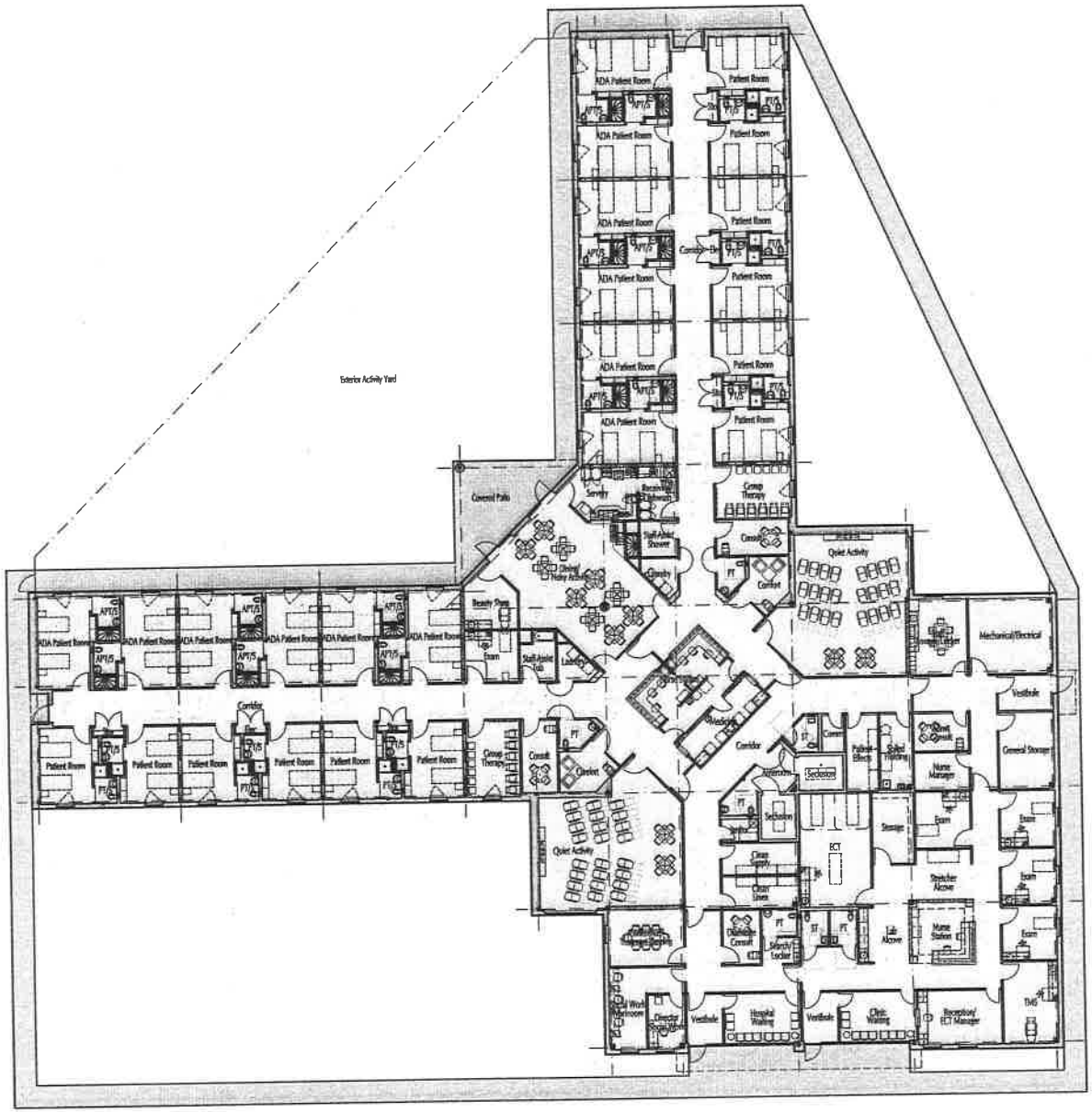
SURVEY BY: MILESTONE DATE: 12/14/06
DRAFTSMAN: D.B DATE: 12/14/06 SCALE: 1" = 200'

DEPUTY CITY ENGINEER DATE CITY ENGINEER DATE

#06218

B. IV.

Floor Plan



LEGEND	
New Building Area - Inpatient Psychiatric Unit	20,820 sf
New Building Area - ECT/TMS Clinic	3,385 sf
TOTAL NEW BUILDING AREA	24,205 sf
Circulation Area - Horizontal	

48 INPATIENT PSYCHIATRIC BEDS

GRAPHIC SCALE

0'	12.5'	25'	50'

NORTH

SCHEMATIC FLOOR PLAN

NEW GERIATRIC PSYCHIATRIC BUILDING
LAKESIDE BEHAVIORAL HEALTH SYSTEM
MEMPHIS, TENNESSEE

SD01-02

U161507

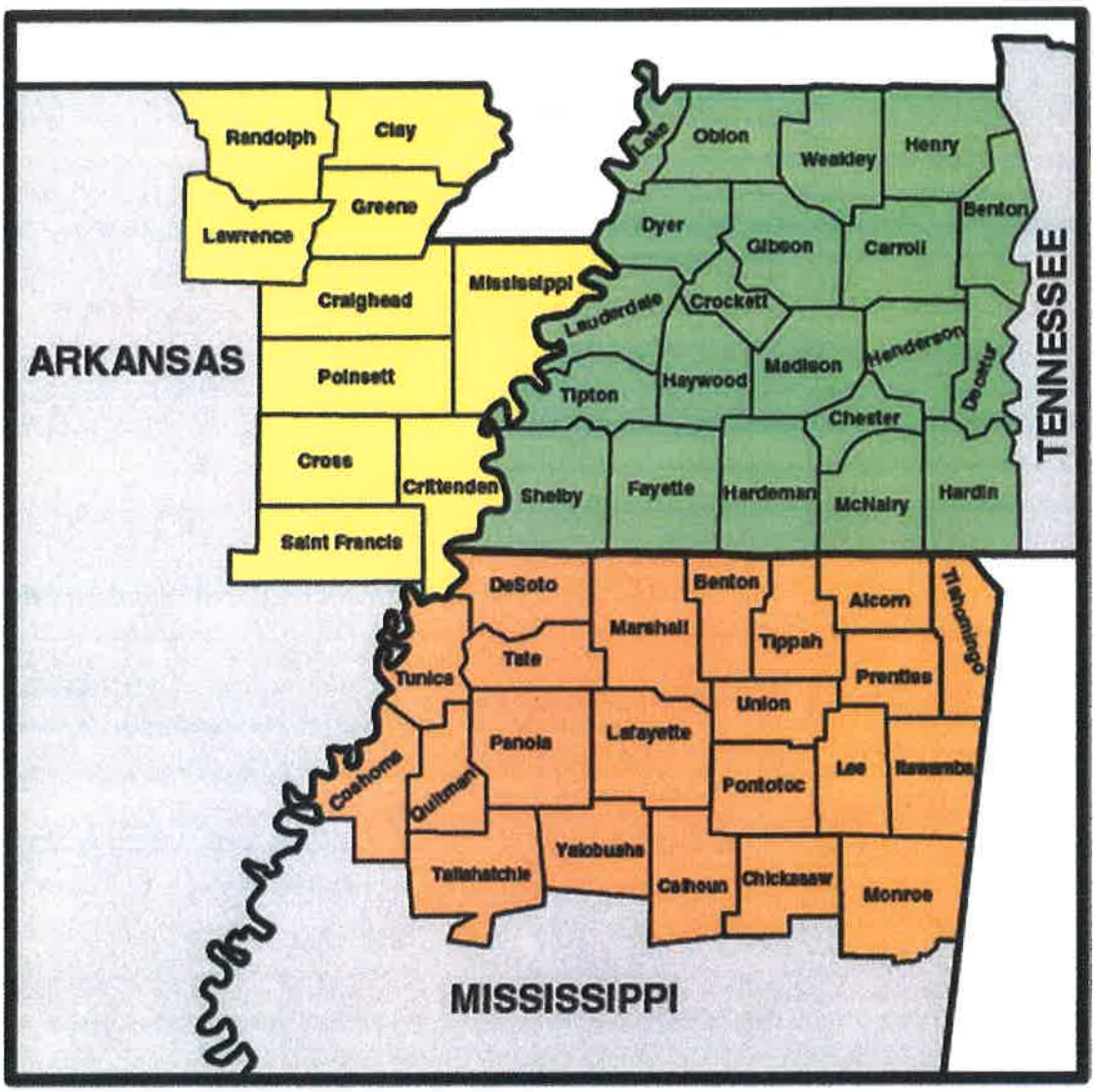
18 MARCH 2015

STENGEL-HILL ARCHITECTURE

REVISED 05.04.15

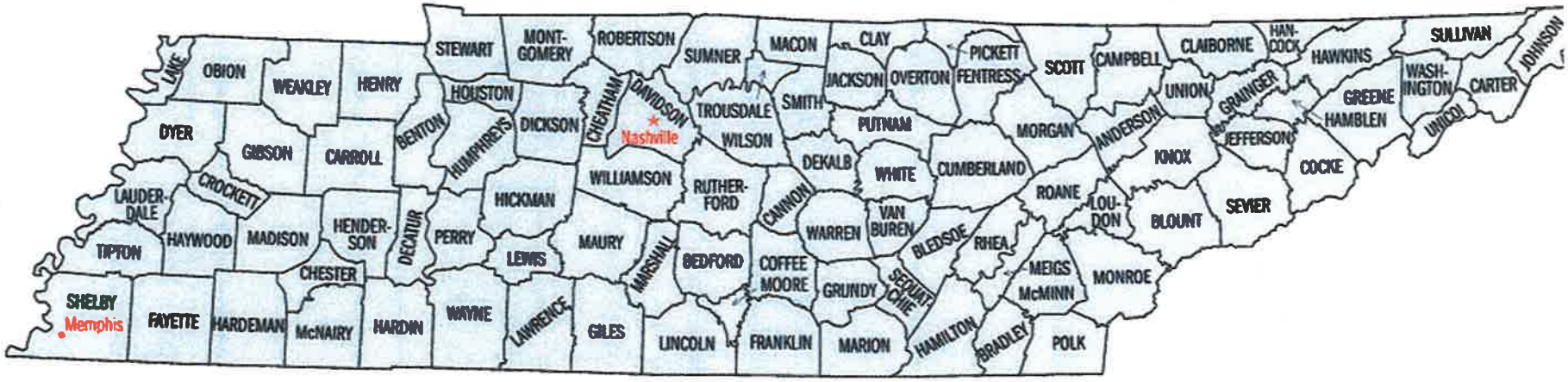
C. Need-3

Service Area Maps


ARKANSAS
TENNESSEE
MISSISSIPPI
Randolph
Clay
Lawrence
Greene
Craighead
Mississippi
Poinsett
Cross
Crittenden
Saint Francis
Lake
Obion
Weakley
Henry
Dyer
Gibson
Carroll
Benton
Lauderdale
Crockett
Tipton
Haywood
Madison
Henderson
Decatur
Chester
Shelby
Fayette
Hardeman
McNairy
Hardin
DeSoto
Benton
Alcorn
Tishomingo
Marshall
Tippah
Tate
Tunica
Prentiss
Union
Panola
Lafayette
Coahoma
Quitman
Pontotoc
Lee
Itawamba
Yalobusha
Tallahatchie
Calhoun
Chickasaw
Monroe

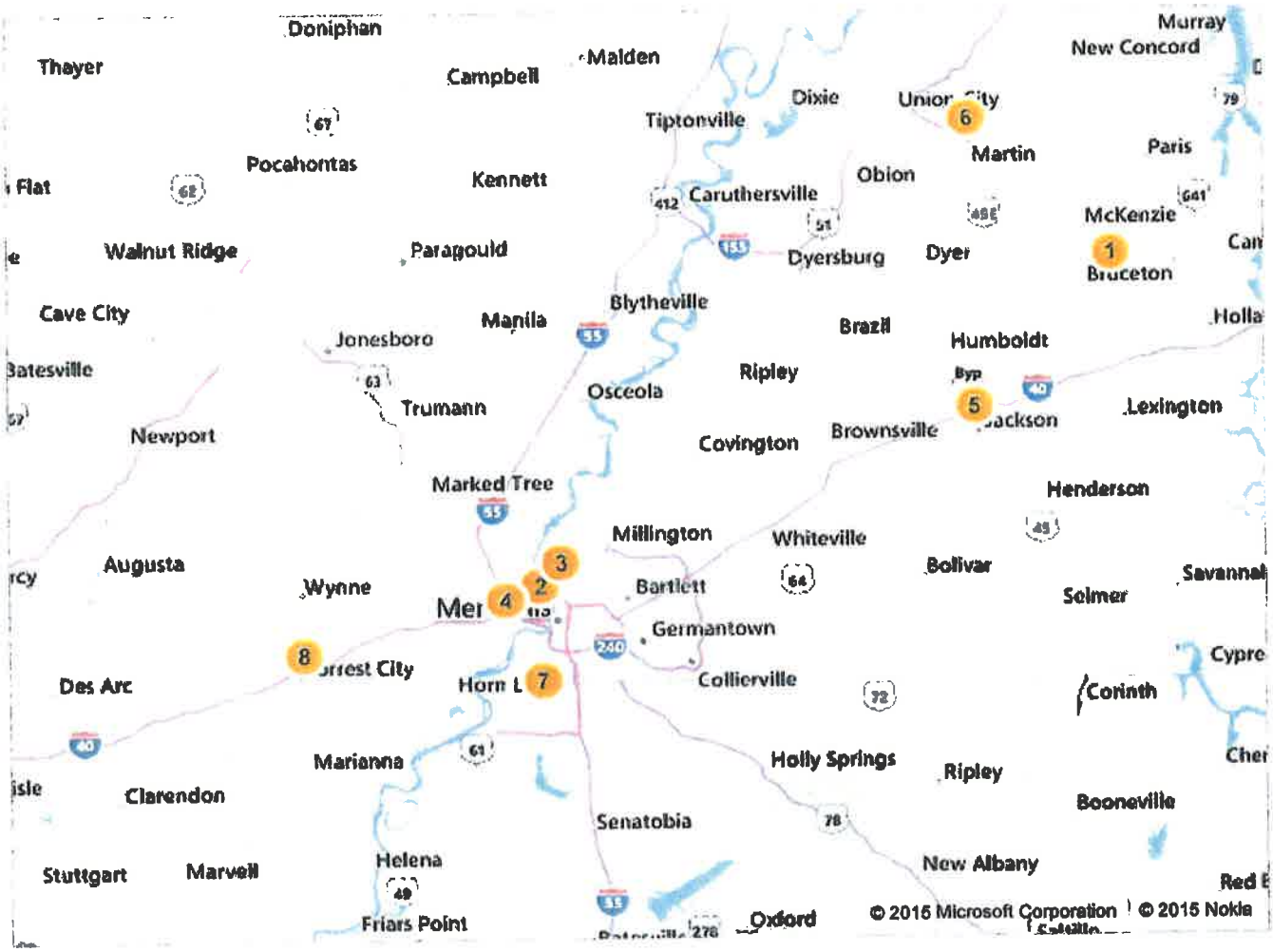
Counties Served in Tennessee include:

Lake	Carroll	Tipton	Chester	*Shelby County where facility is located
Obion	Gibson	Haywood	Hardin	
Weakley	Dyer	Madison	McNairy	
Henry	Crockett	Henderson	Hardeman	
Benton	Lauderdale	Decatur	Fayette	



PSYCHIATRIC GERIATRIC TREATMENT FACILITIES MAP LOCATIONS

1. **Baptist-Huntingdon**
2. **Delta Medical**
3. **Methodist Behavioral**
4. **St. Francis Hospital**
5. **Oak Hills Behavioral**
6. **Martin Behavioral**
7. **Parkwood Behavioral**
8. **Forrest City Medical**



mapquest

Notes

Map of:
2911 Brunswick Rd
Memphis, TN 38133-4198

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Notes

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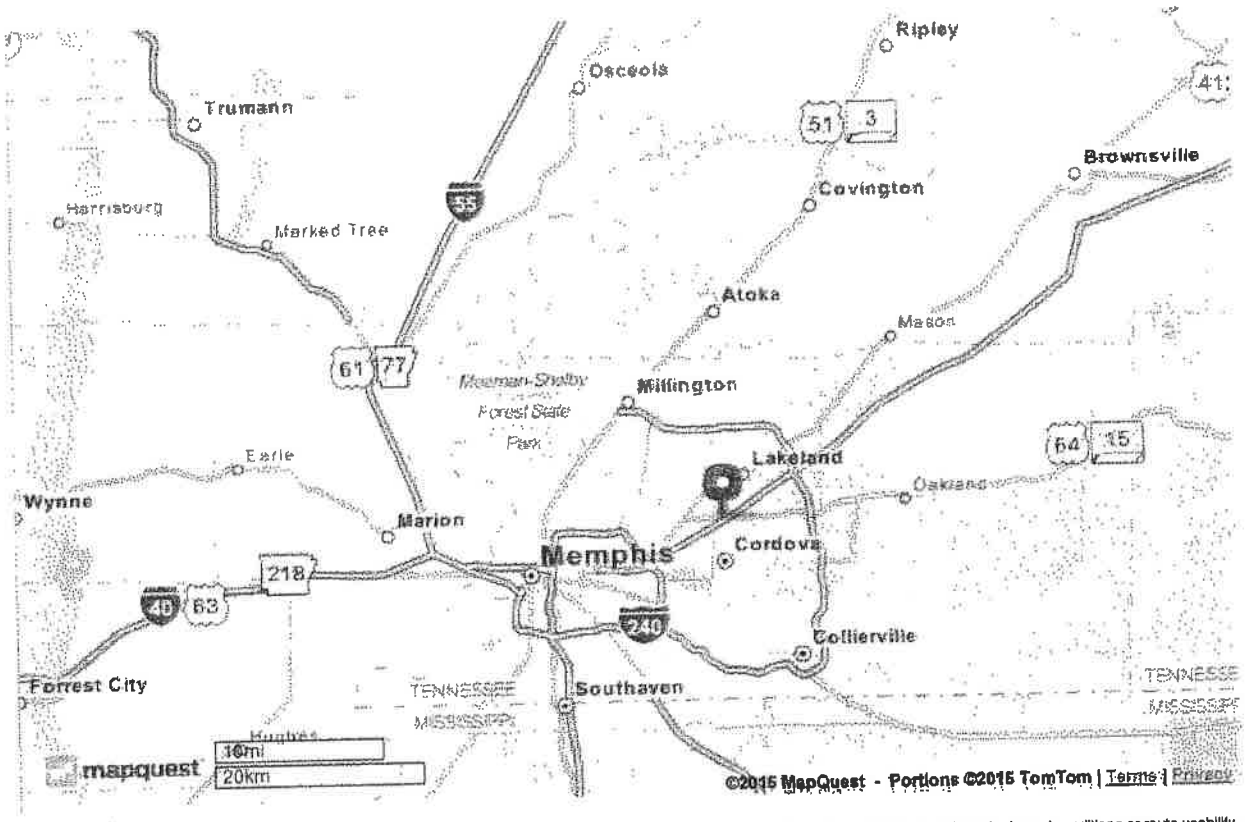
Map of:
2911 Brunswick Rd
Memphis, TN 38133-4198



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C. Economic Feasiblity-1

Documentation of Construction Cost Estimate

STENGEL-HILL ARCHITECTURE

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

RE: New Geriatric Psychiatric Building
Lakeside Behavioral Health System – Universal Health Services, Inc.
Memphis, TN

05 May 2015

SHA.UHS1507

Ms. Hill,

Per our recent conversation with Byron K. Trauger, an attorney working with Lakeside Behavioral Health System on a Certificate of Need submission, we have prepared the following supporting documentation for your review.

I have reviewed the construction cost estimate provided by Lakeside Behavioral Health System in the CON Submission. Based on my experience and knowledge of the current healthcare market, it is my opinion that the projected construction cost of $7,493,247.00 appears to be reasonable for a project of this type and size.

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

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

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

Thank you.

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

BPS/mrs

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

C. Economic Feasiblity-2

Documentation of Availability of Funding

UHS

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

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

P: 610-768-3300

April 27, 2015

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

RE: Lakeside Behavioral Health System 48 Bed Geriatric Psychiatric Replacement Bed CON

Dear Mrs. Hill:

I am the Vice President and Treasurer of Universal Health Services, Inc., the parent corporation of Lakeside Behavioral Health System, which is establishing a CON to replace a 32 bed Geriatric Psychiatric unit with a new 48 bed Geriatric Psychiatric unit with new construction at our current Brunswick Road campus.

Universal Health Services, Inc. is committed to supporting the financial needs of Lakeside Behavioral Health System and I am authorized to represent that subject to approval of our investment committee, Universal Health Services, Inc. is committed to fund the total project cost, working capital, and operating deficits required to complete the 48 bed Geriatric Psychiatric building with new construction in this CON. This project will be funded through the cash flow of Universal Health Services, Inc.

The cash from Universal health Services, Inc.'s operating activates is more than sufficient to fund the proposed project. For the year ending December 31, 2014, Universal health Services, Inc. generated $1.036 billion of net cash flow from operating activities.

Sincerely,

Cheryl K. Ramagano
Vice President and Treasurer
Tel. 610-768-3402

C. Economic Feasibility-10

Financial Statements

BH 1500 257

LAKESIDE HOSPITAL
KEY INDICATORS
For Periods Ending December 31, 2014

DATE: 5/4/2015
TIME: 3:26:39 PM
PAGE: 1

	CURRENT MONTH	BUDGET	VARIANCE	CURRENT YTD	BUDGET YTD	VARIANCE	PRIOR YR YTD	VARIANCE
Inpatient A.D.C.	213.3	185.6	27.7	228.1	202.5	25.6	205.1	23.0
Total FTEs	399.3	354.6	(44.7)	408.8	357.8	(50.9)	359.0	(49.7)
PATIENT REVENUE								
Inpatient Revenue	9,166,706	8,222,473	944,233	115,723,022	105,629,974	10,093,048	106,625,293	9,097,729
Outpatient Revenue	96,932	61,077	35,855	947,663	667,139	280,524	641,910	305,753
TOTAL PATIENT REVENUE	**9,263,638**	**8,283,550**	**980,088**	**116,670,685**	**106,297,113**	**10,373,572**	**107,267,203**	**9,403,482**
REVENUE DEDUCTIONS								
Medicare Deductions	1,496,577	1,247,650	(248,927)	16,667,178	16,179,588	(487,590)	16,331,511	(335,667)
Medicaid Deductions	210,526	169,254	(41,272)	4,014,886	2,202,603	(1,812,283)	2,551,039	(1,463,847)
Supplemental Payments	0	0	0	204	0	(204)	(204)	(408)
Blue Cross Deductions	165,526	150,718	(14,808)	1,423,200	1,925,431	502,231	1,609,221	186,021
HMO/PPO Deductions	1,149,971	852,202	(297,768)	12,857,538	11,069,849	(1,787,689)	14,258,349	1,400,811
Managed M/C Deductions	0	305,575	305,575	0	3,966,669	3,966,669	0	0
Managed M/D Deductions	1,662,199	1,376,893	(285,306)	24,520,852	17,651,891	(6,868,962)	20,150,393	(4,370,459)
Miscellaneous Deductions	46,771	123,142	76,371	1,221,109	1,580,254	359,145	1,579,610	358,501
TOTAL REVENUE DEDUCTIONS	**4,731,570**	**4,225,434**	**(506,136)**	**60,704,967**	**54,576,284**	**(6,128,682)**	**56,479,919**	**(4,225,048)**
NET PATIENT REVENUE	**4,532,068**	**4,058,116**	**473,952**	**55,965,718**	**51,720,828**	**4,244,890**	**50,787,285**	**5,178,434**
Other Revenue	129,454	98,588	30,866	1,317,530	1,051,457	266,073	1,189,086	128,444
NET REVENUE BEFORE BAD DEBT	**4,661,522**	**4,156,704**	**504,819**	**57,283,248**	**52,772,285**	**4,510,963**	**51,976,371**	**5,306,878**
Bad Debt	140,751	175,053	34,302	2,186,756	2,197,500	10,744	2,185,580	(1,176)
NET REVENUE	**4,520,771**	**3,981,651**	**539,120**	**55,096,492**	**50,574,785**	**4,521,707**	**49,790,791**	**5,305,702**
CONTROLLABLE COST								
Salaries	1,572,550	1,403,087	(169,463)	18,930,527	16,837,858	(2,092,669)	16,433,788	(2,496,739)
Employee Benefits	266,522	377,138	110,616	4,516,415	4,559,956	43,541	4,174,441	(341,975)
Professional Fees	403,774	231,090	(172,684)	2,932,242	2,639,328	(292,913)	2,541,879	(390,363)
Purchased Services	220,806	179,433	(41,373)	2,560,266	2,163,839	(396,427)	2,304,748	(255,517)
Maintenance	90,256	42,417	(47,839)	721,265	509,000	(212,265)	653,000	(68,265)
Supplies	301,450	237,351	(64,099)	3,311,392	2,986,997	(324,395)	2,954,022	(357,371)
Insurance	44,563	37,260	(7,303)	456,965	447,119	(9,846)	487,476	30,510
Lease/Rental	22,473	12,714	(9,759)	251,132	152,569	(98,563)	179,060	(72,071)
Travel/Educ/Dues	17,764	9,375	(8,389)	147,434	112,504	(34,930)	109,129	(38,305)
Other Expenses	129,682	97,232	(32,450)	1,330,298	1,166,781	(163,517)	1,168,061	(162,237)
Non-Allocated Expenses	62,559	55,467	(7,092)	560,315	665,604	105,289	529,338	(30,977)
TOTAL CONTROLLABLE COST	**3,132,398**	**2,682,563**	**(449,835)**	**35,718,250**	**32,241,555**	**(3,476,695)**	**31,534,941**	**(4,183,309)**
INCOME FROM OPERATIONS	**1,388,373**	**1,299,087**	**89,286**	**19,378,242**	**18,333,230**	**1,045,012**	**18,255,850**	**1,122,393**
Contribution Margin %	31%	33%	(2%)	35%	36%	(1%)	37%	(1%)

LAKESIDE HOSPITAL
KEY INDICATORS
For Periods Ending December 31, 2014

	CURRENT MONTH	BUDGET	VARIANCE	CURRENT YTD	BUDGET YTD	VARIANCE	PRIOR YR YTD	VARIANCE
FIXED COSTS								
Other Indirect Cost	0	0	0	0	0	0	(1,867)	(1,867)
Depreciation	70,088	81,054	10,966	963,150	972,651	9,501	966,641	3,491
Management Fees	100,900	100,900	0	1,210,800	1,210,800	0	956,880	(253,920)
Capital Charge	205,368	211,163	5,795	2,569,560	2,533,960	(35,600)	2,559,506	(10,054)
TOTAL FIXED COSTS	**376,356**	**393,118**	**16,761**	**4,743,510**	**4,717,411**	**(26,099)**	**4,481,160**	**(262,350)**
INCOME BEFORE TAXES	**1,012,017**	**905,970**	**106,047**	**14,634,732**	**13,615,819**	**1,018,914**	**13,774,690**	**860,043**

LAKESIDE HOSPITAL
BALANCE SHEET
For Periods Ending December 31, 2014

		Dec 2013 BALANCE	Dec 2014 BALANCE
	ASSETS		
{BH BA CASH}	CASH	(161,742)	(99,088)
{BH BA PT AR}	PATIENT A/R	8,408,340	7,965,277
{BH BA ALLOW PT BD}	ALLOWANCE FOR PT BAD DEBT	(297,985)	(226,278)
{BH BA ALL OTH BD}	ALLOWANCE FOR OTHER BAD DEBT	10,656	(11,672)
	TOTAL ALLOWANCE FOR BAD DEBT	(287,329)	(237,950)
{BH BA MC CA}	MEDICARE CONTRACTUAL ALLOWANCE	(993,964)	(810,882)
{BH BA MC REIMB}	MEDICARE NET DRG REIMBURSEMENT	178,220	368,437
{BH BA MC OP CA}	MEDICARE OP CONTRACTUAL ALLOWANCE	(14,450)	(14,250)
{BH BA OTH ACCR CA}	OTHER CONTRACTUALS CURRENT	(1,909,226)	(1,856,111)
{BH BA CST RPT}	COST REPORT RECEIVABLES	684,376	636,536
{BH BA OTH CUR AR}	OTHER A/R CURRENT	453,536	58,005
{BH BA INVENTORY}	INVENTORY	142,610	145,787
{BH BA PREPAID\EXP}	PREPAIDS	83,042	73,426
	TOTAL CURRENT ASSETS	**6,583,412**	**6,229,187**
{BH BA LAND}	LAND	2,430,000	2,430,000
{BH BA LAND IMPR} + {BH BA	BUILDINGS & IMPROVEMENTS	13,301,646	13,617,295
{BH BA EQUIPMENT}	EQUIPMENT	4,302,727	4,459,142
{BH BA CIP} + {BH BA FA ADDI	CONSTRUCTION-IN-PROGRESS	25,614	9,886
	TOTAL FIXED ASSETS	20,059,988	20,516,323
{BH BA ACCU DEP BI} + {BH BA	ACC DEPR-BUILDING & IMPROVEMENTS	(7,188,832)	(7,842,450)
{BH BA ACCU DEP EQ}	ACC DEPR-EQUIPMENT	(2,776,132)	(3,085,664)
	TOTAL ACCR DEPRECIATION	(9,964,964)	(10,928,114)
{BH BA GOODWILL}	GOODWILL	5,220,025	5,220,025
	TOTAL ASSETS	**21,898,461**	**21,037,422**

LAKESIDE HOSPITAL
BALANCE SHEET
For Periods Ending December 31, 2014

		Dec 2013 BALANCE	Dec 2014 BALANCE
	LIABILITIES & EQUITY		
{BH BL AP}	ACCOUNTS PAYABLE	770,456	901,891
{BH BL ACCR PR}	ACCRUED PAYROLL	783,180	978,826
{BH BL ACCR VAC}	ACCRUED VACATION	662,881	774,493
{BH BL ACCR BENEFIT}	ACCRUED BENEFITS	0	72
{BH BL ACC EMP BON}	ACCRUED EMPLOYEE BONUS	33,500	33,500
	TOTAL ACCRUED COMPENSATION	1,479,560	1,786,891
{BH BL ACC TAX}	ACCRUED TAXES OTHER THAN INCOME	256,741	482,452
{BH BL OTH ACCR EXP}	OTHER ACCRUED EXPENSES	0	65,424
	TOTAL CURRENT LIABILITIES	**2,506,757**	**3,236,659**
{BH BL LTD}	LONG TERM DEBT	3,504,000	3,066,000
{BH BL DUE OTHER}	DUE TO/FROM OTHER	141,219	208,788
{BH BL DUE UHS}	INTERCOMPANY REC/PAYABLE	(82,184,394)	(100,778,393)
	TOTAL LIABILITIES	**(76,032,418)**	**(94,266,947)**
{BH BE COM STOCK}	COMMON STOCK	10	10
{BH BE RE}	RETAINED EARNINGS	84,156,179	100,669,626
(410000:699399) + (999995:999999	CURRENT INCOME	13,774,690	14,634,732
	TOTAL EQUITY	**97,930,879**	**115,304,368**
	TOTAL LIABILITIES & EQUITY	**21,898,461**	**21,037,422**

C. Orderly Development 7(c)

Licensing and Accreditation Inspections

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

LICENSE

THE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES GRANTS THIS FULL LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

UHS OF LAKESIDE, LLC

(Name of Licensee)

TO OPERATE A FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE PROVISION OF MENTAL HEALTH, PERSONAL SUPPORT, OR ALCOHOL AND DRUG ABUSE SERVICES:

Lakeside Behavioral Health System

(Name of Facility or Service as Known to the Public)

2911 Brunswick Road, Memphis, TN 38133

(Street Address or Location, City or Town)

THE LICENSEE HAS DEMONSTRATED COMPLIANCE WITH T.C.A. TITLE 33, CHAPTER 2, PART 4 AND WITH RULES OF THE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING DISTINCT CATEGORY OF FACILITY OR SERVICES TO BE PROVIDED.

License Category	Accessible to mobile, non-ambulatory individuals	Approved for persons		Capacity
		hearing loss	vision loss	
Alcohol & Drug Non-Residential Rehabilitation Treatment	Y	Y	Y	n/a
Alcohol & Drug Residential Detoxification Treatment	Y	Y	Y	5
Alcohol & Drug Residential Rehabilitation Treatment	Y	Y	Y	10
Alcohol & Drug Residential Treatment for Children & Youth	Y	Y	Y	5

January 01, 2015	December 31, 2015	L000000015712
Effective Date	Date License Expires	License Number

Commissioner of Mental Health and Substance Abuse Services

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

15712

Site ID. 2248

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

LICENSE

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UHS OF LAKESIDE, LLC

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THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING DISTINCT CATEGORY OF FACILITY OR SERVICES TO BE PROVIDED.

License Category	Accessible to mobile, non-ambulatory individuals	Approved for persons with hearing loss	Approved for persons with vision loss	Capacity
Mental Health Adult Day Treatment Services	Y	Y	Y	n/a
Mental Health Adult Residential Treatment	Y	Y	Y	10
Mental Health Crisis Stabilization Unit	Y	Y	Y	8
Mental Health Hospital	Y	n/a	n/a	261
Mental Health Outpatient Facility	Y	Y	Y	n/a
Mental Health Partial Hospitalization Facility	Y	Y	Y	n/a
Mental Health Residential Treatment for Children & Youth	Y	Y	Y	20
MH Intensive Day Treatment for Children & Adolescents	Y	Y	Y	n/a

January 01, 2015	December 31, 2015	L000000015586
Effective Date	Date License Expires	License Number

Commissioner of Mental Health and Substance Abuse Services

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

15586

Site ID: 2248

Lakeside Behavioral Health System, LLC

Memphis, TN

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

Behavioral Health Care Accreditation Program

June 6, 2013

Accreditation is customarily valid for up to 36 months.

Rebecca J. Patchin, MD.
Chair, Board of Commissioners

Organization ID #: 1646
Print/Reprint Date: 09/25/13

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit, national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

This reproduction of the original accreditation certificate has been issued for use in regulatory/payer agency verification of accreditation by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current accreditation status and for a listing of the organization's locations of care.

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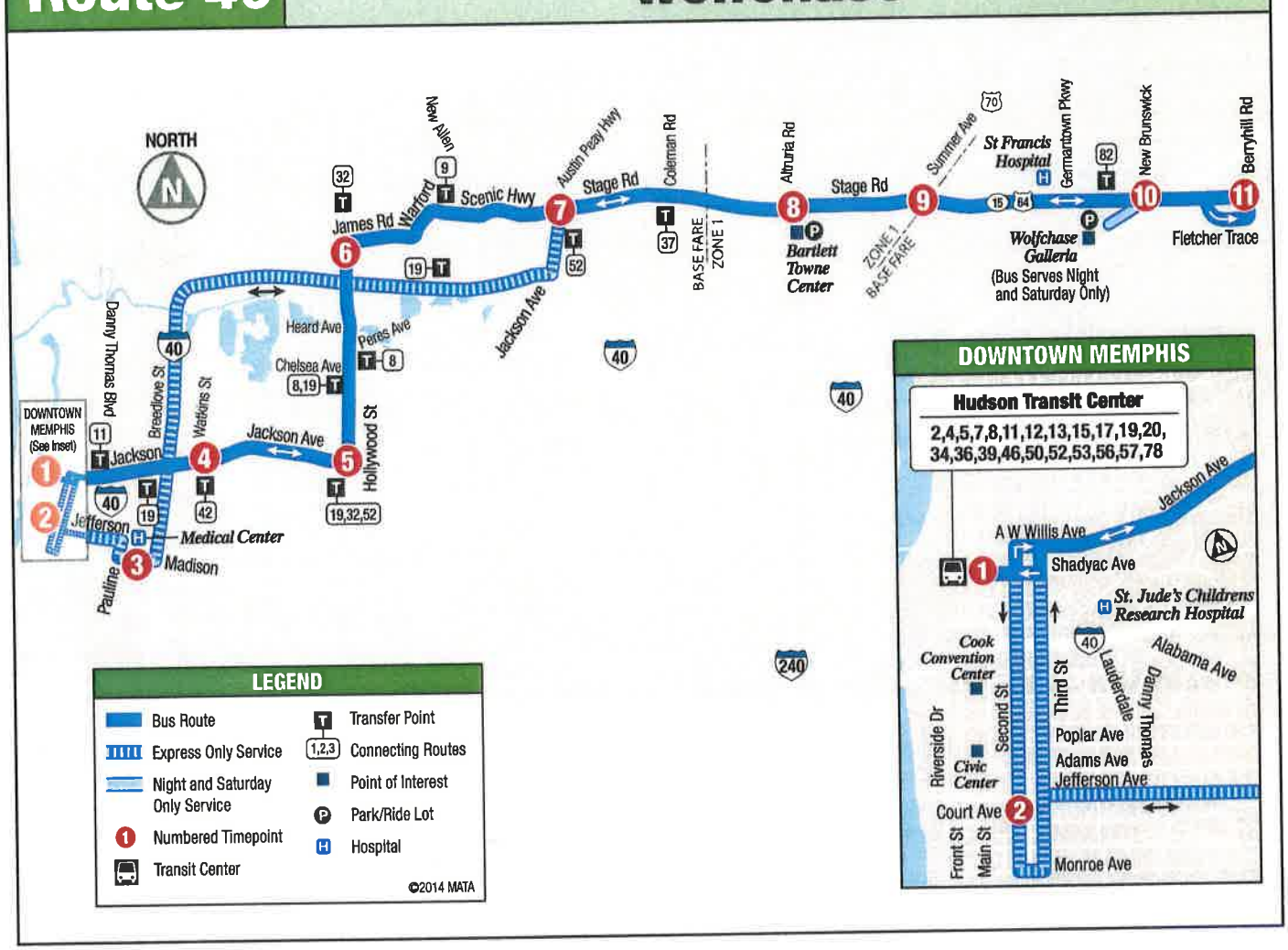
Miscellaneous Information

Route 40 Wolfchase



MONDAY – FRIDAY • OUTBOUND FROM DOWNTOWN

	1 Hudson Transit Center	2 Second St at Court Sq	3 Jefferson at Pauline	4 Jackson Ave at Watkins St	5 Jackson Ave at Hollywood	6 James Rd at Hollywood	7 Jackson Ave at Stage Rd	8 Stage Rd at Altruria Rd	9 Stage Rd at Hwy 70	10 New Brunswick at Stage Rd	11 Berryhill Rd at Stage Rd
AM	5:39	—	—	5:51	5:59	6:07	6:16	6:28	6:35	6:46	6:53
	6:50	—	—	7:02	7:10	7:18	7:27	7:39	7:46	7:57	8:04
	7:50	—	—	8:02	8:10	8:18	8:27	8:39	8:46	8:57	9:04
	9:20	—	—	9:32	9:40	9:48	9:57	10:09	10:16	10:27	10:34
	10:20	—	—	10:32	10:40	10:48	10:57	11:09	11:16	11:27	11:34
	11:50	—	—	12:02	12:10	12:18	12:27	12:39	12:46	12:57	1:04
PM	12:50	—	—	1:02	1:10	1:18	1:27	1:39	1:46	1:57	2:04
	2:20	—	—	2:32	2:40	2:48	2:57	3:09	3:16	3:27	3:34
	3:20	—	—	3:32	3:40	3:48	3:57	4:09	4:16	4:27	4:34
	4:50	4:54	5:02	—	—	—	5:22	5:34	5:41	5:52	5:59
	5:50	—	—	6:02	6:10	6:18	6:27	6:39	6:46	6:57	7:04
	7:15	—	—	7:24	7:31	7:40	7:49	8:00	8:04	8:14	—
	9:15	—	—	9:24	9:31	9:40	9:49	10:00	10:04	10:14	—
	11:15	—	—	11:24	11:31	11:40	11:49	12:00	12:04	12:14	—

Shaded trips indicate express service

MONDAY – FRIDAY • INBOUND TO DOWNTOWN

	11 Berryhill Rd at Stage Rd	10 New Brunswick at Stage Rd	9 Stage Rd at Hwy 70	8 Stage Rd at Altruria Rd	7 Jackson Ave at Stage Rd	6 James Rd at Hollywood	5 Jackson Ave at Hollywood	4 Jackson Ave at Watkins St	3 Jefferson at Pauline	1 Hudson Transit Center
AM	5:56	6:02	6:10	6:16	6:26	—	—	—	6:41	6:50
	6:56	7:02	7:10	7:16	7:26	—	—	—	7:41	7:50
	8:07	8:15	8:25	8:32	8:44	8:53	9:03	9:10	—	9:20
	9:07	9:15	9:25	9:32	9:44	9:53	10:03	10:10	—	10:20
	10:37	10:45	10:55	11:02	11:14	11:23	11:33	11:40	—	11:50
	11:37	11:45	11:55	12:02	12:14	12:23	12:33	12:40	—	12:50
PM	1:07	1:15	1:25	1:32	1:44	1:53	2:03	2:10	—	2:20
	2:07	2:15	2:25	2:32	2:44	2:53	3:03	3:10	—	3:20
	3:37	3:45	3:55	4:02	4:14	4:23	4:33	4:40	—	4:50
	4:37	4:45	4:55	5:02	5:14	5:23	5:33	5:40	—	5:50
	6:02	6:10	6:20	6:27	6:39	6:48	6:58	7:05	—	7:15
	7:07	7:14	7:23	7:30	7:41	7:50	7:57	8:05	—	8:15
	—	8:17	8:26	8:30	8:42	8:50	8:58	9:05	—	9:15
	—	10:17	10:26	10:30	10:42	10:50	10:58	11:05	—	11:15

Shaded trips indicate express service

SATURDAY • OUTBOUND FROM DOWNTOWN

	1 Hudson Transit Center	4 Jackson Ave at Watkins St	5 Jackson Ave at Hollywood	6 James Rd at Hollywood	7 Jackson Ave at Stage Rd	8 Stage Rd at Altruria Rd	9 Stage Rd at Hwy 70	10 New Brunswick at Stage Rd
AM	7:30	7:37	7:42	7:48	7:54	8:02	8:05	8:14
	8:15	8:24	8:31	8:40	8:49	9:00	9:04	9:14
	9:15	9:24	9:31	9:40	9:49	10:00	10:04	10:14
	10:15	10:24	10:31	10:40	10:49	11:00	11:04	11:14
	11:15	11:24	11:31	11:40	11:49	12:00	12:04	12:14
PM	12:15	12:24	12:31	12:40	12:49	1:00	1:04	1:14
	1:15	1:24	1:31	1:40	1:49	2:00	2:04	2:14
	2:15	2:24	2:31	2:40	2:49	3:00	3:04	3:14
	3:15	3:24	3:31	3:40	3:49	4:00	4:04	4:14
	4:15	4:24	4:31	4:40	4:49	5:00	5:04	5:14
	5:15	5:24	5:31	5:40	5:49	6:00	6:04	6:14
	6:15	6:24	6:31	6:40	6:49	7:00	7:04	7:14
	7:15	7:23	7:29	7:37	7:46	7:56	8:00	8:10

SATURDAY • INBOUND TO DOWNTOWN

	10 New Brunswick at Stage Rd	9 Stage Rd at Hwy 70	8 Stage Rd at Altruria Rd	7 Jackson Ave at Stage Rd	6 James Rd at Hollywood	5 Jackson Ave at Hollywood	4 Jackson Ave at Watkins St	1 Hudson Transit Center
AM	8:17	8:26	8:30	8:42	8:50	8:58	9:05	9:15
	9:17	9:26	9:30	9:42	9:50	9:58	10:05	10:15
	10:17	10:26	10:30	10:42	10:50	10:58	11:05	11:15
	11:17	11:26	11:30	11:42	11:50	11:58	**12:05**	**12:15**
PM	**12:17**	**12:26**	**12:30**	**12:42**	**12:50**	**12:58**	**1:05**	**1:15**
	1:17	**1:26**	**1:30**	**1:42**	**1:50**	**1:58**	**2:05**	**2:15**
	2:17	**2:26**	**2:30**	**2:42**	**2:50**	**2:58**	**3:05**	**3:15**
	3:17	**3:26**	**3:30**	**3:42**	**3:50**	**3:58**	**4:05**	**4:15**
	4:17	**4:26**	**4:30**	**4:42**	**4:50**	**4:58**	**5:05**	**5:15**
	5:17	**5:26**	**5:30**	**5:42**	**5:50**	**5:58**	**6:05**	**6:15**
	6:17	**6:26**	**6:30**	**6:42**	**6:50**	**6:58**	**7:05**	**7:15**
	7:17	**7:26**	**7:30**	**7:42**	**7:50**	**7:58**	**8:05**	**8:15**
	8:17	**8:26**	**8:30**	**8:42**	**8:50**	**8:58**	**9:05**	**9:15**

SUNDAY • OUTBOUND FROM DOWNTOWN

	1 Hudson Transit Center	4 Jackson Ave at Watkins St	5 Jackson Ave at Hollywood	6 James Rd at Hollywood	7 Jackson Ave at Stage Rd	8 Stage Rd at Altruria Rd	9 Stage Rd at Hwy 70	10 New Brunswick at Stage Rd
AM	10:15	10:24	10:31	10:40	10:49	11:00	11:04	11:14
PM	**12:15**	**12:24**	**12:31**	**12:40**	**12:49**	**1:00**	**1:04**	**1:14**
	2:15	**2:24**	**2:31**	**2:40**	**2:49**	**3:00**	**3:04**	**3:14**
	4:15	**4:24**	**4:31**	**4:40**	**4:49**	**5:00**	**5:04**	**5:14**

SUNDAY • INBOUND TO DOWNTOWN

	10 New Brunswick at Stage Rd	9 Stage Rd at Hwy 70	8 Stage Rd at Altruria Rd	7 Jackson Ave at Stage Rd	6 James Rd at Hollywood	5 Jackson Ave at Hollywood	4 Jackson Ave at Watkins St	1 Hudson Transit Center
AM	11:17	11:26	11:30	11:42	11:50	11:58	**12:05**	**12:14**
PM	**1:17**	**1:26**	**1:30**	**1:42**	**1:50**	**1:58**	**2:05**	**2:14**
	3:17	**3:26**	**3:30**	**3:42**	**3:50**	**3:58**	**4:05**	**4:14**
	5:17	**5:26**	**5:30**	**5:42**	**5:50**	**5:58**	**6:05**	**6:14**

Legal Notices: Shelby County 523

SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on May 29, 2015 on or about 10:00 A.M. local time, at the Southwest Corner, Adams Avenue Entrance of the Shelby County Courthouse, Memphis, Tennessee, conducted by the Substitute Trustee as identified and set forth herein below, pursuant to Deed of Trust executed by RICHARD LEVANGIE AND KIMBERLY M. TOMA-LEVANGIE, to Rhonda Sunby, Trustee, on October 31, 2002, as instrument No. 02178240 in the real property records of Shelby County Register's Office, Tennessee.

Owner of Debt: THE BANK OF NEW YORK MELLON TRUST COMPANY, N.A., AS SUCCESSOR-IN-INTEREST TO ALL PERMITTED SUCCESSORS AND ASSIGNS OF BANK ONE, NATIONAL ASSOCIATION, AS TRUSTEE FOR CERTIFICATE HOLDERS OF CARRINGTON

[illegible] each parcel is not part of the legal description of the property sold herein and in the event of any discrepancy, the legal description referenced herein shall control.

SALE IS SUBJECT TO OCCUPANTS' RIGHTS IN POSSESSION

THE RIGHT IS RESERVED TO ADJOURN THE DAY OF THE SALE TO ANOTHER DAY, TIME AND PLACE CERTAIN WITHOUT FURTHER PUBLICATION, UPON ANNOUNCEMENT AT THE TIME AND PLACE FOR THE SALE SET FORTH ABOVE. THE TRUSTEE/SUBSTITUTE TRUSTEE RESERVES THE RIGHT TO RESCIND THE SALE IF THE SALE IS SET ASIDE FOR ANY REASON. THE PURCHASER AT THE SALE SHALL BE ENTITLED ONLY TO A RETURN OF THE DEPOSIT PAID. THE PURCHASER SHALL HAVE NO FURTHER RECOURSE AGAINST THE GRANTOR, THE GRANTEE, OR THE TRUSTEE.

OTHER INTERESTED PARTIES: GREEN TREE SERVICING LLC AND ACCELERATED VENTURES, LLC

THIS IS AN ATTEMPT TO COLLECT A DEBT AND ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

If applicable, the notice requirements of T.C.A. 35-5-112 have been met.

All right of equity of redemption, statutory and otherwise, and homestead are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee.

If the U.S. Department of Treasury/IRS, the State of Tennessee Department of Revenue, or the State of Tennessee Department of Labor or Workforce Development are listed as Interested Parties in the advertisement, then the Notice of this foreclosure is being given to them and the sale will be subject to [illegible]

Legal Notices: Shelby County 523

the applicable governmental entities' right to redeem the property as required by 26 U.S.C. 7425 and T.C.A. §67-1-1433.

This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded at any time. If the sale is set aside for any reason, the Purchaser at the sale shall be entitled only to a return of the deposit paid. The Purchaser shall have no further recourse against the Mortgagor, the Mortgagee or the Mortgagee's attorney.

M.W.ZM File No. 15-001010-670

JASON S. MANGRUM, J.P. SELLER'S

LORI LIANE LONG, Substitute Trustee(s)

PREMIER BUILDING, SUITE 404

2217 MARYLAND WAY

BRENTWOOD, TN 37027

PHONE: (615) 228-3630

EMAIL: [illegible]

Legal Notices: General 526

ALL INTERESTED BIDDERS

The Board of Education of the Shelby County Schools will accept written bids for a Chiller Replacement @ Keystone Elementary and Modular Classroom Installation @ Barrett's Chapel Elementary.

Visit our website for additional information: http://www.scsk12.org/vf/procurement/bids.php

Questions concerning Bid/RFP should be addressed to Wendy Parties, (901) 416-5533 or emailed to parwenw@scsk12.org

Thank you for supporting Shelby County Schools.

Curtis Butler, Director
Procurement Services

ALL INTERESTED BIDDERS

The Shelby County Board of [illegible]

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1607 (c) (1) and the Rules of the Health Services and Development Agency, that:

UHS of Lakeside, LLC, d/b/a Lakeside Behavioral Health System, a psychiatric hospital, with an ownership type of Limited Liability Company, owned and managed by Universal Health Services, Inc., intends to file an Application for a Certificate of Need for construction of a new 48-bed Geriatric building in Memphis, Tennessee (Shelby County), into which existing licensed psychiatric beds will be moved. The capital cost is estimated at $9,593,296. The building will be constructed on the northeast section of the campus owned by the facility located at 2911 Brunswick Road. No additional acute beds are requested with the application. The project does not add any major medical equipment or initiate or discontinue any other health service.

The anticipated date of filing the application is on or before May 15, 2015. The contact person for the project is Anna Joy Sobkin, who may be reached at Lakeside Behavioral Health System, 2911 Brunswick Road, Memphis, TN 38133; (901) 372-4774.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for a hearing should be sent to:

Health Services and Development Agency
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Pursuant to TCA § 68-11-1607 (c) (1); (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Transportation

903 - Airplanes & Related Services
905 - ATV & Go-Karts, Motorcycles
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955 - Trucks, Buses & Vans
960 - Automobiles For Sale

Trucks, SUV's and Vans 955

CADILLAC '13 Escalade Luxury, white, 38K miles, #26121. Barbara Wright, 901-761-1900
BUD DAVIS CADILLAC

CADILLAC '14 Escalade, white, Luxury pkg, $58,964 incl $499 doc, excl tit. #26134. Alec, 901-388-7600
BUD DAVIS CADILLAC

CHEVROLET 2011, Silverado, Quad-Cab, 4-WD, bedliner. Just turned 34K mi.; adult owned. $26,000. Call: 901-837-4525

GMC '07 SLE YUKON XL Garaged, 1 owner, 95,400 mil, new tires (85/14), Blue Book priced at $15,566. 901-751-2070, 409-8771

PLYMOUTH '99 Voyager Burgundy ext., Good Body, Good Tires, Needs Work, $1000. 901-857-8837

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PAULA'S BACK!

COLLIERVILLE AUTO CENTER
Welcomes Paula Keltner
To the Sales Staff!

2012 Mercedes E350 Sport 4M, 21K miles.....$31,895

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CADILLAC '77 Deville, less than 39K miles, garage kept, great shape/condition, $4500. Call 443-890-8843

CHEVROLET '12 Impala, lots of equipment, $15,988 incl $499 doc, excl tit. Call Keith, 901-218-9105
BUD DAVIS CADILLAC

CHEVROLET '13 MALIBU & CRUZE! Several to choose from. Jesse, 901-761-1900
BUD DAVIS CADILLAC

CHEVROLET '14 Corvette, black, black leather, Nav, heads up, #26859. Stephen, 901-388-4946
BUD DAVIS CADILLAC

MASERATI '91, red convertible w/two tops, 41,000 miles.

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Support Letters

THE UNIVERSITY of TENNESSEE
HEALTH SCIENCE CENTER

COLLEGE of MEDICINE

Department of Psychiatry
920 Madison Avenue, 2nd Floor
Memphis, TN 38163
Phone: (901) 448-2400
Fax: (901) 448-1684

May 05, 2015

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

RE: Lakeside Behavioral Health System –New Construction-Geriatric Building

Dear. Ms. Hill:

On behalf of The University of Tennessee College of Medicine, Department of Psychiatry, I want to express our strong support for Lakeside's CON application to build a new Geriatric building on their campus. Lakeside is a premier facility providing specialized behavioral health and addictive disease services for over 45 years. Lakeside has a strong reputation with patients and families as well as medical-surgical hospitals, physician practices, nursing homes and assisted living facilities in Shelby County, West Tennessee and Northern, MS.

The University of Tennessee College of Medicine, Department of Psychiatry began working with Lakeside in July 2014 through a Graduate Medical Education Affiliation Agreement. The Resident and Fellow rotations have been very successful to date with very positive feedback from those assigned to Lakeside.

The need for mental health resources for the aging population is acute. In fact in their September 2013 factsheet, the World Health Organization stated older adults, those aged 60 or above, increased from 9.2 percent in 1990 to 11.7 percent in 2013, and will continue to grow to an estimated 21.1 percent by 2050. While many have good mental health, over 20% of adults aged 60 and over suffer from a mental or neurological disorder. The most common neuropsychiatric disorders in this age group include depression along with anxiety disorders and some substance use problems. Unfortunately around a quarter of deaths are from self-harm from those aged 60 or above.

Mental health problems are often under-identified by health-care professionals and older people themselves, and the stigma surrounding mental illness makes people reluctant to seek help. Many are reluctant to go for help due to the fear associated with mental disorders and lack of trust in the quality and effectiveness of treatment. Prompt recognition and treatment are essential which includes both psychosocial interventions and medications. Lakeside has both the psychiatric and medical expertise, as well as a solid reputation, of providing care for this increasing vulnerable population.

Lakeside is known for managing not only the mental health needs of their patients but also managing medical issues that the patient may have during the course of their treatment such as the need for IV hydration.

Lakeside is currently providing care for our aging population on two units on their campus. We definitely value the need for this new building, and enthusiastically endorse Lakeside's CON application. A single building designed to care for individuals seeking mental health care who may also require some assistance with activities of daily living clearly supports the orderly development of healthcare in West Tennessee. Please feel free to contact me with any questions.

Sincerely,

James A. Greene, M.D.
Chairman, Psychiatry
College of Medicine

KIRBY PINES
FOUNDATION

Thomas A. O'Malley
6465 N. Quail Hollow Rd.
Suite 400
Memphis, TN 38120

May 5, 2015

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

RE: Lakeside Behavioral Health Systems – New Construction – Geriatric Care Facility

Dear Ms. Melanie Hill:

I am writing this letter to offer my recommendation for Lakeside Behavioral Health Systems and the development of their new Geriatric Facility, mainly as someone that has used the services of Lakeside.

I want to express my strong support for Lakeside's CON application to build a new Geriatric facility on their campus. Lakeside is a premier facility providing specialized behavioral health and addictive disease services for over 45 years. As a lifelong Memphian, Lakeside has a strong reputation with patients and families as well as medical-surgical hospitals, physician practices, nursing homes and assisted living facilities in Shelby County, West Tennessee and Northern, MS.

Lakeside is known for managing not only the mental health needs of their patients but also managing medical issues that the patient may have during the course of their treatment such as their medicine management. I speak as someone that has used Lakeside in the past, my [redacted] was admitted to Lakeside in 2012 from her assisted living facility [redacted]. It was frustrating with the staff of [redacted] because they were not skilled in the diagnosis and treatment of a geriatric patient that had vascular dementia. The only solution that we were able to agree on was observation and treatment at Lakeside. This decision was based on feedback from those who I know in the business of geriatric support. [redacted] was aware of her surroundings. However, it was the treatment from Lakeside and in service training that assisted my family [redacted] and return to [redacted] both family and patient satisfaction was strong for the overall treatment provided.

Lakeside at this time is providing care for more of the Memphis aging population on two units on their campus. I definitely see not only the value but the need for this new building, and enthusiastically endorse Lakeside's CON application.

I am also a leader in the local geriatric community by providing assistance to residents at Kirby Pines as well as local Veterans in acquiring Veterans Benefits. A single building designed to care for individuals seeking mental health care who may also require some assistance with activities of daily living clearly supports the orderly development of healthcare in West Tennessee. Please feel free to contact me with any questions.

Sincerely,

Thomas A. O'Malley
Foundation Director
Kirby Pines Foundation
tomalley@kirbypines.com
901.568.0643
fax: 901.363.3894

TAO\me

ATTENDANT CARE SERVICES
GERIATRIC CARE SOLUTIONS

April 30, 2015

Ms. Joy Golden
Chief Executive Officer
Lakeside Behavioral Health System
2911 Brunswick Road
Memphis ,TN 38133

RE: Support for new geriatric building

Dear Ms. Golden:

As a practicing geriatric care manager since 1999 in the Memphis and Shelby County area, I am accurately aware of the need for quality inpatient psychiatric care for our geriatric population. Lakeside is my facility of choice for inpatient geriatric psychiatric treatment. A new geriatric specific building on the Lakeside campus employing the latest design and care components will afford even better treatment options for this vulnerable population.

I welcome the day that I will be able to refer my clients to this new unit. This endeavor has my full support.

Regards,

Kathryn Feinstone, LCSW, NCGC
Owner and President
Attendant Care Services, Inc

4515 Poplar Avenue, Suite 327 • Memphis, TN 38117
Office Phone: (901) 685-3911 • Fax: (901) 685-3915

KIRBY PINES
FOUNDATION

Thomas A. O'Malley
6465 N. Quail Hollow Rd.
Suite 400
Memphis, TN 38120

May 5, 2015

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

RE: Lakeside Behavioral Health Systems – New Construction – Geriatric Care Facility

Dear Ms. Melanie Hill:

I am writing this letter to offer my recommendation for Lakeside Behavioral Health Systems and the development of their new Geriatric Facility, mainly as someone that has used the services of Lakeside.

I want to express my strong support for Lakeside's CON application to build a new Geriatric facility on their campus. Lakeside is a premier facility providing specialized behavioral health and addictive disease services for over 45 years. As a lifelong Memphian, Lakeside has a strong reputation with patients and families as well as medical-surgical hospitals, physician practices, nursing homes and assisted living facilities in Shelby County, West Tennessee and Northern, MS.

Lakeside is known for managing not only the mental health needs of their patients but also managing medical issues that the patient may have during the course of their treatment such as their medicine management. I speak as someone that has used Lakeside in the past, my [redacted] was admitted to Lakeside in 2012 from her assisted living facility [redacted]. It was frustrating with the staff of [redacted] because they were not skilled in the diagnosis and treatment of a geriatric patient that had vascular dementia. The only solution that we were able to agree on was observation and treatment at Lakeside. This decision was based on feedback from those who I know in the business of geriatric support. [redacted] was aware of her surroundings. However, it was the treatment from Lakeside and in service training that assisted my family [redacted] and return to [redacted] both family and patient satisfaction was strong for the overall treatment provided.

Pathways
Behavioral Health Services™

An affiliate of West Tennessee Healthcare

April 29, 2015

To Whom It May Concern:

This letter is presented in support of the Lakeside's CON application to build a new Geriatric Unit on their campus. Pathways has worked with Lakeside a number of years, and we have enjoyed the professional working relationship extended to our team.

Pathway's objective is to provide the highest level of quality care and customer service, and to exceed the expectations of our patients and their family members. By partnering with organizations sharing the same philosophy, a patient's treatment goals and customer service expectations can be met. Through our work with Lakeside, we know they provide individualized, safe, timely, comprehensive, and well documented treatment for the patients in our community entrusted in their care.

Lakeside is known for managing not only the mental health needs of their patients but also managing medical issues that the patient may have during the course of their treatment. Based on feedback from those we have referred to Lakeside both family and patient satisfaction is strong for the overall treatment provided.

We are aware Lakeside is currently providing care for Geriatric patients on two units on their campus. We definitely value the need for this new Geriatric building, and strongly recommend approval of Lakeside's CON application. A Geriatric building designed to care for individuals seeking mental health care who may also require some assistance with activities of daily living clearly supports the orderly development of healthcare in West Tennessee. Please feel free to contact me with any questions.

Sincerely,

Pam Henson

Pam Henson, LPC
Executive Director

JACKSON CORPORATE OFFICE
238 Summar Drive • Jackson, Tennessee 38301 • (731)-541-8200 • FAX: (731)-541-8327

Date: May 4, 2015

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

RE: Lakeside Behavioral Health System –New Construction-Geriatric Building

Dear. Ms. Hill:

On behalf of Foxbridge Assisted Living & Memory Care Community, I want to express our strong support for Lakeside's CON application to build a new Geriatric building on their campus. Lakeside is a premier facility providing specialized behavioral health and addictive disease services for over 45 years. Lakeside has a strong reputation with patients and families as well as medical-surgical hospitals, physician practices, nursing homes and assisted living facilities in Shelby County, West Tennessee and Northern, MS.

Lakeside is known for managing not only the mental health needs of their patients but also managing medical issues that the patient may have during the course of their treatment such as the need for IV hydration. Based on feedback from those who have referred to Lakeside, both family and patient satisfaction is strong for the overall treatment provided.

Lakeside is currently providing care for our aging population on two units on their campus. We definitely value the need for this new building, and enthusiastically endorse Lakeside's CON application. A single building designed to care for individuals seeking mental health care who may also require some assistance with activities of daily living clearly supports the orderly development of healthcare in West Tennessee.

In closing, let me add that Lakeside is the closest Behavioral Health Services to Foxbridge and extremely convenient to our families. Lakeside has always given our residents excellent service. Please feel free to contact me with any questions.

Sincerely,

Kathy Garbus

Kathy Garbus
Executive Director

PHONE (901) 377-0101 • FAX (901) 377-6841
www.foxbridge.org
2180 MANGUM ROAD • MEMPHIS, TENNESSEE 38134

Regional One Health

April 29, 2015

RE: Lakeside Behavioral Health System –Letter of Support for New Geriatric Building

This letter is presented in support of the Lakeside's CON application to build a new Geriatric Unit on their campus. **Regional One** Health has worked with Lakeside a number of years, and we have enjoyed the professional working relationship extended to our team.

Regional One Health's objective is to provide the highest level of quality care and customer service, and to exceed the expectations of our patients and their family members. By partnering with organizations sharing the same philosophy, a patient's treatment goals and customer service expectations can be met. Through our work with Lakeside, we know they provide individualized, safe, timely, comprehensive, and well documented treatment for the patients in our community entrusted in their care.

Lakeside is known for managing not only the mental health needs of their patients but also managing medical issues that the patient may have during the course of their treatment. Based on feedback from those we have referred to Lakeside both family and patient satisfaction is strong for the overall treatment provided.

We are aware Lakeside is currently providing care for Geriatric patients on two units on their campus. We definitely value the need for this new Geriatric building, and strongly recommend approval of Lakeside's CON application. A Geriatric building designed to care for individuals seeking mental health care who may also require some assistance with activities of daily living clearly supports the orderly development of healthcare in West Tennessee. Please feel free to contact me with any questions at (901) 545-6763.

Sincerely,

Rob Sumter, PhD
Executive VP and COO/**Regional One** Health

Reginald Coopwood, MD
President and CEO/**Regional One** Health

SENIOR RESOURCE CONSULTANTS, LLC
A Geriatric Care Consulting Service

Date: April 28, 2015

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

RE: Lakeside Behavioral Health System –New Construction-Geriatric Building

Dear. Ms. Hill:

On behalf of Senior Resource Consultants, I want to express our strong support for Lakeside's CON application to build a new Geriatric building on their campus. Lakeside is a premier facility providing specialized behavioral health and addictive disease services for over 45 years. Lakeside has a strong reputation with patients and families as well as medical-surgical hospitals, physician practices, nursing homes and assisted living facilities in Shelby County, West Tennessee and Northern, MS.

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Sincerely,
Phyllis Kallaher, RNCC 901 409-3349
Pat Smith, MS, LPC 901 262-5425

QUINCO
Mental Health Centers
Real Help. Real Close.

10710 Old Highway 64 • Bolivar, TN 38008
Voice: 731-658-6113 • Fax: 731-658-6165

Date: May 6, 2015

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

RE: Lakeside Behavioral Health System –New Construction-Geriatric Building

Dear. Ms. Hill:

On behalf of Quinco Mental Health Inc, I want to express our strong support for Lakeside's CON application to build a new Geriatric building on their campus. Lakeside is a premier facility providing specialized behavioral health and addictive disease services for over 45 years. Lakeside has a strong reputation with patients and families as well as medical-surgical hospitals, physician practices, nursing homes and assisted living facilities in Shelby County, West Tennessee and Northern, MS.

Mental health problems are often under-identified by health-care professionals and older people themselves, and the stigma surrounding mental illness makes people reluctant to seek help. Many are reluctant to go for help due to the fear associated with mental disorders and lack of trust in the quality and effectiveness of treatment. Prompt recognition and treatment are essential which includes both psychosocial interventions and medications. Lakeside has both the psychiatric and medical expertise, as well as a solid reputation, of providing care for this increasing vulnerable population. Based on feedback from those who have referred to Lakeside, both family and patient satisfaction is strong for the overall treatment provided.

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Sincerely,

Jeff Helton LPC-MHSP
Quinco Crisis Director

MAY 14 '15 PM2:59

Carey Counseling Center, Inc.

☐ 408 Virginia Street
P. O. Box 30
Paris, TN 38242
(731) 642-0521

☐ 1263 Hwy. 45 ByPass N.
P. O. Box 439
Trenton, TN 38382
(731) 855-2871

☐ 19410 W. Main Street
P. O. Box 793
Huntingdon, TN 38344
(731) 986-4411

☐ 300 Highway 641
P. O. Box 207
Camden, TN 38320
(731) 584-6999

☐ 201 W. Main, Suite C
P. O. Box 186
Union City, TN 38281
(731) 885-8810

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

May 7, 2015

RE: Lakeside Behavioral Health System –New Construction-Geriatric Building

Dear. Ms. Hill:

On behalf of Carey Counseling Center, I want to express our strong support for Lakeside's CON application to build a new Geriatric building on their campus. Lakeside is a premier facility providing specialized behavioral health and addictive disease services for over 45 years. Lakeside has a strong reputation with patients and families as well as medical-surgical hospitals, physician practices, nursing homes and assisted living facilities in Shelby County, West Tennessee and Northern, MS.

Mental health problems are often under-identified by health-care professionals and older people themselves, and the stigma surrounding mental illness makes people reluctant to seek help. Many are reluctant to go for help due to the fear associated with mental disorders and lack of trust in the quality and effectiveness of treatment. Prompt recognition and treatment are essential which includes both psychosocial interventions and medications. Lakeside has both the psychiatric and medical expertise, as well as a solid reputation, of providing care for this increasing vulnerable population. Based on feedback from those who have referred to Lakeside, both family and patient satisfaction is strong for the overall treatment provided.

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Sincerely,

Sean Jones, LCSW
Carey Counseling Center
Crisis Director

THE UNIVERSITY of TENNESSEE
HEALTH SCIENCE CENTER

COLLEGE of MEDICINE

Department of Psychiatry
920 Madison Avenue, 2nd Floor
Memphis, TN 38163
Phone: (901) 448-2400
Fax: (901) 448-1684

May 05, 2015

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

RE: Lakeside Behavioral Health System –New Construction-Geriatric Building

Dear. Ms. Hill:

On behalf of The University of Tennessee College of Medicine, Department of Psychiatry, I want to express our strong support for Lakeside's CON application to build a new Geriatric building on their campus. Lakeside is a premier facility providing specialized behavioral health and addictive disease services for over 45 years. Lakeside has a strong reputation with patients and families as well as medical-surgical hospitals, physician practices, nursing homes and assisted living facilities in Shelby County, West Tennessee and Northern, MS.

The University of Tennessee College of Medicine, Department of Psychiatry began working with Lakeside in July 2014 through a Graduate Medical Education Affiliation Agreement. The Resident and Fellow rotations have been very successful to date with very positive feedback from those assigned to Lakeside.

The need for mental health resources for the aging population is acute. In fact in their September 2013 factsheet, the World Health Organization stated older adults, those aged 60 or above, increased from 9.2 percent in 1990 to 11.7 percent in 2013, and will continue to grow to an estimated 21.1 percent by 2050. While many have good mental health, over 20% of adults aged 60 and over suffer from a mental or neurological disorder. The most common neuropsychiatric disorders in this age group include depression along with anxiety disorders and some substance use problems. Unfortunately around a quarter of deaths are from self-harm from those aged 60 or above.

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Lakeside is currently providing care for our aging population on two units on their campus. We definitely value the need for this new building, and enthusiastically endorse Lakeside's CON application. A single building designed to care for individuals seeking mental health care who may also require some assistance with activities of daily living clearly supports the orderly development of healthcare in West Tennessee. Please feel free to contact me with any questions.

Sincerely,

James A. Greene, M.D.
Chairman, Psychiatry
College of Medicine

QUINCO
Mental Health Centers
Real Help. Real Close.

10710 Old Highway 64 • Bolivar, TN 38008
Voice: 731-658-6113 • Fax: 731-658-6165

Date: May 6, 2015

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

RE: Lakeside Behavioral Health System –New Construction-Geriatric Building

Dear. Ms. Hill:

On behalf of Quinco Mental Health Inc, I want to express our strong support for Lakeside's CON application to build a new Geriatric building on their campus. Lakeside is a premier facility providing specialized behavioral health and addictive disease services for over 45 years. Lakeside has a strong reputation with patients and families as well as medical-surgical hospitals, physician practices, nursing homes and assisted living facilities in Shelby County, West Tennessee and Northern, MS.

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Sincerely,

Jeff Helton LPC-MHSP
Quinco Crisis Director

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

June 1, 2015

Anna J. Golden
Lakeside Behavioral Health
2911 Brunswick Road
Memphis, TN 38133

RE: Certificate of Need Application -- Lakeside Behavioral Health System - CN1505-019
Lakeside Behavioral Health seeks approval for a major construction project requiring a capital expenditure greater than $5 million. A 48-bed building will be constructed on campus to house geriatric psychatiric beds which will be relocated from another area of the campus. This project will not increase the licensed bed capacity of the hospital. The project cost is $9,393,796.

Dear Ms. Golden:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Marthagem Whitlock at the Tennessee Department of Mental Health and Substance Abuse Services for Certificate of Need review by the Division of Planning, Research, & Forensics. Ms. Whitlock or someone from her office may contact you for additional information or clarification while the application is under review by the Department. Ms. Whitlock's contact information is Marthagem.Whitlock@tn.gov or 615-532-6717.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on June 1, 2015. The first 60 days of the cycle are assigned to the Department of Mental Health and Substance Abuse Services, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the 60-day period, a written report from the Department or its representative will be forwarded to this office for Agency review within the 30-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on August 26, 2015.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(4) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(5) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

cc: Marthagem Whitlock, TDMHSAS, PRF

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Marthagem Whitlock, Assistant Commissioner of Planning, Research, & Forensics
TN Department of Mental Health and Substance Abuse Services
Division of Planning, Research & Forensics
Fifth Floor, Andrew Jackson Building
500 Deaderick Street
Nashville, TN 37243

FROM: Melanie M. Hill
Executive Director

DATE: June 1, 2015

RE: Certificate of Need Application
Lakeside Behavioral Health System - CN1505-019

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a 60-day review period to begin on June 1, 2015 and end on August 1, 2015.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: Anna J. Golden

LAKESIDE
BEHAVIORAL HEALTH SYSTEM

May 05, 2015

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

RE: Lakeside Behavioral Health System –New Construction-Geriatric Building

Dear Ms. Hill:

This letter transmits an original and two copies of Lakeside Behavioral Health System's Letter of Intent to build a new 48-bed Geriatric building on existing property owned by the facility.

I will be the designated contact person for the Lakeside project. Bryon Trauger, with Trauger and Tuke, Attorneys at Law, is the legal counsel who will be working with Lakeside.

We look forward to working with the Agency on this project.

Respectfully,

Anna Joy Golden

Anna Joy Golden, MSN, RN
CEO/Managing Director
Lakeside Behavioral Health System
2911 Brunswick Road
Memphis, TN 38133
901-377-4774

LETTER OF INTENT-HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Commercial Appeal, which is a newspaper of general circulation in Shelby County, Tennessee, on or before May 10, 2015, for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et. seq., and the Rules of the Health Services and Development Agency, that:

UHS of Lakeside, LLC., d/b/a Lakeside Behavioral Health System, a psychiatric hospital, with an ownership type of Limited Liability Company, owned and managed by Universal Health Services, Inc., intends to file an Application for a Certificate of Need for construction of a new 48-bed Geriatric building in Memphis, Tennessee (Shelby County), into which existing licensed psychiatric beds will be moved. The capital cost is estimated at $9,393,796. The building will be constructed on the northeast section of the campus owned by the facility located at 2911 Brunswick Road. No additional acute beds are requested with the application. The project does not add any major medical equipment or initiate or discontinue any other health service.

The anticipated date of filling the application is on or before May 15, 2015. The contact person for the project is Anna Joy Golden, who may be reached at Lakeside Behavioral Health System, 2911 Brunswick Road, Memphis, TN 38133; (901) 377-4774.

Anna Joy Golden	May 5, 2015	anna.golden@uhsinc.com
Signature	Date	(E-Mail Address)

Article to Run in the Commercial Appeal on Sunday May 10, 2015

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et. seq., and the Rules of the Health Services and Development Agency, that:

UHS of Lakeside, LLC., d/b/a Lakeside Behavioral Health System, a psychiatric hospital, with an ownership type of Limited Liability Company, owned and managed by Universal Health Services, Inc., intends to file an Application for a Certificate of Need for construction of a new 48-bed Geriatric building in Memphis, Tennessee (Shelby County), into which existing licensed psychiatric beds will be moved. The capital cost is estimated at $9,393,796. The building will be constructed on the northeast section of the campus owned by the facility located at 2911 Brunswick Road. No additional acute beds are requested with the application. The project does not add any major medical equipment or initiate or discontinue any other health service.

The anticipated date of filling the application is on or before May 15, 2015. The contact person for the project is Anna Joy Golden, who may be reached at Lakeside Behavioral Health System, 2911 Brunswick Road, Memphis, TN 38133; (901) 377-4774.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for a hearing should be sent to:

Health Services and Development Agency
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Pursuant to TCA § 68-11-1607 (c) (1); (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

SUPPLEMENTAL #1
May 22, 2015
11:56 am

COPY

SUPPLEMENTAL – 1

Lakeside Behavioral Health System

CN1505-019

SUPPLEMENTAL #1
May 22, 2015
11:56 am

May 22, 2015

Phillip M. Earhart, HSD Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Re: CON Application CN1505-019
Lakeside Behavioral Health System

Dear Mr. Earhart:

This letter responds to your recent request for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

1. **Section A, Applicant Profile Item 5**
   The applicant notes there will not be a management/operating entity. Please clarify the reason management fees are designated in the Historical Data Chart.
   RESPONSE:
   The expenses noted are revenues transferred to the parent company for the parent's centralized consulting and support of the hospital. Corporate support is provided in areas such as Accounting, Finance, Human Resources, Information Systems, Internal Audit, Legal Services, Regulatory Compliance, Quality Improvement, Risk Management, Reimbursement, and Insurance. Transfers are accounting transactions standard in a company that owns and operates a number of facilities. The fees are not a part of a separate contractual relationship between UHS of Lakeside, LLC d/b/a Lakeside Behavioral Health System and the parent company, UHS, Inc. They do not indicate a separate (non-affiliate) management entity within the meaning of HSDA rules or the Projected Data Chart. If approved, no additional fees will be assessed to the facility for this proposal.

2. **Section A, Applicant Profile Item 6**
   The Trust Deed Release is noted. However, please clarify the relationship between the applicant and J.P. Morgan and how the provided documentation confirms ownership.
   RESPONSE:
   There is no current relationship between applicant and J.P. Morgan. Documents attached are the Deed of Trust which shows release of encumbrance from J.P. Morgan dated 9/3/2014, and the original title insurance showing ownership by Universal Health Services, Inc. the parent company of the applicant.

3. **Section B. I. Project Description**
   Please clarify if the applicant's geriatric unit accepts patients 55+ or 65+.

SUPPLEMENTAL #1

May 22, 2015
11:56 am

RESPONSE:
The geriatric unit serves older adult male and female patients typically age 65+ who are in need of acute psychiatric stabilization. In 2014 with over 700 admissions to the geriatric unit, the average age patient cared for was 71. However, on occasion as is the current practice, based on a physician order patients can be admitted to this unit who are under the age of 65 if they need assistance with their Activities of Daily Living (ADLs).

4. **Section B. II. A. Need**
The square footage and cost per square footage chart is noted. However, please revise the chart to include the Proposed Final Cost/SF section and resubmit.
RESPONSE:

Table Two: Construction Costs	
Square Feet	24,205 SF
Construction Cost	$6,644,547
Construction Cost PSF	$275 PSF
Proposed Final Total Cost PSF	$387.22

Please indicate the existing average patient room size and the proposed patient room size of the 48 bed newly constructed building.

Table Three: Geriatric Building Size	
1. Building Area	24,205 SF
2. Building Type	Single story, central services and two patient wings; ECT and TMS procedure areas
3. Size of the Site	2.0 acres
4. Licensed Beds	48-all current CON beds in operation. No additional beds requested.
5. Patient Room Size - Existing Rooms - Proposed Rooms	 220 SF (Includes Bathroom) 313 SF ADA Rooms / 246 SF Non ADA Rooms (Includes Bathroom)

If approved, please clarify how the existing building and the overflow space on the West Adult unit will be used.
RESPONSE:
Lakeside offers five specialty track programs on the adult unit to help individualize the patient's treatment during their inpatient stay. These include Bipolar Spectrum, Young Adult, Trauma Resolution, Suicide Prevention and Chemical Dependency. Patients are assigned to a specific track based on clinical presentation in order to maximize their treatment during their inpatient episode of care.

If approval is obtained for the new Geriatric building construction, Lakeside will utilize the existing 31-bed geriatric building to provide programming for patients ages 18-25. In 2014 Lakeside averaged 69 admissions per month for young adults who are appropriate for this Young Adult Specialty Track. This represents a 21% admission growth above the prior year for this age population.

Lakeside's Young Adult Program is designed to address the age-specific issues of this population which include graduation, college, independence, marriage, family and future. To prepare our patients to meet these challenges, the Young Adult Program offers an integrated continuum of care for individuals with mental health or dual diagnosis disorders. Patients and their families participate in a comprehensive therapeutic approach, consisting of individual and multi-family therapies designed to assist them in dealing with the special challenges facing the family and the young adult patient.

This young adult target patient population currently served on West will be programmed separately in the repurposed geriatric building. Once vacant, the current geriatric building will require very limited reconditioning to be operational, which will include additional fencing to allow improved outside access for recreational therapy for patients in Lakeside's park like campus setting.

Use of the existing geriatric overflow space on the West adult unit will be used to separate the co-occurring chemical dependency patients from the general West population. This will promote their individualized treatment to support their recovery. Chemical Dependency is a progressive potentially fatal disease that has long-term emotional and physical impact on the individual and the whole family. When accompanied with other mental health problems, it is essential to treat both. In 2014, Lakeside averaged a census of 15.7 patients on the West unit with a co-occurring diagnosis. Patient satisfaction is impacted when chronically mentally ill patients and patients with co-occurring chemical dependency and other mental health issues are treated on the same adult unit. The 17 bed overflow space currently in use for the geriatric population will allow these dual diagnosis patients to program separately in their own milieu.

Please complete the chart below breaking out the bed accommodation mix for the proposed project.

RESPONSE:

Service Area Patient Accommodation Mix-Most Recent JAR Period

Lakeside Behavioral Health System	Total Licensed Beds	Total Private Beds	Total Semi-Private Beds	Total
Overall-Current CON BEDS	**261**	**4**	**257**	**261**
After completion of Proposed Project	*261*	*4*	*257*	*261*
Geriatric Current	*48*	*1*	*47*	*48*
Geriatric after completion of Proposed Project	*48*	*0*	*48*	*48*

5. **Section B. III. A. Plot Plan**
The plot plan is noted. Please revise the plot plan to include parking areas and access point from Brunswick Road.
RESPONSE: See attached revised plot plan

SUPPLEMENTAL #1

May 22, 2015
11:56 am

6. **Section B. IV. Floor Plan**
The floor plan is noted. However, please provide a larger more legible copy for review.
RESPONSE: See attached larger/legible floor plan (depicted on three pages)

7. **Section C. (Need) 1. Specific Criteria (Construction, Renovation, Expansion, and Replacement of Healthcare Institutions) Item 3**
The applicant has provided suicide rates per 100,000 pop. in Tennessee. Please provide suicide rates per 100,000 population for the latest reporting period for each Tennessee County in the service area . The data is found on the Tennessee Suicide Prevention Network (TSPN) Web-site located at http://tspn.org/wp-content/uploads/2004-13-NUMBERS-ALL.pdf
RESPONSE:
Our Tennessee service area suicide rate per 100,000 populations averages 19.88%. This is compared to Tennessee's suicide rate per 100,000 populations of 15.7%

County	Suicide Rate Per 100,000 population
Shelby	9.5
Madison	12.2
Tipton	14.6
Dyer	20.9
Gibson	20.2
Fayette	15.5
Obion	22.5
McNairy	38.3
Henderson	17.8
Carroll	21
Hardeman	15.2
Hardin	34.6
Lauderdale	10.8
Lake	25.9
Weakley	29
Crockett	13.7
Benton	30.7
Henry	27.9
Haywood	0
Decatur	25.7
Chester	11.5

Average 19.88
http://tspn.org/wp-content/uploads/2004-13-NUMBERS-ALL.pdf

8. **Section C. (Need) 3. Service Area County Level Map**
Please list in the narrative on page 25 the following that represents the applicant's service area: 21 Tennessee Counties, 22 Mississippi Counties and the 10 Arkansas Counties.

SUPPLEMENTAL #1

May 22, 2015
11:56 am

Service Area County Table			
County	**Tennessee (21)**	**Mississippi (22)**	**Arkansas (10)**
	Shelby	Desoto	Randolph
	Hardeman	Marshall	Clay
	McNairy	Benton	Lawrence
	Hardin	Alcorn	Greene
	Tipton	Tishomingo	Craighead
	Haywood	Tunica	Mississippi
	Madison	Tate	Poinsett
	Henderson	Tippah	Cross
	Decatur	Prentiss	Crittenden
	Lauderdale	Coahoma	St. Francis
	Crockett	Quitman	
	Gibson	Panola	
	Carroll	Lafayette	
	Benton	Pontotoc	
	Dyer	Lee	
	Obion	Itawamba	
	Weakley	Monroe	
	Henry	Chickasaw	
	Lake	Yalobusha	
	Chester	Tallahatchie	
	Fayette	Quitman	
		Union	

The County level map designating the applicant's declared service area is noted. However, please provide distinctive highlighting/ markings to readily differentiate the service area counties from the other non- service area counties and resubmit.
RESPONSE: See attached revised map

9. **Section C, Need, Item 4.A.**
Your response to this item is noted. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the following table and include data for each county in your proposed service area.
RESPONSE: See attached Population Data Tables

10. **Section C, Need, Item 4.B.**
The applicant states Lakeside is an enrollment location for the Affordable Care Act. Please provide the inpatient mental health benefits available under the Affordable Care Act.
RESPONSE:
The Affordable Care Act was signed into law on March 23, 2010, with the overall purpose to ensure all individuals have access to quality health care services. There are five (5) Managed Care Organizations that offer plans in the State of Tennessee, and all plans offer mental health and substance abuse services. The MCO's in Tennessee are BCBS, Humana, Cigna, Community Health Alliance and Assurant Health. The ACA guarantees coverage of 10 categories considered "essential health benefits", and one of these is mental health and substance abuse services to include mental/behavioral health inpatient services. All private health insurance plans offered in the Marketplace offer the same set of "essential health benefits" which are

considered the minimum requirements according to the ACA. Lakeside serves as an enrollment location in order to connect the community with quality healthcare and ensure existing patients have access to quality step down options.
https://www.healthcare.gov/coverage/mental-health-substance-abuse-coverage/

11. Section C, Need, Item 6
Please provide the following utilization for Lakeside by services as indicated in the following table:
RESPONSE:

Bed Type Acute Inpatient CON Beds	2012	2013	2014	% Change 12-14	Year One	Year Two
Hospital						
Beds	261	261	261	0.0%	261	261
Admissions	6,687	7,629	8,456	26.5%	8,918	9,129
Average Daily Census (ADC)	174.0	205.1	228.1	31.1%	239.4	245.1
Average Length of Stay (ALOS)	9.5	9.8	9.8	3.6%	9.8	9.8
%Occupancy	66.7%	78.6%	87.4%	31.1%	91.7%	93.9%
Children and Adolescent (0-17)						
Beds	55	55	55	0.0%	55	55
Admissions	1,356	1,456	1,743	28.5%	1,883	1,973
ADC	36.5	38.9	51.4	40.9%	53.8	54.2
ALOS	9.8	9.7	10.8	9.6%	10.4	10.0
%Occupancy	66.3%	70.7%	93.4%	40.9%	97.8%	98.6%
Adult (18-65)						
Beds	158	158	158	0.0%	158	158
Admissions	4,837	5,727	6,207	28.3%	6,493	6,544
ADC	113.2	138.4	147.8	30.6%	154.8	156.0
ALOS	8.5	8.8	8.7	1.8%	8.7	8.7
%Occupancy	71.6%	87.6%	93.4%	30.6%	98.0%	98.7%
Geriatric (65+)						
Beds	48	48	48	0.0%	48	48
Admissions	494	446	506	2.4%	542	612
ADC	24.4	27.8	28.9	18.5%	30.9	34.9
ALOS	18.0	22.8	20.8	15.7%	20.8	20.8
%Occupancy	50.8%	57.9%	60.1%	18.5%	64.3%	72.6%

12. Section C. (Economic Feasibility) Item 4
Please clarify why there are no management fees in the Projected Data Chart.
RESPONSE:
The expenses noted are revenues transferred to the parent company for the parent's centralized consulting and support of the hospital. Corporate support is provided in areas such as Accounting, Finance, Human Resources, Information Systems, Internal Audit, Legal Services, Regulatory Compliance, Quality Improvement, Risk Management, Reimbursement, and Insurance. Transfers are accounting transactions standard in a company that owns and operates a number of facilities. The fees are not a part of a separate contractual relationship between UHS of Lakeside, LLC, d/b/a Lakeside Behavioral Health System, and the parent company, UHS, Inc. They do not indicate a separate (non-affiliate) management entity within the meaning of HSDA rules or the Projected Data Chart. If approved, no additional fees will be assessed to the facility for this proposal.

SUPPLEMENTAL #1

May 22, 2015
11:56 am

Please clarify what the Projected Data Chart represents (this is confusing).
RESPONSE: See Supplemental revised charts attachment Section C (Economic Feasibility) 4 – Projected Data for Hospital and Projected Data for Gero-Volume Growth.

The Projected Days of 730 in Year One and 2,190 in Year Two on the Projected Data Chart do not match the patient days of 4,142 in 2016 and 6,205 in 2017 in the chart on page 42. Please clarify.
RESPONSE: See Revised chart below.

Lakeside Behavioral Health Systems Projected Utilization Years One and Two Geriatric Projected Volume Growth 2016-2017		
	Year One	Year Two
Admission Growth	36	105
Patient Day Growth	730	2,190
Average Daily Census Growth	2.0	6.0
Average Annual Occupancy Growth	0.8%	2.3%

Source: Lakeside corporate management

Please provide a Projected Data Chart for the proposed project and for the hospital as a whole with both clearly labeled.
RESPONSE: See Supplemental revised charts attachment Section C (Economic Feasibility) 4 – Projected Data for Hospital and Projected Data for Gero-Volume Growth.

There are calculation errors in the net operating revenue columns for Year One and Two. Please revise and resubmit.
RESPONSE: See Supplemental revised charts attachment Section C (Economic Feasibility) 4 – Projected Data for Hospital and Projected Data for Gero-Volume Growth.

Please complete the following for D.9 Other Expenses in the Projected Data chart.

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year One	Year Two
1. Real Estate Taxes	$271,734	$271,734
2. Utilities	$ 32,862	$ 32,586
3. Professional Fees	$ 11,803	$ 35,618
4. Purchased Services	$ 8,740	$ 26,221
5. Maintenance	$ 1,200	$ 9,280
6. Insurance	$ 820	$ 2,461
Total Other Expenses	**$327,159**	**$377,900**

SUPPLEMENTAL #1

May 22, 2015
11:56 am

13. Section C. (Economic Feasibility) Item 5

Table sixteen identifying the project's average gross charge, average deduction from operating revenue and average net charge is noted. The amounts do not match up with the Projected Data Chart. Please clarify and resubmit if needed.

RESPONSE: See revised chart below:

Average Charges, Deductions, Net Charges, Net Operating Income (Gero Volume Growth Only)		
	Year One	**Year Two**
Patient Days	730	2,190
Admissions or Discharges	36	105
Average Gross IP Charge Per Day	$1,382	$1,397
Average Gross IP Charge Per Admission	$28,019	$29,139
Average Deduction from Operating Revenue per day	$698	$706
Average Deduction from Operating Revenue per Admission	$14,145	$14,717
Average Net Charge (Net Operating Revenue) Per Day	$684	$691
Average Net Charge (Net Operating Revenue) Per Admission	$13,874	$14,422
Average Net Operating Income after Expenses, Per Day	($589)	$184
Average Net Operating Income after Expenses, Per Admission	($11,937)	$3,842

Source: Lakeside corporate management

14. Section C. (Economic Feasibility) Item 9.

The percent of Gross Revenue for TennCare and Medicare do not match the Projected Data Chart. Please clarify and resubmit the table if needed to match the Projected Data Chart for the proposed project.

RESPONSE: Prior data submitted was for the pay mix of the entire hospital. Revised chart below is for the geriatric proposal only. See revised chart below:

The proposed project appears to be a geriatric unit consisting mostly of 65+ patients; please explain why the applicant expects TennCare/Medicaid gross revenue to be more than Medicare in Year One?

RESPONSE: Prior data submitted was for the pay mix of the entire hospital. Revised chart below is for the geriatric proposal only. See revised chart below:

Medicare and TennCare/Medicaid Revenues, Year One Growth		
	Medicare	TennCare/Medicaid
Gross Revenue	$747,820	$69,500
Percent of Gross Revenue	74%	7%

Source: Lakeside corporate management

SUPPLEMENTAL #1

May 22, 2015
11:56 am

15. **Section C. (Economic Feasibility) Item 10**
Since the proposed project will be funded by Universal Health Services, Inc., please provide a copy of the parent company's audited financial statements for the most recently completed period for which the balance sheet and income statements are available.
RESPONSE: See attached 2014 parent company, UHS, Inc. published Annual Report.

16. **Section C. Orderly Development, Item 7.d**
Please provide a copy of the latest Joint Commission Accreditation survey.
RESPONSE: See attached Joint Commission Accreditation survey
Lakeside's last Joint Commission Accreditation survey was conducted June 2013. A copy is attached. Additionally, Lakeside has been recognized by The Joint Commission as a Top Performer on Key Quality Measures for the past two years, 2012, and 2013.

Please indicate the date of the last survey by the Tennessee Department of Mental Health and Substance Abuse Services. If needed, please provide a copy of survey and acceptance of the corrective action plan, if applicable.
RESPONSE:
The last date of survey by the Tennessee Department of Mental Health and Substance Abuse Services was conducted on November 7, 2014. A copy of the survey and acceptance of the correction action plan dated December 12, 2014 is attached.

17. **Section C. Orderly Development** Item 8 and 9
Items 8 and 9 are applicable. Please provide a response.
RESPONSE: Answer is "None" to both questions 8 and 9

18. **Project Completion forecast Chart**
The Project Completion Forecast Chart is noted. However, please enter the Agency projected Initial Decision Date on top of the page and resubmit.
RESPONSE: See attached revised chart

Please advise of any additional information you may need. We look forward to working with the agency on this project.

Respectfully,

Anna Joy Golden, MSN, RN
CEO/Managing Director
Lakeside Behavioral Health System
2911 Brunswick Road
Memphis, TN 38133
901-377-4774

SUPPLEMENTAL #1
May 22, 2015
11:56 am

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF SHELBY

NAME OF FACILITY: UHS of Lakeside, LLC d/b/a/ Lakeside Behavioral Health System

I, Anna Joy Golden, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Anna Joy Golden / CEO Managing Director
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 22nd day of May, 2015, witness my hand at office in the County of Shelby, State of Tennessee.

Gail Outland
NOTARY PUBLIC

GAIL OUTLAND STATE OF TENNESSEE NOTARY PUBLIC SHELBY COUNTY

My commission expires My Commission Expires: September 21, 2015.

HF-0043

Revised 7/02

SUPPLEMENTAL #1
May 22, 2015
11:56 am

Supplemental 1
CN1505-019

Section A-Applicant

Profile Item 6

SUPPLEMENTAL #1

May 22, 2015
11:56 am

Tom Leatherwood

Shelby County Register / Archives

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

14089782

09/03/2014 - 09:54 AM

4 PGS	
ERICA	1246888 - 14089782
VALUE	0.00
MORTGAGE TAX	0.00
TRANSFER TAX	0.00
RECORDING FEE	20.00
DP FEE	2.00
REGISTER'S FEE	0.00
WALK THRU FEE	0.00
TOTAL AMOUNT	22.00

TOM LEATHERWOOD

REGISTER OF DEEDS SHELBY COUNTY TENNESSEE

1075 Mullins Station, Suite W165 ~ Memphis, Tennessee 38134 (901) 222-8100
Website: http://register.shelby.tn.us Email: Tom.Leatherwood@shelbycountytn.gov
Join us on Facebook

This instrument was prepared by: Jarret S. Stephens, Esq.

RECORD AND RETURN TO:
Norton Rose Fulbright
666 Fifth Avenue
New York, NY 10103
Attn.: Jarret S. Stephens, Esq.

TRUST DEED RELEASE

WHEREAS, by that certain Deed of Trust, Assignment of Leases and Rents, Financing Statement, Fixture Filing and Security Agreement (**"Trust Deed"**) heretofore recorded in the Register's Office of Shelby County, Tennessee, certain real property was conveyed by the hereinafter named Grantor to Frank Alvstad, as Trustee, for the purpose of securing the indebtedness described in such Trust Deed; and

WHEREAS, all of the indebtedness has been satisfied in full; and

WHEREAS, said Trust Deed is briefly described as follows, to-wit:

GRANTOR:	UHS OF LAKESIDE, LLC
BENEFICIARY:	JPMORGAN CHASE BANK, N.A., as Collateral Agent
DATE:	December 30, 2010
RECORDED:	January 13, 2011
INSTRUMENT NO.:	11005122

As such Trust Deed was amended by that certain First Amendment to Deed of Trust, Assignment of Leases and Rents, Financing Statement, Fixture Filing and Security Agreement, dated December 31, 2012, by and between Grantor and Beneficiary, and recorded in the records of Shelby County on January 17, 2013 as Instrument No. 13008397.

NOW, THEREFORE, in consideration of the premises, the undersigned, Beneficiary, as legal owner and holder of the Trust Deed and the indebtedness secured thereby, acknowledges full satisfaction thereof, and hereby releases and discharges the lien of said Trust Deed, and to this end, quit claims and conveys unto said Grantor, all of Beneficiary's right, title and interest in and to the real estate described in said Trust Deed, to which reference is made for a particular description of said property.

The undersigned covenants with Grantor that it is the legal owner of the indebtedness described in and secured by said Trust Deed and that it has the lawful right to release and

discharge the lien thereof.

IN WITNESS WHEREOF Beneficiary has caused its corporate name to be signed hereto by and through its proper officers duly authorized so to do, this the 26 day of August, 2014.

JPMorgan Chase Bank, N.A., as Collateral Agent

By: _____
Name: Dawn L. LeeLum
Title: Executive Director

STATE OF New York)

COUNTY OF New York)

Before me, Margarita Torres, a Notary Public of said State and County aforesaid, personally appeared Dawn Lee LUM, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself (or herself) to be Executive Director of JPMorgan Chase Bank, N.A., as Collateral Agent, the within named Beneficiary, a corporation, and that s he as such _____, executed the foregoing instrument for the purpose therein contained, by signing the name of the corporation by himself (or herself) as _____.

WITNESS my hand and seal, at office in _____, this the 26 day of August, 2014

_____
Notary Public

My Commission Expires 1 day of May, 2018.

Margarita Torres
Notary Public, State of New York
Qualified in Bronx County
Certificate Filed in New York County
Commission #: 01TO6041062
My Commission Expires: May 1, 2018

40892706.1

SUPPLEMENTAL #1

May 22, 2015
11:56 am

I, Seth Schlusberg, do hereby make oath that I am a licensed attorney and/or the custodian of the electronic version of the attached document tendered for registration herewith and that this is a true and correct copy of the original document executed and authenticated according to law.

X_____
Seth Schlusberg

State of New York :
: SS
County of New York :

On this 2nd day of Sept. 2014, Damariz, Valentin personally appeared before me, Angela Fletcher, a notary public for this county and state who acknowledged that this certification of an electronic document is true and correct and whose signature I have witnessed.

X_____
Damariz Valentin, Notary Public

DAMARIZ VALENTIN
NOTARY PUBLIC, STATE OF N.Y.
REG. #01VA6033427
QUALIFIED IN BRONX COUNTY
MY COMMISSION EXPIRES 11/15/2017

SUPPLEMENTAL #1

May 22, 2015
11:56 am

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

Filing Information

Name: **UHS OF LAKESIDE, LLC**

General Information

SOS Control #	**000601571**	Formation Locale:	DELAWARE
Filing Type:	Limited Liability Company - Foreign	Date Formed:	06/02/2000
	04/30/2009 12:30 PM	Fiscal Year Close	12
Status:	Active	Member Count:	2
Duration Term:	Perpetual		
Managed By:	Director Managed		

Registered Agent Address
C T CORPORATION SYSTEM
STE 2021
800 S GAY ST
KNOXVILLE, TN 37929-9710

Principal Address
2911 BRUNSWICK RD
MEMPHIS, TN 38133-4105

The following document(s) was/were filed in this office on the date(s) indicated below:

Date Filed	Filing Description	Image #
03/23/2015	2014 Annual Report	B0073-8162
	Member Count Changed From: 3 To: 2	
03/19/2014	Assumed Name Renewal	7304-2158
	Assumed Name Changed From: LAKESIDE BEHAVIORAL HEALTH SYSTEM To: LAKESIDE BEHAVIORAL HEALTH SYSTEM	
	Expiration Date Changed From: 04/30/2014 To: 03/19/2019	
03/14/2014	Assumed Name Renewal	7299-2672
	Assumed Name Changed From: LAKESIDE CLINICS To: LAKESIDE CLINICS	
	Expiration Date Changed From: 04/30/2014 To: 03/14/2019	
02/25/2014	2013 Annual Report	A0216-2890
02/19/2013	2012 Annual Report	A0156-1249
	Member Count Changed From: 1 To: 3	
	Managed By Changed From: Member Managed To: Director Managed	
06/26/2012	2011 Annual Report	A0134-2414
	Principal Address 1 Changed From: 2911 BRUNSWICK ROAD To: 2911 BRUNSWICK RD	
	Principal Postal Code Changed From: 38133 To: 38133-4105	
	Principal County Changed From: No value To: SHELBY COUNTY	

SUPPLEMENTAL #1

May 22, 2015
11:56 am

Filing Information

Name: **UHS OF LAKESIDE, LLC**

06/02/2012	Notice of Determination	A0127-0619
02/18/2011	2010 Annual Report	6834-2950
03/03/2010	2009 Annual Report	6666-0445
04/30/2009	Initial Filing	6529-0768
04/30/2009	Common Amendment	6529-0770
04/30/2009	Assumed Name	6529-0775
04/30/2009	Assumed Name	6529-0776
04/30/2009	Assumed Name	6529-0777
04/30/2009	Assumed Name	6529-0778

Active Assumed Names (if any)	Date	Expires
LAKESIDE CLINICS	04/30/2009	03/14/2019
LAKESIDE BEHAVIORAL HEALTH SYSTEM	04/30/2009	03/19/2019

ALTA Loan Policy (6-17-06)

May 22, 2015
11:56 am

LOAN POLICY OF TITLE INSURANCE
ISSUED BY

stewart®
title guaranty company

Any notice of claim and any other notice or statement in writing required to be given to the Company under this Policy must be given to the Company at the address shown in Section 17 of the Conditions.

COVERED RISKS

SUBJECT TO THE EXCLUSIONS FROM COVERAGE, THE EXCEPTIONS FROM COVERAGE CONTAINED IN SCHEDULE B, AND THE CONDITIONS, STEWART TITLE GUARANTY COMPANY, a Texas corporation (the "Company") insures as of Date of Policy and, to the extent stated in Covered Risks 11, 13, and 14, after Date of Policy, against loss or damage, not exceeding the Amount of Insurance, sustained or incurred by the Insured by reason of:

1. Title being vested other than as stated in Schedule A.
2. Any defect in or lien or encumbrance on the Title. This Covered Risk includes but is not limited to insurance against loss from
   (a) A defect in the Title caused by
      (i) forgery, fraud, undue influence, duress, incompetency, incapacity, or impersonation;
      (ii) failure of any person or Entity to have authorized a transfer or conveyance;
      (iii) a document affecting Title not properly created, executed, witnessed, sealed, acknowledged, notarized, or delivered;
      (iv) failure to perform those acts necessary to create a document by electronic means authorized by law;
      (v) a document executed under a falsified, expired, or otherwise invalid power of attorney;
      (vi) a document not properly filed, recorded, or indexed in the Public Records including failure to perform those acts by electronic means authorized by law; or
      (vii) a defective judicial or administrative proceeding.
   (b) The lien of real estate taxes or assessments imposed on the Title by a governmental authority due or payable, but unpaid.
   (c) Any encroachment, encumbrance, violation, variation, or adverse circumstance affecting the Title that would be disclosed by an accurate and complete land survey of the Land. The term "encroachment" includes encroachments of existing improvements located on the Land onto adjoining land, and encroachments onto the Land of existing improvements located on adjoining land.
3. Unmarketable Title.
4. No right of access to and from the Land.
5. The violation or enforcement of any law, ordinance, permit, or governmental regulation (including those relating to building and zoning) restricting, regulating, prohibiting, or relating to
   (a) the occupancy, use, or enjoyment of the Land;
   (b) the character, dimensions, or location of any improvement erected on the Land;
   (c) the subdivision of land; or
   (d) environmental protection

stewart®
title guaranty company

Chairman of the Board

President

Countersigned:

Authorized Countersignature

Stewart Title Company - TN Overhead
Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

Part 1 of Policy Serial No. **M-9302-2184434**

if a notice, describing any part of the Land, is recorded in the Public Records setting forth the violation or intention to enforce, but only to the extent of the violation or enforcement referred to in that notice.

6. An enforcement action based on the exercise of a governmental police power not covered by Covered Risk 5 if a notice of the enforcement action, describing any part of the Land, is recorded in the Public Records, but only to the extent of the enforcement referred to in that notice.
7. The exercise of the rights of eminent domain if a notice of the exercise, describing any part of the Land, is recorded in the Public Records.
8. Any taking by a governmental body that has occurred and is binding on the rights of a purchaser for value without Knowledge.
9. The Invalidity or unenforceability of the lien of the Insured Mortgage upon the Title. This Covered Risk includes but is not limited to insurance against loss from any of the following impairing the lien of the Insured Mortgage:
   (a) forgery, fraud, undue influence, duress, incompetency, incapacity, or impersonation;
   (b) failure of any person or Entity to have authorized a transfer or conveyance;
   (c) the Insured Mortgage not being properly created, executed, witnessed, sealed, acknowledged, notarized, or delivered;
   (d) failure to perform those acts necessary to create a document by electronic means authorized by law;
   (e) a document executed under a falsified, expired, or otherwise invalid power of attorney;
   (f) a document not properly filed, recorded, or indexed in the Public Records including failure to perform those acts by electronic means authorized by law; or
   (g) a defective judicial or administrative proceeding.
10. The lack of priority of the lien of the Insured Mortgage upon the Title over any other lien or encumbrance.
11. The lack of priority of the lien of the Insured Mortgage upon the Title
   (a) as security for each and every advance of proceeds of the loan secured by the Insured Mortgage over any statutory lien for services, labor, or material arising from construction of an improvement or work related to the Land when the improvement or work is either:
      (i) contracted for or commenced on or before Date of Policy; or
      (ii) contracted for, commenced, or continued after Date of Policy if the construction is financed, in whole or in part, by proceeds of the loan secured by the Insured Mortgage that the Insured has advanced or is obligated on Date of Policy to advance; and
   (b) over the lien of any assessments for street improvements under construction or completed at Date of Policy.
12. The Invalidity or unenforceability of any assignment of the Insured Mortgage, provided the assignment is shown in Schedule A, or the failure of the assignment shown in Schedule A to vest title to the Insured Mortgage in the named Insured assignee free and clear of all liens.
13. The invalidity, unenforceability, lack of priority, or avoidance of the lien of the Insured Mortgage upon the Title
   (a) resulting from the avoidance in whole or in part, or from a court order providing an alternative remedy, of any transfer of all or any part of the title to or any interest in the Land occurring prior to the transaction creating the lien of the Insured Mortgage because that prior transfer constituted a fraudulent or preferential transfer under federal bankruptcy, state insolvency, or similar creditors' rights laws; or
   (b) because the Insured Mortgage constitutes a preferential transfer under federal bankruptcy, state insolvency, or similar creditors' rights laws by reason of the failure of its recording in the Public Records
      (i) to be timely, or
      (ii) to impart notice of its existence to a purchaser for value or to a judgment or lien creditor.
14. Any defect in or lien or encumbrance on the Title or other matter included in Covered Risks 1 through 13 that has been created or attached or has been filed or recorded in the Public Records subsequent to Date of Policy and prior to the recording of the Insured Mortgage in the Public Records.

The Company will also pay the costs, attorneys' fees, and expenses incurred in defense of any matter insured against by this Policy, but only to the extent provided in the Conditions.

EXCLUSIONS FROM COVERAGE

The following matters are expressly excluded from the coverage of this policy, and the Company will not pay loss or damage, costs, attorneys' fees, or expenses that arise by reason of:

1. (a) Any law, ordinance, permit, or governmental regulation (including those relating to building and zoning) restricting, regulating, prohibiting, or relating to
      (i) the occupancy, use, or enjoyment of the Land;
      (ii) the character, dimensions, or location of any improvement erected on the Land;
      (iii) the subdivision of land; or
      (iv) environmental protection; or the effect of any violation of these laws, ordinances, or governmental regulations. This Exclusion 1(a) does not modify or limit the coverage provided under Covered Risk 5.
   (b) Any governmental police power. This Exclusion 1(b) does not modify or limit the coverage provided under Covered Risk 6.
2. Rights of eminent domain. This Exclusion does not modify or limit the coverage provided under Covered Risk 7 or 8.
3. Defects, liens, encumbrances, adverse claims, or other matters:
   (a) created, suffered, assumed, or agreed to by the Insured Claimant;
   (b) not Known to the Company, not recorded in the Public Records at Date of Policy, but Known to the Insured Claimant and not disclosed in writing to the Company by the Insured Claimant prior to the date the Insured Claimant became an Insured under this policy;
   (c) resulting in no loss or damage to the Insured Claimant;
   (d) attaching or created subsequent to Date of Policy (however, this does not modify or limit the coverage provided under Covered Risk 11, 13, or 14); or
   (e) resulting in loss or damage that would not have been sustained if the Insured Claimant had paid value for the Insured Mortgage.
4. Unenforceability of the lien of the Insured Mortgage because of the inability or failure of an Insured to comply with applicable doing-business laws of the state where the Land is situated.
5. Invalidity or unenforceability in whole or in part of the lien of the Insured Mortgage that arises out of the transaction evidenced by the Insured Mortgage and is based upon usury or any consumer credit protection or truth-in-lending law.
6. Any claim, by reason of the operation of federal bankruptcy, state insolvency, or similar creditors' rights laws, that the transaction creating the lien of the Insured Mortgage, is
   (a) a fraudulent conveyance or fraudulent transfer, or
   (b) a preferential transfer for any reason not stated in Covered Risk 13(b) of this policy.
7. Any lien on the Title for real estate taxes or assessments imposed by governmental authority and created or attaching between Date of Policy and the date of recording of the Insured Mortgage in the Public Records. This Exclusion does not modify or limit the coverage provided under Covered Risk 11(b).

1. DEFINITION OF TERMS

The following terms when used in this policy mean:

(a) "Amount of Insurance": The amount stated in Schedule A, as may be increased or decreased by endorsement to this policy, increased by Section 8(b) or decreased by Section 10 of these Conditions.

(b) "Date of Policy": The date designated as "Date of Policy" in Schedule A.

(c) "Entity": A corporation, partnership, trust, limited liability company, or other similar legal entity.

(d) "Indebtedness": The obligation secured by the Insured Mortgage including one evidenced by electronic means authorized by law, and if that obligation is the payment of a debt, the Indebtedness is the sum of

(i) the amount of the principal disbursed as of Date of Policy;

(ii) the amount of the principal disbursed subsequent to Date of Policy;

(iii) the construction loan advances made subsequent to Date of Policy for the purpose of financing in whole or in part the construction of an improvement to the Land or related to the Land that the Insured was and continued to be obligated to advance at Date of Policy and at the date of the advance;

(iv) interest on the loan;

(v) the prepayment premiums, exit fees, and other similar fees or penalties allowed by law;

(vi) the expenses of foreclosure and any other costs of enforcement;

(vii) the amounts advanced to assure compliance with laws or to protect the lien or the priority of the lien of the Insured Mortgage before the acquisition of the estate or interest in the Title;

(viii) the amounts to pay taxes and insurance; and

(ix) the reasonable amounts expended to prevent deterioration of improvements; but the Indebtedness is reduced by the total of all payments and by any amount forgiven by an Insured.

(e) "Insured": The Insured named in Schedule A.

(i) The term "Insured" also includes

(A) the owner of the Indebtedness and each successor in ownership of the Indebtedness, whether the owner or successor owns the Indebtedness for its own account or as a trustee or other fiduciary, except a successor who is an obligor under the provisions of Section 12(c) of these Conditions;

(B) the person or Entity who has "control" of the "transferable record," if the Indebtedness is evidenced by a "transferable record," as these terms are defined by applicable electronic transactions law;

(C) successors to an Insured by dissolution, merger, consolidation, distribution, or reorganization;

(D) successors to an Insured by its conversion to another kind of Entity;

(E) a grantee of an Insured under a deed delivered without payment of actual valuable consideration conveying the Title

(1) if the stock, shares, memberships, or other equity interests of the grantee are wholly-owned by the named Insured,

(2) if the grantee wholly owns the named Insured, or

(3) if the grantee is wholly-owned by an affiliated Entity of the named Insured, provided the affiliated Entity and the named Insured are both wholly-owned by the same person or Entity;

(F) any government agency or instrumentality that is an insurer or guarantor under an insurance contract or guaranty insuring or guaranteeing the Indebtedness secured by the Insured Mortgage, or any part of it, whether named as an Insured or not;

(ii) With regard to (A), (B), (C), (D), and (E) reserving, however, all rights and defenses as to any successor that the Company would have had against any predecessor Insured, unless the successor acquired the Indebtedness as a purchaser for value without Knowledge of the asserted defect, lien, encumbrance, or other matter insured against by this policy.

(f) "Insured Claimant": An Insured claiming loss or damage.

(g) "Insured Mortgage": The Mortgage described in paragraph 4 of Schedule A.

(h) "Knowledge" or "Known": Actual knowledge, not constructive knowledge or notice that may be imputed to an Insured by reason of the Public Records or any other records that impart constructive notice of matters affecting the Title.

(i) "Land": The land described in Schedule A, and affixed improvements that by law constitute real property. The term "Land" does not include any property beyond the lines of the area described in Schedule A, nor any right, title, interest, estate, or easement in abutting streets, roads, avenues, alleys, lanes, ways, or waterways, but this does not modify or limit the extent that a right of access to and from the Land is insured by this policy.

(j) "Mortgage": Mortgage, deed of trust, trust deed, or other security instrument, including one evidenced by electronic means authorized by law.

(k) "Public Records": Records established under state statutes at Date of Policy for the purpose of imparting constructive notice of matters relating to real property to purchasers for value and without Knowledge. With respect to Covered Risk 5(d), "Public Records" shall also include environmental protection liens filed in the records of the clerk of the United States District Court for the district where the Land is located.

(l) "Title": The estate or interest described in Schedule A.

(m) "Unmarketable Title": Title affected by an alleged or apparent matter that would permit a prospective purchaser or lessee of the Title or lender on the Title or a prospective purchaser of the Insured Mortgage to be released from the obligation to purchase, lease, or lend if there is a contractual condition requiring the delivery of marketable title.

2. CONTINUATION OF INSURANCE

The coverage of this policy shall continue in force as of Date of Policy in favor of an Insured after acquisition of the Title by an Insured or after conveyance by an Insured, but only so long as the Insured retains an estate or interest in the Land, or holds an obligation secured by a purchase money Mortgage given by a purchaser from the Insured, or only so long as the Insured shall have liability by reason of warranties in any transfer or conveyance of the Title. This policy shall not continue in force in favor of any purchaser from the Insured of either (i) an estate or interest in the Land, or (ii) an obligation secured by a purchase money Mortgage given to the Insured.

3. NOTICE OF CLAIM TO BE GIVEN BY INSURED CLAIMANT

The Insured shall notify the Company promptly in writing (i) in case of any litigation as set forth in Section 5(a) of these Conditions, (ii) in case Knowledge shall come to an Insured of any claim of title or interest that is adverse to the Title or the lien of the Insured Mortgage, as insured, and that might cause loss or damage for which the Company may be liable by virtue of this policy, or (iii) if the Title or the lien of the Insured Mortgage, as insured, is rejected as Unmarketable Title. If the Company is prejudiced by the failure of the Insured Claimant to provide prompt notice, the Company's liability to the Insured Claimant under the policy shall be reduced to the extent of the prejudice.

4. PROOF OF LOSS

In the event the Company is unable to determine the amount of loss or damage, the Company may, at its option, require as a condition of payment that the Insured Claimant furnish a signed proof of loss. The proof of loss must describe the defect, lien, encumbrance, or other matter insured against by this policy that constitutes the basis of loss or damage and shall state, to the extent possible, the basis of calculating the amount of the loss or damage.

5. **DEFENSE AND PROSECUTION OF ACTIONS**

(a) Upon written request by the Insured, and subject to the options contained in Section 7 of these Conditions, the Company, at its own cost and without unreasonable delay, shall provide for the defense of an Insured in litigation in which any third party asserts a claim covered by this policy adverse to the Insured. This obligation is limited to only those stated causes of action alleging matters insured against by this policy. The Company shall have the right to select counsel of its choice (subject to the right of the Insured to object for reasonable cause) to represent the Insured as to those stated causes of action. It shall not be liable for and will not pay the fees of any other counsel. The Company will not pay any fees, costs, or expenses incurred by the Insured in the defense of those causes of action that allege matters not insured against by this policy.

(b) The Company shall have the right, in addition to the options contained in Section 7 of these Conditions, at its own cost, to institute and prosecute any action or proceeding or to do any other act that in its opinion may be necessary or desirable to establish the Title or the lien of the Insured Mortgage, as insured, or to prevent or reduce loss or damage to the Insured. The Company may take any appropriate action under the terms of this policy, whether or not it shall be liable to the Insured. The exercise of these rights shall not be an admission of liability or waiver of any provision of this policy. If the Company exercises its rights under this subsection, it must do so diligently.

(c) Whenever the Company brings an action or asserts a defense as required or permitted by this policy, the Company may pursue the litigation to a final determination by a court of competent jurisdiction, and it expressly reserves the right, in its sole discretion, to appeal any adverse judgment or order.

6. **DUTY OF INSURED CLAIMANT TO COOPERATE**

(a) In all cases where this policy permits or requires the Company to prosecute or provide for the defense of any action or proceeding and any appeals, the Insured shall secure to the Company the right to so prosecute or provide defense in the action or proceeding, including the right to use, at its option, the name of the Insured for this purpose. Whenever requested by the Company, the Insured, at the Company's expense, shall give the Company all reasonable aid (i) in securing evidence, obtaining witnesses, prosecuting or defending the action or proceeding, or effecting settlement, and (ii) in any other lawful act that in the opinion of the Company may be necessary or desirable to establish the Title, the lien of the Insured Mortgage, or any other matter as insured. If the Company is prejudiced by the failure of the Insured to furnish the required cooperation, the Company's obligations to the Insured under the policy shall terminate, including any liability or obligation to defend, prosecute, or continue any litigation, with regard to the matter or matters requiring such cooperation.

(b) The Company may reasonably require the Insured Claimant to submit to examination under oath by any authorized representative of the Company and to produce for examination, inspection, and copying, at such reasonable times and places as may be designated by the authorized representative of the Company, all records, in whatever medium maintained, including books, ledgers, checks, memoranda, correspondence, reports, e-mails, disks, tapes, and videos whether bearing a date before or after Date of Policy, that reasonably pertain to the loss or damage. Further, if requested by any authorized representative of the Company, the Insured Claimant shall grant its permission, in writing, for any authorized representative of the Company to examine, inspect, and copy all of these records in the custody or control of a third party that reasonably pertain to the loss or damage. All information designated as confidential by the Insured Claimant provided to the Company pursuant to this Section shall not be disclosed to others unless, in the reasonable judgment of the Company, it is necessary in the administration of the claim. Failure of the Insured Claimant to submit for examination under oath, produce any reasonably requested information, or grant permission to secure reasonably necessary information from third parties as required in this subsection, unless prohibited by law or governmental regulation, shall terminate any liability of the Company under this policy as to that claim.

7. **OPTIONS TO PAY OR OTHERWISE SETTLE CLAIMS; TERMINATION OF LIABILITY**

In case of a claim under this policy, the Company shall have the following additional options:

(a) To Pay or Tender Payment of the Amount of Insurance or to Purchase the Indebtedness.

(i) To pay or tender payment of the Amount of Insurance under this policy together with any costs, attorneys' fees, and expenses incurred by the Insured Claimant that were authorized by the Company up to the time of payment or tender of payment and that the Company is obligated to pay; or

(ii) To purchase the Indebtedness for the amount of the Indebtedness on the date of purchase, together with any costs, attorneys' fees, and expenses incurred by the Insured Claimant that were authorized by the Company up to the time of purchase and that the Company is obligated to pay.

When the Company purchases the Indebtedness, the Insured shall transfer, assign, and convey to the Company the Indebtedness and the Insured Mortgage, together with any collateral security.

Upon the exercise by the Company of either of the options provided for in subsections (a)(i) or (ii), all liability and obligations of the Company to the Insured under this policy, other than to make the payment required in those subsections, shall terminate, including any liability or obligation to defend, prosecute, or continue any litigation.

(b) To Pay or Otherwise Settle With Parties Other Than the Insured or With the Insured Claimant.

(i) to pay or otherwise settle with other parties for or in the name of an Insured Claimant any claim insured against under this policy. In addition, the Company will pay any costs, attorneys' fees, and expenses incurred by the Insured Claimant that were authorized by the Company up to the time of payment and that the Company is obligated to pay; or

(ii) to pay or otherwise settle with the Insured Claimant the loss or damage provided for under this policy, together with any costs, attorneys' fees, and expenses incurred by the Insured Claimant that were authorized by the Company up to the time of payment and that the Company is obligated to pay.

Upon the exercise by the Company of either of the options provided for in subsections (b)(i) or (ii), the Company's obligations to the Insured under this policy for the claimed loss or damage, other than the payments required to be made, shall terminate, including any liability or obligation to defend, prosecute, or continue any litigation.

8. **DETERMINATION AND EXTENT OF LIABILITY**

This policy is a contract of indemnity against actual monetary loss or damage sustained or incurred by the Insured Claimant who has suffered loss or damage by reason of matters insured against by this policy.

(a) The extent of liability of the Company for loss or damage under this policy shall not exceed the least of

(i) the Amount of Insurance,

(ii) the Indebtedness,

(iii) the difference between the value of the Title as insured and the value of the Title subject to the risk insured against by this policy, or

(iv) if a government agency or instrumentality is the Insured Claimant, the amount it paid in the acquisition of the Title or the Insured Mortgage in satisfaction of its insurance contract or guaranty.

(b) If the Company pursues its rights under Section 5 of these Conditions and is unsuccessful in establishing the Title or the lien of the Insured Mortgage, as insured,
(i) the Amount of Insurance shall be increased by 10%, and
(ii) the Insured Claimant shall have the right to have the loss or damage determined either as of the date the claim was made by the Insured Claimant or as of the date it is settled and paid.

(c) In the event the Insured has acquired the Title in the manner described in Section 2 of these Conditions or has conveyed the Title, then the extent of liability of the Company shall continue as set forth in Section 8(a) of these Conditions.

(d) In addition to the extent of liability under (a), (b), and (c), the Company will also pay those costs, attorneys' fees, and expenses incurred in accordance with Sections 5 and 7 of these Conditions.

9. LIMITATION OF LIABILITY

(a) If the Company establishes the Title, or removes the alleged defect, lien, or encumbrance, or cures the lack of a right of access to or from the Land, or cures the claim of Unmarketable Title, or establishes the lien of the Insured Mortgage, all as insured, in a reasonably diligent manner by any method, including litigation and the completion of any appeals, it shall have fully performed its obligations with respect to that matter and shall not be liable for any loss or damage caused to the Insured.

(b) In the event of any litigation, including litigation by the Company or with the Company's consent, the Company shall have no liability for loss or damage until there has been a final determination by a court of competent jurisdiction, and disposition of all appeals, adverse to the Title or to the lien of the Insured Mortgage, as insured.

(c) The Company shall not be liable for loss or damage to the Insured for liability voluntarily assumed by the Insured in settling any claim or suit without the prior written consent of the Company.

10. REDUCTION OF INSURANCE; REDUCTION OR TERMINATION OF LIABILITY

(a) All payments under this policy, except payments made for costs, attorneys' fees, and expenses, shall reduce the Amount of Insurance by the amount of the payment. However, any payments made prior to the acquisition of Title as provided in Section 2 of these Conditions shall not reduce the Amount of Insurance afforded under this policy except to the extent that the payments reduce the Indebtedness.

(b) The voluntary satisfaction or release of the Insured Mortgage shall terminate all liability of the Company except as provided in Section 2 of these Conditions.

11. PAYMENT OF LOSS

When liability and the extent of loss or damage have been definitely fixed in accordance with these Conditions, the payment shall be made within 30 days.

12. RIGHTS OF RECOVERY UPON PAYMENT OR SETTLEMENT

(a) The Company's Right to Recover

Whenever the Company shall have settled and paid a claim under this policy, it shall be subrogated and entitled to the rights of the Insured Claimant in the Title or Insured Mortgage and all other rights and remedies in respect to the claim that the Insured Claimant has against any person or property, to the extent of the amount of any loss, costs, attorneys' fees, and expenses paid by the Company. If requested by the Company, the Insured Claimant shall execute documents to evidence the transfer to the Company of these rights and remedies. The Insured Claimant shall permit the Company to sue, compromise, or settle in the name of the Insured Claimant and to use the name of the Insured Claimant in any transaction or litigation involving these rights and remedies..

If a payment on account of a claim does not fully cover the loss of the Insured Claimant, the Company shall defer the exercise of its right to recover until after the Insured Claimant shall have recovered its loss.

(b) The Insured's Rights and Limitations

(i) The owner of the Indebtedness may release or substitute the personal liability of any debtor or guarantor, extend or otherwise modify the terms of payment, release a portion of the Title from the lien of the Insured Mortgage, or release any collateral security for the Indebtedness, if it does not affect the enforceability or priority of the lien of the Insured Mortgage.

(ii) If the Insured exercises a right provided in (b)(i), but has Knowledge of any claim adverse to the Title or the lien of the Insured Mortgage insured against by this policy, the Company shall be required to pay only that part of any losses insured against by this policy that shall exceed the amount, if any, lost to the Company by reason of the impairment by the Insured Claimant of the Company's right of subrogation.

(c) The Company's Rights Against Noninsured Obligors

The Company's right of subrogation includes the Insured's rights against non-insured obligors including the rights of the Insured to indemnities, guaranties, other policies of insurance, or bonds, notwithstanding any terms or conditions contained in those instruments that address subrogation rights.

The Company's right of subrogation shall not be avoided by acquisition of the Insured Mortgage by an obligor (except an obligor described in Section 1(e)(i)(F) of these Conditions) who acquires the Insured Mortgage as a result of an indemnity, guarantee, other policy of insurance, or bond, and the obligor will not be an Insured under this policy.

13. ARBITRATION

Either the Company or the Insured may demand that the claim or controversy shall be submitted to arbitration pursuant to the Title Insurance Arbitration Rules of the American Land Title Association ("Rules"). Except as provided in the Rules, there shall be no joinder or consolidation with claims or controversies of other persons. Arbitrable matters may include, but are not limited to, any controversy or claim between the Company and the Insured arising out of or relating to this policy, any service in connection with its issuance or the breach of a policy provision, or to any other controversy or claim arising out of the transaction giving rise to this policy. All arbitrable matters when the Amount of Insurance is $2,000,000 or less shall be arbitrated at the option of either the Company or the Insured. All arbitrable matters when the Amount of Insurance is in excess of $2,000,000 shall be arbitrated only when agreed to by both the Company and the Insured. Arbitration pursuant to this policy and under the Rules shall be binding upon the parties. Judgment upon the award rendered by the Arbitrator(s) may be entered in any court of competent jurisdiction.

14. LIABILITY LIMITED TO THIS POLICY; POLICY ENTIRE CONTRACT

(a) This policy together with all endorsements, if any, attached to it by the Company is the entire policy and contract between the Insured and the Company. In interpreting any provision of this policy, this policy shall be construed as a whole.

(b) Any claim of loss or damage that arises out of the status of the Title or lien of the Insured Mortgage or by any action asserting such claim shall be restricted to this policy.

(c) Any amendment of or endorsement to this policy must be in writing and authenticated by an authorized person, or expressly incorporated by Schedule A of this policy.

(d) Each endorsement to this policy issued at any time is made a part of this policy and is subject to all of its terms and provisions. Except as the endorsement expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsement, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance.

15. **SEVERABILITY**
In the event any provision of this policy, in whole or in part, is held invalid or unenforceable under applicable law, the policy shall be deemed not to include that provision or such part held to be invalid, but all other provisions shall remain in full force and effect.

16. **CHOICE OF LAW; FORUM**
(a) Choice of Law: The Insured acknowledges the Company has underwritten the risks covered by this policy and determined the premium charged therefor in reliance upon the law affecting interests in real property and applicable to the interpretation, rights, remedies, or enforcement of policies of title insurance of the jurisdiction where the Land is located.
Therefore, the court or an arbitrator shall apply the law of the jurisdiction where the Land is located to determine the validity of claims against the Title or the lien of the Insured Mortgage that are adverse to the Insured and to interpret and enforce the terms of this policy. In neither case shall the court or arbitrator apply its conflicts of law principles to determine the applicable law.
(b) Choice of Forum: Any litigation or other proceeding brought by the Insured against the Company must be filed only in a state or federal court within the United States of America or its territories having appropriate jurisdiction.

17. **NOTICES, WHERE SENT**
Any notice of claim and any other notice or statement in writing required to be given to the Company under this policy must be given to the Company at Claims Department, P.O. Box 2029, Houston, Texas 77252-2029.

ALTA Loan Policy (6-17-06)

SUPPLEMENTAL #1

May 22, 2015
11:56 am

SCHEDULE A

Name and Address of Title Insurance Company: Stewart Title Guaranty Company
P.O. Box 2029
Houston, Texas 77252-2029

File No.: 210090075

Policy No.: M-9302-2184434

Loan No.:

*Address Reference: 2911-3015 Brunswick Road, Memphis, Tennessee

Amount of Insurance: $14,500,000.00

Premium: $14,043.55

Date of Policy: January 13, 2011 at 2:21 P.M.

1. Name of Insured:

   JPMorgan Chase Bank, N.A., as Collateral Agent, its successors and/or assigns.

2. The estate or interest in the Land that is encumbered by the Insured Mortgage is:

   Fee Simple

3. Title is vested in:

   UHS of Lakeside, LLC, a Delaware limited liability company

4. The Insured Mortgage, and its assignments, if any, are described as follows:

   Deed of Trust, Assignment of Leases and Rents, Financing Statement, Fixture Filing and Security Agreement executed by UHS of Lakeside, LLC to Frank Alvstad, Trustee for JPMorgan Chase Bank, N.A. dated December 30, 2010 and filed for record on January 13, 2010 at 2:21 P.M. in Instrument No. 11005122, Register's Office for Shelby County, Tennessee.

5. The Land referred to in this policy is described as follows:

   SEE ATTACHED EXHIBIT A

6. This policy incorporates by reference those ALTA endorsements selected below:

   - ☐ 4-06 (Condominium)
   - ☐ 4.1-06
   - ☐ 5-06 (Planned Unit Development)
   - ☐ 5.1-06
   - ☐ 6-06 (Variable Rate)
   - ☐ 6.2-06 (Variable Rate--Negative Amortization)
   - ☐ 8.1-06 (Environmental Protection Lien) Paragraph b refers to the following state statute(s): NONE
   - ☐ 9-06 (Restrictions, Encroachments, Minerals)
   - ☐ 13.1-06 (Leasehold Loan)
   - ☐ 14-06 (Future Advance-Priority)
   - ☐ 14.1-06 (Future Advance-Knowledge)
   - ☐ 14.3-06 (Future Advance-Reverse Mortgage)
   - ☐ 22-06 (Location), the type of improvement is a _____, and the street address is as show n above.

*FOR COMPANY REFERENCE PURPOSE ONLY, NOT AN INSURING PROVISION.

stewart title guaranty company

0025 W/BLOCKS

SUPPLEMENTAL #1

May 22, 2015
11:56 am

SCHEDULE A

EXHIBIT A

The land referred to in this commitment/policy is situated in the State of Tennessee, County of Shelby and is described as follows:

Beginning at an iron pin found in the west line of Brunswick Road (40 feet from centerline) and the south line of the "Rivera" property as described in Instrument FP 7114; thence southwestwardly along a curve to the right having a radius of 532.96 feet and along the northwesterly line of Brunswick Road a distance of 407.23 feet (deed = 407.03 feet) (chord = South 23 Degrees 45 minutes 32 seconds West 397.39 feet); thence South 51 degrees 55 minutes 00 seconds West and along the northwesterly line of Brunswick Road a distance of 447.42 (deed = South 52 degrees 53 minutes west 375.45 feet) to a point of curvature; thence southwestwardly along a curve to the right having a radius of 532.96 feet and along the northwesterly line of Brunswick Road a distance of 497.17 feet (chord = south 78 degrees 38 minutes 27 seconds west 479.34 feet) to a point of tangency; thence north 74 degrees 38 minutes 05 seconds west and along the northerly line of Brunswick Road a distance of 42.21 feet (deed = north 70 degrees 17 minutes 02 seconds west 68.50 feet) to a point; thence north 15 degrees 21 minutes 55 seconds east a distance of 5.00 feet (deed = north 19 degrees 42 minutes 58 seconds east) to a point of curvature, said point being 45 feet from centerline; thence continuing westwardly along the north line of Brunswick Road and along a curve to the left having a radius of 590.68 feet a distance of 691.84 feet (chord = south 71 degrees 48 minutes 41 seconds west 652.97 feet) to a point of tangency; thence south 38 degrees 15 minutes 26 seconds west and along the northwesterly line of Brunswick Road a distance of 163.53 feet (deed = south 36 degrees 31 minutes 49 seconds west 117.36 feet) to a point of curvature; thence along said curve to the right having a radius of 527.96 feet and along the northwesterly line of Brunswick Road a distance of 306.30 feet (deed = 306 feet) to an iron pin found in the east line of the "Loewenberg" property as described in Instrument G6 6442; thence North 04 degrees 08 minutes 51 seconds west and along the said east line a distance of 1473.01 feet to an iron pin found in the south line of the "McClanahan Properties" property as described in Instrument AY 8561; thence North 86 degrees 11 minutes 01 seconds east and along the said south line a distance of 663.58 feet to an iron pin set in the west line of the "Goff" property as described in Book 4258, Page 336; thence south 04 degrees 49 minutes 02 seconds east and along the said west line a distance of 431.35 feet to an iron pin set in the south line of said "Goff" property; thence North 84 degrees 41 minutes 12 seconds east and along said south line a distance of 1411.28 feet to the point of beginning.

Being part of the same property conveyed to UHS of Lakeside, Inc., a Delaware corporation by Special Warranty Deed dated August 18, 2000 from Crescent Real Estate Funding VII, L.P., a Delaware limited partnership as recorded in Instrument KK 9907, Register's Office for Shelby County, Tennessee. The said UHS of Lakeside, Inc. having since changed the name of the company to UHS of Lakeside, LLC, a Delaware limited liability company as recorded in Instrument No. 11008063, Register's Office for Shelby County, Tennessee.

ALTA Loan Policy (6-17-06)

SUPPLEMENTAL #1

May 22, 2015
11:56 am

SCHEDULE B
PART I

File No.: 210090075

Policy No.: M-9302-2184434

EXCEPTIONS FROM COVERAGE

This policy does not insure against loss or damage (and the Company will not pay costs, attorneys' fees, or expenses) that arise by reason of:

1. Real Property Taxes for the year 2011 and subsequent years, a lien, not yet due and payable.

2. Easements and releases of easements dated August 24, 1970, by and between Tranquilaire Nursing Home, Inc., ENendale Utility District and W. D. Galbreath and G. G. Heflin as Trustee under a certain Deed of Trust recorded in Instrument F6 5361, in the Registers Office, Shelby County, Tennessee, for the construction and maintenance of underground sewer pipes; manholes and cleancut fittings and the construction and maintenance of any underground water pipe and water entering device, and being the same as shown on survey by Davis Engineering Company, Inc. dated June 14, 2000, last revised June 26, 2000.

3. Fourteen foot easement contract to The City of Memphis recorded in Instrument E9 3790 for the purpose of correcting description of easement recorded in Registers Office Record Book and designated in Instrument E8 5717, in said Registers Office, and being the same as shown on said survey.

4. Eight foot easement contract from H. T. Severs and Edith Severs to City of Memphis active through Memphis Light, Gas and Water Division, its successors and assigns recorded in Book 5032, Page 309, in said Registers Office, an easement or right of way to construct, maintain and operate an electric transmission or distribution Line(s) at near, over, across, under and upon the land described herein, and being the same as shown on said survey.

5. Easement contract to the City of Memphis acting through Memphis Light, Gas and Water Division recorded in Instrument E9 3791, in said Register's Office, to construct, maintain and service and electric transmission or distribution line(s), and being the same as shown on said survey.

6. Permanent Water Easement Agreement as recorded in Instrument No. 03064787, Register's Office for Shelby County, Tennessee.

7. Encroachment of fences as shown on said survey dated June 14, 2000 of Davis Engineering Company, Inc., 5350 Poplar Avenue, Suite 317, Memphis, Tennessee 38119 and designated Project No. 20000369-8. The term "encroachment" includes encroachments of existing improvements located on the land adjoining and encroachments onto the land of existing improvements located on adjoining land.

8. Rights of Barris & Associates – Rick Harrell as tenant in possession under an unrecorded lease with no rights of first refusal or option to purchase.

stewart title guaranty company

ALTA Loan Policy (6-17-06)

SUPPLEMENTAL #1

May 22, 2015
11:56 am

SCHEDULE B
PART II

File No.: 210090075

Policy No.: M-9302-2184434

In addition to the matters set forth in Part I of this Schedule, the Title is subject to the following matters, and the Company insures against loss or damage sustained in the event that they are not subordinate to the lien of the Insured Mortgage:

- NONE -

stewart title guaranty company

SUPPLEMENTAL #1
May 22, 2015
11:56 am

WHAT DO THE STEWART TITLE COMPANIES DO WITH YOUR PERSONAL INFORMATION?

Federal and applicable state law and regulations give consumers the right to limit some but not all sharing. Federal and applicable state law regulations also require us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand how we use your personal information. This privacy notice is distributed on behalf of the Stewart Title Guaranty Company and its affiliates (the Stewart Title Companies), pursuant to Title V of the Gramm-Leach-Bliley Act (GLBA).

The types of personal information we collect and share depend on the product or service that you have sought through us. This information can include social security numbers and driver's license number.

All financial companies, such as the Stewart Title Companies, need to share customers' personal information to run their everyday business—to process transactions and maintain customer accounts. In the section below, we list the reasons that we can share customers' personal information; the reasons that we choose to share; and whether you can limit this sharing.

Reasons we can share your personal information	Do we share?	Can you limit this sharing?
For our everyday business purposes— to process your transactions and maintain your account. This may include running the business and managing customer accounts, such as processing transactions, mailing, and auditing services, and responding to court orders and legal investigations.	Yes	No
For our marketing purposes— to offer our products and services to you.	Yes	No
For joint marketing with other financial companies	No	We don't share
For our affiliates' everyday business purposes— information about your transactions and experiences. Affiliates are companies related by common ownership or control. They can be financial and nonfinancial companies. *Our affiliates may include companies with a Stewart name; financial companies, such as Stewart Title Company*	Yes	No
For our affiliates' everyday business purposes— information about your creditworthiness.	No	We don't share
For our affiliates to market to you	Yes	No
For nonaffiliates to market to you. Nonaffiliates are companies not related by common ownership or control. They can be financial and nonfinancial companies.	No	We don't share

We may disclose your personal information to our affiliates or to nonaffiliates as permitted by law. If you request a transaction with a nonaffiliate, such as a third party insurance company, we will disclose your personal information to that nonaffiliate. [We do not control their subsequent use of information, and suggest you refer to their privacy notices.]

Sharing practices	
How often do the Stewart Title Companies notify me about their practices?	We must notify you about our sharing practices when you request a transaction.
How do the Stewart Title Companies protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal and state law. These measures include computer, file, and building safeguards.
How do the Stewart Title Companies collect my personal information?	We collect your personal information, for example, when you • request insurance-related services • provide such information to us We also collect your personal information from others, such as the real estate agent or lender involved in your transaction, credit reporting agencies, affiliates or other companies.
What sharing can I limit?	Although federal and state law give you the right to limit sharing (e.g., opt out) in certain instances, we do not share your personal information in those instances.

Contact Us

If you have any questions about this privacy notice, please contact us at: Stewart Title Guaranty Company, 1980 Post Oak Blvd., Privacy Officer, Houston, Texas 77056

File No.: 210090075

ALTA Form 1-06 (Street Assessments)

SUPPLEMENTAL #1

May 22, 2015
11:56 am

ENDORSEMENT

ATTACHED POLICY NUMBER M-9302-2184434
ISSUED BY

stewart title guaranty company

File No.: 210090075

Charge: $100.00

The Company insures against loss or damage sustained by the Insured by reason of the lack of priority of the lien of the Insured Mortgage over the lien of any assessments for street improvements under construction or completed at Date of Policy.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Date: January 13, 2011

Signed under seal for the Company, but this endorsement is to be valid only when it bears an authorized countersignature.

Countersigned by:

Stewart Title Company - TN Overhead Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

stewart title guaranty company

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Senior Chairman of the Board

Chairman of the Board

President

Endorsement Serial No.	**E-1111-7875788**

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AMERICAN LAND TITLE ASSOCIATION

stewart

ALTA Form 6-06 (Variable Rate Mortgage) Revised 10/16/08

SUPPLEMENTAL #1

May 22, 2015
11:56 am

ENDORSEMENT

ATTACHED TO POLICY NUMBER M-9302-2184434
ISSUED BY

stewart title guaranty company

File No.: 210090075

Charge: $100.00

The Company insures against loss or damage sustained by the Insured by reason of:

1. The invalidity or unenforceability of the lien of the Insured Mortgage resulting from its provisions that provide for changes in the rate of interest.
2. Loss of priority of the lien of the Insured Mortgage as security for the unpaid principal balance of the loan, together with interest as changed in accordance with the provisions of the Insured Mortgage, which loss of priority is caused by the changes in the rate of interest.

"Changes in the rate of interest", as used in this endorsement, shall mean only those changes in the rate of interest calculated pursuant to the formula provided in the loan documents secured by the Insured Mortgage at Date of Policy.

This endorsement does not insure against loss or damage based upon:

1. usury, or
2. any consumer credit protection or truth in lending law.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Date: January 13, 2011

Signed under seal for the Company, but this endorsement is to be valid only when it bears an authorized countersignature.

Countersigned by:

Stewart Title Company - TN Overhead
Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

stewart title guaranty company

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Senior Chairman of the Board

Chairman of the Board

President

Endorsement Serial No.	**E-1111-7290546**

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AMERICAN LAND TITLE ASSOCIATION

ALTA Form 8.2-06 (Commercial Environmental Protection Lien) Adopted 10/16/08

SUPPLEMENTAL #1
May 22, 2015
11:56 am

ENDORSEMENT

ATTACHED TO POLICY NUMBER M-9302-2184434
ISSUED BY

stewart title guaranty company

File No.: 210090075

Charge: $100.00

The Company insures against loss or damage sustained by the Insured by reason of an environmental protection lien that, at Date of Policy, is recorded in the Public Records or filed in the records of the clerk of the United States district court for the district in which the Land is located, unless the environmental protection lien is set forth as an exception in Schedule B.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Date: January 13, 2011

Signed under seal for the Company, but this endorsement is to be valid only when it bears an authorized countersignature.

Countersigned by:

Stewart Title Company - TN Overhead
Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

stewart title guaranty company

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Senior Chairman of the Board

Chairman of the Board

President

Endorsement Serial No.	E-1111-2465930

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AMERICAN LAND TITLE ASSOCIATION

ALTA Form 9.3 (Restrictions, Encroachments, Minerals –Loan Policy)

SUPPLEMENTAL #1

May 22, 2015
11:56 am

ENDORSEMENT

ATTACHED TO POLICY NUMBER M-9302-2184434
ISSUED BY

stewart title guaranty company

File No.: 210090075

Charge: $2,320.00

The Company insures against loss or damage sustained by the Insured by reason of:

1. The existence, at Date of Policy, of any of the following unless expressly excepted in Schedule B:
   a. Covenants, conditions, or restrictions under which the lien of the insured mortgage can be divested, subordinated or extinguished, or its validity, priority or enforceability impaired.
   b. Unless expressly excepted in Schedule B:
      i. Present violations on the land of any enforceable covenants, conditions, or restrictions, or existing improvements on the land that violate any building setback lines shown on a plat of subdivision recorded or filed in the public records.
      ii. Any instrument referred to in Schedule B as containing covenants, conditions, or restrictions on the land that, in addition, (A) establishes an easement on the land; (B) provides a lien for liquidated damages; (C) provides for a private charge or assessment; (D) provides for an option to purchase, a right of first refusal, or the prior approval of a future purchaser or occupant.
      iii. Any encroachment of existing improvements located on the land onto adjoining land, or any encroachment onto the land of existing improvements located on adjoining land.
      iv. Any encroachment of existing improvements located on the land onto that portion of the land subject to any easement excepted in Schedule B.
      v. Any notices of violation of covenants, conditions, or restrictions relating to environmental protections recorded or filed in the public records.
2. Any future violation on the land of any existing covenants, conditions, or restrictions occurring prior to the acquisition of title by the Insured, provided the violation results in
   a. invalidity, loss of priority, or unenforceability of the lien of the insured mortgage; or
   b. loss of title if the Insured shall acquire title in satisfaction of the indebtedness.
3. Damage to existing improvements, including lawns, shrubbery, or trees, located or encroaching on that portion of the land subject to any easement excepted in Schedule B, which damage results from the exercise of the right to maintain the easement for the purpose for which it was granted or reserved.
4. Damage to improvement, including lawns, shrubbery, or trees, located on the land on or after Date of Policy resulting from the future exercise of any right to use the surface of the land for the extraction or development of minerals excepted from the description of the land or excepted in Schedule B.
5. Any final court order or judgment requiring the removal from any land adjoining the land of any encroachment excepted in Schedule B.
6. Any final court order or judgment denying the right to maintain any existing improvements on the land because of any violation of covenants, conditions, or restrictions, or building setback lines shown on a plat of subdivision recorded or filed in the public records.

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AMERICAN LAND TITLE ASSOCIATION

stewart title guaranty company

ALTA Form 9.3 (Restrictions, Encroachments, Minerals –Loan Policy)

SUPPLEMENTAL #1

May 22, 2015
11:56 am

Wherever in this endorsement the words "covenants, conditions, or restrictions" appear, they do not include the terms, covenants, conditions, or limitations contained in an instrument creating a lease.

As used in paragraphs 1.b.i. and 6, the words "covenants, conditions, or restrictions" do not include any covenants, conditions, or restrictions (a) relating to obligations of any type to perform maintenance, repair, or remediation on the land, or (b) pertaining to environmental protection of any kind or nature, including hazardous or toxic matters, conditions, or substances, except to the extent that a notice of a violation or alleged violation affecting the Land has been recorded or filed in the public records at Date of Policy and is not excepted in Schedule B.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Date: January 13, 2011

Signed under seal for the Company, but this endorsement is to be valid only when it bears an authorized countersignature.

Countersigned by:

Stewart Title Company - TN Overhead
Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

stewart
title guaranty company

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Senior Chairman of the Board

Chairman of the Board

President

Endorsement Serial No.	E-1111-7429798

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AMERICAN LAND TITLE ASSOCIATION

stewart

SUPPLEMENTAL #1

May 22, 2015
11:56 am

EXHIBIT B

BOS FILE NO.	LOCAL FILE NO.	FACILITY	ADDRESS	CITY	COUNTY	ST	Liability Amount
10070805	331008	Southwest Healthcare	36485 Inland Valley Drive	Wildomar/ Murietta	Riverside	CA	115,729,000.00
10070835	20101194	Brentwood Hospital	1006 Highland Avenue	Shreveport	Caddo	LA	12,568,354.00
10070840		Brynn Marr Behavioral Heath Care System	192 Village Drive	Jacksonville	Onslow	NC	13,653,983.00
10070839	10070839	Old Vineyard Behavioral Health Services	3637 Old Vineyard Road	Winston-Salem	Forsythe	NC	10,643,000.00
10070848	10090148	Saint Mary's Hospital	305 South 5th	Enid	Garfield	OK	17,608,000.00
10070849	10090157	Shadow Mountain Behavioral Health System	6262 South Sheridan Road	Tulsa	Tulsa	OK	14,963,696.00
10070858	10-045	Aiken Regional Medical Center	302 University Parkway	Aiken	Aiken	SC	42,937,000.00
10070859	10-044	Three Rivers Behavioral Health	2900 Sunset Boulevard West	West Columbia	Lexington	SC	14,197,283.00
10070861	210090074	Rolling Hills Hospital	2014 Quail Hollow Circle	Franklin	Williamson	TN	27,299,374.00
10070860	210090075	Lakeside BHS	2911-3015 Brunswick Road	Memphis	Shelby	TN	14,500,000.00

ALTA Form 12-06 (Aggregation)

SUPPLEMENTAL #1

May 22, 2015
11:56 am

ENDORSEMENT

ATTACHED TO POLICY NUMBER M-9302-2184434
ISSUED BY

stewart title guaranty company

File No.: 210090075

Charge: $100.00

The following policies are issued in conjunction with one another:

See attached Exhibit B

Notwithstanding the provisions of Section 8(a)(i) of the Conditions of this policy, the Amount of Insurance available to cover the Company's liability for loss or damage under this policy at the time of payment of loss hereunder shall be the aggregate of the Amount of Insurance under this policy and the other policies identified above. At no time shall the Amount of Insurance under this policy and the other policies identified above exceed, in the aggregate, **$284,099,690**. Subject to the provisions of Section 10(a) of the Conditions of the policies, all payments made by the Company under this policy or any of the other policies identified above, except the payments made for costs, attorney's fees, and expenses, shall reduce the aggregate Amount of Insurance by the amount of the payment.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Date: January 13, 2011

Signed under seal for the Company, but this endorsement is to be valid only when it bears an authorized countersignature.

Countersigned by:

Stewart Title Company - TN Overhead Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

stewart title guaranty company

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Senior Chairman of the Board

Chairman of the Board

President

Endorsement Serial No.	E-1111-1887280

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AMERICAN LAND TITLE ASSOCIATION

stewart title guaranty company

SUPPLEMENTAL #1

ENDORSEMENT

May 22, 2015

ATTACHED TO POLICY NUMBER M-9302-2184434 **11:56 am**

ISSUED BY

stewart title guaranty company

File No.: 210090075 **Charge:** $100.00

1. The insurance for Advances added by Sections 2 & 3 of this endorsement is subject to the exclusions in Section 4 of this endorsement and the Exclusions from Coverage in the Policy, except Exclusion 3(d), the provisions of the Conditions, and the exceptions contained in Schedule B.

   a. "Agreement," as used in this endorsement, shall mean the note or loan agreement secured by the Insured Mortgage or the Insured Mortgage.

   b. "Advances," as used in this endorsement, shall mean only those advances of principal indebtedness made after the Date of Policy as provided in the Agreement, including expenses of foreclosure, amounts advanced pursuant to the Insured Mortgage to pay taxes and insurance, assure compliance with laws, or to protect the lien of the Insured Mortgage before the time of acquisition of the Title, and reasonable amounts expended to prevent deterioration of improvements, together with interest on those advances.

2. The Company insures against loss or damage sustained by the Insured by reason of:

   a. The invalidity or unenforceability of the lien of the Insured Mortgage as security for each Advance.

   b. The lack of priority of the lien of the Insured Mortgage as security for each Advance over any lien or encumbrance on the Title.

   c. The invalidity or unenforceability or loss of priority of the lien of the Insured Mortgage as security for the Indebtedness and Advances resulting from (i) re-Advances and repayments of Indebtedness, (ii) lack of outstanding Indebtedness before an Advance, or (iii) the failure of the Insured Mortgage to comply with the requirements of state law of the state in which the Land is located to secure Advances.

3. The Company also insures against loss or damage sustained by the Insured by reason of:

   a. The invalidity or unenforceability of the lien of the Insured Mortgage resulting from any provisions of the Agreement that provide for (i) interest on interest, (ii) changes in the rate of interest, or (iii) the addition of unpaid interest to the Indebtedness.

   b. Loss of priority of the lien of the Insured Mortgage as security for the Indebtedness, interest on interest, or interest as changed in accordance with the provisions of the Insured Mortgage, which loss of priority is caused by (i) changes in the rate of interest, (ii) interest on interest, or (iii) increases in the Indebtedness resulting from the addition of unpaid interest.

   "Changes in the rate of interest," as used in this endorsement, shall mean only those changes in the rate of interest calculated pursuant to a formula provided in the Insured Mortgage at Date of Policy.

4. This endorsement does not insure against loss or damage (and the Company will not pay costs, attorneys' fees, or expenses) resulting from:

   a. Advances made after a Petition for Relief under the Bankruptcy Code (11 U.S.C.) has been filed by or on behalf of the mortgagor.

   b. The loss of priority of the lien of the Insured Mortgage, as security for Advances, to the lien of real estate taxes or assessments on the Title imposed by governmental authority arising after Date of Policy.

   c. The loss of priority of the lien of the Insured Mortgage as security for any Advance, to a federal tax lien, which Advance is made after the earlier of (i) actual knowledge of the Insured that a federal tax lien was filed against the mortgagor, or (ii) the expiration of more than forty-five days after notice of a federal tax lien filed against the mortgagor.

   d. The loss of priority of the lien of the Insured Mortgage as security for Advances to any federal or state environmental protection lien.

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AMERICAN LAND TITLE ASSOCIATION

SUPPLEMENTAL #1

May 22, 2015
11:56 am

e. Usury, or any consumer credit protection or truth-in-lending law.

5. The Amount of Insurance shall include Advances.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Date: January 13, 2011

Signed under seal for the Company, but this endorsement is to be valid only when it bears an authorized countersignature.

Countersigned by:

Stewart Title Company - TN Overhead
Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

stewart title guaranty company

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Senior Chairman of the Board

Chairman of the Board

President

Endorsement Serial No.	E-1111-7020645

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ALTA Form 14.2-06 (Future Advance-Letter of Credit) w/o MML (02/28/09)

SUPPLEMENTAL #1

May 22, 2015

11:56 am

ENDORSEMENT

ATTACHED TO POLICY NUMBER M-9302-2184434

ISSUED BY

stewart title guaranty company

File No.: 210090075

Charge: $100.00

1. The insurance for Advances added by Section 2 of this endorsement is subject to the exclusions in Section 3 of this endorsement and the Exclusions from Coverage in the Policy, except Exclusion 3(d), the provisions of the Conditions, and the exceptions contained in Schedule B.
   a. "Agreement," as used in this endorsement, shall mean the letter of credit, and its reimbursement agreement, the repayment of Advances under which is secured by the Insured Mortgage.
   b. "Advance," as used in this endorsement, shall mean only an advance made after Date of Policy as provided in the Agreement, including expenses of foreclosure, amounts advanced pursuant to the Insured Mortgage to pay taxes and insurance, assure compliance with laws, or to protect the lien of the Insured Mortgage before the time of acquisition of the Title, and reasonable amounts expended to prevent deterioration of improvements, together with interest on those advances.

2. The Company insures against loss or damage sustained by the Insured by reason of:
   a. The invalidity or unenforceability of the lien of the Insured Mortgage as security for each Advance.
   b. The lack of priority of the lien of the Insured Mortgage as security for each Advance over any lien or encumbrance on the Title.
   c. The invalidity or unenforceability or loss of priority of the lien of the Insured Mortgage as security for the Indebtedness, Advances and unpaid interest resulting from (i) re-Advances and repayments of Indebtedness, (ii) earlier periods of no indebtedness owing during the term of the Insured Mortgage, or (iii) the Insured Mortgage not complying with the requirements of state law of the state in which the Land is located to secure Advances.

3. This endorsement does not insure against loss or damage (and the Company will not pay costs, attorneys' fees, or expenses) resulting from:
   a. The lien of real estate taxes or assessments on the Title imposed by governmental authority arising after Date of Policy; or
   b. Any federal or state environmental protection lien; or
   c. Limitations, if any, imposed under the Bankruptcy Code on the amount that may be recovered from the mortgagor's estate.

4. The Indebtedness shall include Advances.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Date: January 13, 2011

Signed under seal for the Company, but this endorsement is to be valid only when it bears an authorized countersignature.

Countersigned by:

Stewart Title Company - TN Overhead
Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

stewart title guaranty company

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Senior Chairman of the Board

Chairman of the Board

President

Endorsement Serial No.	E-1111-6030676

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AMERICAN LAND TITLE ASSOCIATION

ALTA Form 17-06 (Access and Entry)

SUPPLEMENTAL #1
May 22, 2015
11:56 am

ENDORSEMENT

ATTACHED TO POLICY NUMBER M-9302-2184434
ISSUED BY

stewart title guaranty company

File No.: 210090075

Charge: $100.00

The Company insures against loss or damage sustained by the Insured if, at Date of Policy (i) the Land does not abut and have both actual vehicular and pedestrian access to and from Brunswick Road (the "Street"), (ii) the Street is not physically open and publicly maintained, or (iii) the Insured has no right to use existing curb cuts or entries along that portion of the Street abutting the Land.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Date: January 13, 2011

Signed under seal for the Company, but this endorsement is to be valid only when it bears an authorized countersignature.

Countersigned by:

Stewart Title Company - TN Overhead
Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

stewart title guaranty company

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Senior Chairman of the Board

Chairman of the Board

President

Endorsement Serial No.	E-1111-5795692

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stewart title guaranty company

ALTA Form 17.2-06 (Utility Access) Adopted 10/16/08

SUPPLEMENTAL #1
May 22, 2015
11:56 am

ENDORSEMENT

ATTACHED TO POLICY NUMBER M-9302-2184434
ISSUED BY

stewart title guaranty company

File No.: 210090075

Charge: $100.00

The Company insures against loss or damage sustained by the Insured by reason of the lack of a right of access to the following utilities or services: **[CHECK ALL THAT APPLY]**

☒ Water service	☐ Natural gas service	☒ Telephone service
☒ Electrical power service	☒ Sanitary sewer	☐ Storm water drainage
☐ _____	☐ _____	☐ _____

either over, under or upon rights-of-way or easements for the benefit of the Land because of:

(1) a gap or gore between the boundaries of the Land and the rights-of-way or easements;

(2) a gap between the boundaries of the rights-of-way or easements; or

(3) a termination by a grantor, or its successor, of the rights-of-way or easements.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Date: January 13, 2011

Signed under seal for the Company, but this endorsement is to be valid only when it bears an authorized countersignature.

Countersigned by:

Stewart Title Company - TN Overhead
Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

stewart title guaranty company

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Senior Chairman of the Board

Chairman of the Board

President

Endorsement Serial No.	E-1111-5328862

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AMERICAN LAND TITLE ASSOCIATION

ALTA Form 18-06 (Single Tax Parcel)

SUPPLEMENTAL #1

May 22, 2015
11:56 am

ENDORSEMENT

ATTACHED TO POLICY NUMBER M-9302-2184434
ISSUED BY

stewart title guaranty company

File No.: 210090075

Charge: $100.00

The Company insures against loss or damage sustained by the Insured by reason of the Land being taxed as part of a larger parcel of land or failing to constitute a separate tax parcel for real estate taxes.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Date: January 13, 2011

Signed under seal for the Company, but this endorsement is to be valid only when it bears an authorized countersignature.

Countersigned by:

Stewart Title Company - TN Overhead Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

stewart title guaranty company

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Senior Chairman of the Board

Chairman of the Board

President

Endorsement Serial No.	**E-1111-7684968**

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AMERICAN LAND TITLE ASSOCIATION

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ALTA Form 19-06 (Contiguity-Multiple Parcels)

SUPPLEMENTAL #1
May 22, 2015
11:56 am

ENDORSEMENT

ATTACHED TO POLICY NUMBER M-9302-2184434
ISSUED BY

stewart title guaranty company

File No.: 210090075

Charge: $100.00

The Company insures against loss or damage sustained by the Insured by reason of:

the presence of any gaps, strips, or gores separating any of the contiguous boundary lines described above.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Date: January 13, 2011

Signed under seal for the Company, but this endorsement is to be valid only when it bears an authorized countersignature.

Countersigned by:

Stewart Title Company - TN Overhead Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

stewart title guaranty company

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Senior Chairman of the Board

Chairman of the Board

President

Endorsement Serial No.	E-1111-3053064

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AMERICAN LAND TITLE ASSOCIATION

stewart title guaranty company

ALTA Form 20-06 (First Loss-Multiple Parcel Transactions)

SUPPLEMENTAL #1

May 22, 2015
11:56 am

ENDORSEMENT

ATTACHED TO POLICY NUMBER M-9302-2184434
ISSUED BY

stewart title guaranty company

File No.: 210090075

Charge: $100.00

This endorsement is effective only if the Collateral includes at least two parcels of real property.

1. For the purposes of this endorsement:
   a. "Collateral" means all property, including the Land, given as security for the Indebtedness.
   b. "Material Impairment Amount" means the amount by which any matter covered by this policy for which a claim is made diminishes the value of the Collateral below the Indebtedness.

2. In the event of a claim resulting from a matter insured against by this policy, the Company agrees to pay that portion of the Material Impairment Amount that does not exceed the limits of liability imposed by Sections 2 and 8 of the Conditions without requiring:
   a. maturity of the Indebtedness by acceleration or otherwise,
   b. pursuit by the Insured of its remedies against the Collateral,
   c. pursuit by the Insured of its remedies under any guaranty, bond or other insurance policy.

3. Nothing in this endorsement shall impair the Company's right of subrogation. However, the Company agrees that its right of subrogation shall be subordinate to the rights and remedies of the Insured. The Company's right of subrogation shall include the right to recover the amount paid to the Insured pursuant to paragraph 2 from any debtor or guarantor of the Indebtedness, after payment or other satisfaction of the remainder of the Indebtedness and other obligations secured by the lien of the Insured Mortgage. The Company shall have the right to recoup from the Insured Claimant any amount received by it in excess of the Indebtedness up to the amount of the payment under paragraph 2.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Date: January 13, 2011

Signed under seal for the Company, but this endorsement is to be valid only when it bears an authorized countersignature.

Countersigned by:

Stewart Title Company - TN Overhead
Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

stewart title guaranty company

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Senior Chairman of the Board

Chairman of the Board

President

Endorsement Serial No.	E-1111-5135523

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AMERICAN LAND TITLE ASSOCIATION

stewart title guaranty company

ALTA Form 22 (Location)

SUPPLEMENTAL #1

May 22, 2015

11:56 am

ENDORSEMENT

ATTACHED TO POLICY NUMBER M-9302-2184434

ISSUED BY

stewart title guaranty company

Charge: $100.00

File No.: 210090075

The Company insures against loss or damage sustained by the Insured by reason of the failure of a commercial building, known as 2911-3015 Brunswick Road, Memphis, Tennessee, to be located on the Land at Date of Policy.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Date: January 13, 2011

Signed under seal for the Company, but this endorsement is to be valid only when it bears an authorized countersignature.

Countersigned by:

Stewart Title Company - TN Overhead
Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

stewart title guaranty company

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Senior Chairman of the Board

Chairman of the Board

President

Endorsement Serial No.	E-1111-8601508

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stewart title guaranty company

ALTA Form 22.1 (Location and Map)

SUPPLEMENTAL #1
May 22, 2015
11:56 am

ENDORSEMENT

ATTACHED TO POLICY NUMBER M-9302-2184434
ISSUED BY

stewart title guaranty company

Charge: $100.00

File No.: 210090075

The Company insures against loss or damage sustained by the Insured by reason of the failure of (i) a commercial building, known as 2911-3015 Brunswick Road, Memphis, Tennessee, to be located on the Land at Date of Policy, or (ii) the map, if any, attached to this policy to correctly show the location and dimensions of the Land according to the Public Records.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Date: January 13, 2011

Signed under seal for the Company, but this endorsement is to be valid only when it bears an authorized countersignature.

Countersigned by:

Stewart Title Company - TN Overhead Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

stewart title guaranty company

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Senior Chairman of the Board

Chairman of the Board

President

Endorsement Serial No.	E-1111-6707624

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AMERICAN LAND TITLE ASSOCIATION

stewart

ALTA Form 24-06 (Doing Business) Adopted 10/16/08

SUPPLEMENTAL #1
May 22, 2015
11:56 am

ENDORSEMENT

ATTACHED TO POLICY NUMBER M-9302-2184434
ISSUED BY

stewart title guaranty company

Charge: $100.00

File No.: 210090075

The Company insures against loss or damage sustained by the Insured by reason of the invalidity or unenforceability of the lien of the Insured Mortgage on the ground that making the loan secured by the Insured Mortgage constituted a violation of the "doing business" laws of the State where the Land is located because of the failure of the Insured to qualify to do business under those laws.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Date: January 13, 2011

Signed under seal for the Company, but this endorsement is to be valid only when it bears an authorized countersignature.

Countersigned by:

Stewart Title Company - TN Overhead Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

stewart title guaranty company

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Senior Chairman of the Board

Chairman of the Board

President

Endorsement Serial No.	E-1111-4251852

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AMERICAN LAND TITLE ASSOCIATION

ALTA Form 25-06 (Same as Survey) Adopted 10/16/08

SUPPLEMENTAL #1

May 22, 2015
11:56 am

ENDORSEMENT

ATTACHED TO POLICY NUMBER M-9302-2184434
ISSUED BY

stewart
title guaranty company

Charge: $100.00

File No.: 210090075

The Company insures against loss or damage sustained by the Insured by reason of the failure of the Land as described in Schedule A to be the same as that identified on the survey made by Davis Engineering Company, Inc., 5350 Poplar Avenue, Suite 317, Memphis, Tennessee 38119 dated June 14, 2000, and designated Job No. 20000369-8.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Date: January 13, 2011

Signed under seal for the Company, but this endorsement is to be valid only when it bears an authorized countersignature.

Countersigned by:

Stewart Title Company - TN Overhead
Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

stewart
title guaranty company

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Senior Chairman of the Board

Chairman of the Board

President

Endorsement Serial No.	E-1111-2333683

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AMERICAN LAND TITLE ASSOCIATION

ALTA Form 26-06 (Subdivision) Adopted 10/16/08

SUPPLEMENTAL #1

May 22, 2015
11:56 am

ENDORSEMENT

ATTACHED TO POLICY NUMBER M-9302-2184434
ISSUED BY

stewart title guaranty company

Charge: $100.00

File No.: 210090075

The Company insures against loss or damage sustained by the Insured by reason of the failure of the Land to constitute a lawfully created parcel according to the subdivision statutes and local subdivision ordinances applicable to the Land.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Date: January 13, 2011

Signed under seal for the Company, but this endorsement is to be valid only when it bears an authorized countersignature.

Countersigned by:

Stewart Title Company - TN Overhead
Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

stewart title guaranty company

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Senior Chairman of the Board

Chairman of the Board

President

Endorsement Serial No.	**E-1111-8726277**

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stewart

AMERICAN LAND TITLE ASSOCIATION

ALTA Form 27-06 (Usury) Adopted 10/16/08

SUPPLEMENTAL #1

May 22, 2015
11:56 am

ENDORSEMENT

ATTACHED TO POLICY NUMBER M-9302-2184434
ISSUED BY

stewart title guaranty company

File No.: 210090075

Charge: $2,320.00

The Company insures against loss or damage sustained by the Insured by reason of the invalidity or unenforceability of the lien of the Insured Mortgage as security for the Indebtedness because the loan secured by the Insured Mortgage violates the usury law of the state where the Land is located.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Date: January 13, 2011

Signed under seal for the Company, but this endorsement is to be valid only when it bears an authorized countersignature.

Countersigned by:

Stewart Title Company - TN Overhead
Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

stewart title guaranty company

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Senior Chairman of the Board

Chairman of the Board

President

Endorsement Serial No.	E-1111-6172953

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AMERICAN LAND TITLE ASSOCIATION

ALTA Form 28-06 (Easement – Damage or Enforced Removal) Revised 02/03/10

SUPPLEMENTAL #1

May 22, 2015
11:56 am

ENDORSEMENT

ATTACHED TO POLICY NUMBER M-9302-2184434
ISSUED BY

stewart title guaranty company

File No.: 210090075

Charge: $100.00

The Company insures against loss or damage sustained by the Insured if the exercise of the granted or reserved rights to use or maintain the easement(s) referred to in Exception(s) 2 through 7 of Schedule B results in:

(1) damage to an existing building located on the Land, or

(2) enforced removal or alteration of an existing building located on the Land.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Signed under seal for the Company, but this endorsement is to be valid only when it bears an authorized countersignature.

Countersigned by:

Stewart Title Company - TN Overhead
Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

stewart title guaranty company

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Senior Chairman of the Board

Chairman of the Board

President

Endorsement Serial No.	E-1111-4158612

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AMERICAN LAND TITLE ASSOCIATION

SUPPLEMENTAL #1

May 22, 2015
11:56 am

ENDORSEMENT

ATTACHED TO POLICY NUMBER M-9302-2184434
ISSUED BY

stewart
title guaranty company

File No.: 210090075

Charge: $100.00

CLTA Exercise of Surface Rights for Extraction of Water Endorsement (06-03-05) 103.5

The Company hereby insures the insured against loss which the insured shall sustain by reason of damage to existing improvements, including lawns, shrubbery or trees, resulting from the exercise of any right to use the surface of the land for the extraction or development of water excepted from the description of the land or shown as a reservation in Schedule B.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Date: January 13, 2011
Signed under seal for the Company, but this endorsement is to be valid only when it bears an authorized countersignature.

Countersigned by:

Stewart Title Company - TN Overhead
Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

stewart
title guaranty company

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Senior Chairman of the Board

Chairman of the Board

President

Endorsement Serial No.	E-1111-10173257

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AMERICAN LAND TITLE ASSOCIATION

stewart

SUPPLEMENTAL #1

May 22, 2015
11:56 am

ENDORSEMENT

ATTACHED TO POLICY NUMBER M-9302-2184434
ISSUED BY

stewart title guaranty company

File No.: 210090075

Charge: $100.00

TAX DEED EXTINGUISHING EASEMENT

The Company insures against loss or damage sustained by the insured if:
The easement interests vested in the insured afforded by any instrument described in Schedule A of this policy may be divested or lost as the result of the non-payment of real estate taxes, or the foreclosure of any lien or mortgage affecting the servient parcel.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Date: January 13, 2011
Signed under seal for the Company, but this endorsement is to be valid only when it bears an authorized countersignature.

Countersigned by:

Stewart Title Company - TN Overhead Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

stewart title guaranty company

STEWART TITLE GUARANTY INCORPORATED 1908 TEXAS

Senior Chairman of the Board

Chairman of the Board

President

Endorsement Serial No.	E-1111-3042707

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AMERICAN LAND TITLE ASSOCIATION

stewart

SUPPLEMENTAL #1

File No.: 210090075

UHS of Lakeside, Inc., a Delaware corporation

May 22, 2015

11:56 am

ENDORSEMENT

STG Deletion of Arbitration Clause in Loan Policy Endorsement

Attached to Policy No.

M-9302-2184434

Issued by

STEWART TITLE

GUARANTY COMPANY

HEREIN CALLED THE COMPANY

Section 13 of the Conditions, relating to arbitration, is hereby deleted in its entirety.

This endorsement is made a part of the policy and is subject to all of the terms and provisions thereof and of any prior endorsements thereto. Except to the extent expressly stated, it neither modifies any of the terms and provisions of the policy and any prior endorsements, nor does it extend the effective date of the policy and any prior endorsements, nor does it increase the face amount thereof.

Signed under seal for the Company, but this Endorsement is to be valid only when it bears an authorized countersignature, this the 13th day of January, 2011.

STEWART TITLE
GUARANTY COMPANY

Stewart Morris Jr.
Chairman of the Board

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Malcolm S. Morris
President

Countersigned

Sandra S. Jack
Authorized Countersignature

Stewart Title Company - TN Overhead
Company

1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

SUPPLEMENTAL #1

STG Mortgage Tax Endorsement 1.1

Order No.: 210090075

May 22, 2015
11:56 am

ENDORSEMENT
Attached to Policy No.
M-9302-2184434
Issued by

STEWART TITLE
GUARANTY COMPANY
HEREIN CALLED THE COMPANY

The Company hereby affirmatively insures the Insured against loss or damage by reason of the non-payment or additional payment of a mortgage or related tax due with respect to the execution, delivery, recording or enforcement of Insured Mortgage or the indebtedness secured thereby.

The total liability of the Company under said policy and under this and any other endorsements thereto shall not exceed, in the aggregate, the amount of liability stated on the face of said policy, as the same may be specifically amended in dollar amount by this or any other endorsements, and the costs which the Company is obligated to pay under the Conditions and Stipulations of the policy.

This endorsement is made a part of the policy and is subject to all of the terms and provisions thereof and of any prior endorsements thereto. Except to the extent expressly stated, it neither modifies any of the terms and provisions of the policy and any prior endorsements, nor does it extend the effective date of the policy and any prior endorsements, nor does it increase the face amount thereof.

IN WITNESS WHEREOF, the Company has caused this Endorsement to be signed and sealed, and valid when countersigned by an authorized officer or agent of the Company, all in accordance with its By-Laws.

STEWART TITLE
GUARANTY COMPANY

Stewart Morris Jr.
Chairman of the Board

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Malcolm S. Morris
President

Countersigned

Sandra S. Jack
Authorized Countersignature

Stewart Title Company - TN Overhead
Company

1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

SUPPLEMENTAL #1

Order No.: 210090075

May 22, 2015

11:50am

STG Reverter Endorsement

CLTA Enforceability of Reverter Rights in CC&R Endorsement 100.12

Attached to Policy No.
M-9302-2184434
Issued by

STEWART TITLE
GUARANTY COMPANY
HEREIN CALLED THE COMPANY

Charge: $100.00

The Company hereby insures the insured against loss or damage which the insured shall sustain by reason of the enforcement or attempted enforcement of any reverter, right of re-entry or right or power of termination of the estate or interest referred to in Schedule A upon a breach of the covenants, conditions and restrictions referred to in Schedule B.

For purposes of this endorsement, the words "covenants," "conditions" or "restrictions" shall not be deemed to refer to or include any "covenants", "conditions" or "restrictions" relating to environmental protection, except to the extent that a notice of a violation or alleged violation affecting the land has been recorded in the public records at Date of Policy and is not excepted in Schedule B.

This endorsement is made a part of the policy and is subject to all of the terms and provisions thereof and of any prior endorsements thereto. Except to the extent expressly stated, it neither modifies any of the terms and provisions of the policy and any prior endorsements, nor does it extend the effective date of the policy and any prior endorsements, nor does it increase the face amount thereof.

IN WITNESS WHEREOF, the Company has caused this Endorsement to be signed and sealed, and valid when countersigned by an authorized officer or agent of the Company, all in accordance with its By-Laws.

STEWART TITLE
GUARANTY COMPANY

Stewart Morris Jr.
Chairman of the Board

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Malcolm S. Morris
President

Countersigned

Sandra S. Jack
Authorized Countersignature

Stewart Title Company - TN Overhead
Company
1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

SUPPLEMENTAL #1

File No.: 210090075

UHS of Lakeside, Inc., a Delaware corporation

May 22, 2015

11:56 am

CLTA Development of Minerals Endorsement (06-03-05) 100.29

Attached to Policy No.

M-9302-2184434

Issued by

STEWART TITLE

GUARANTY COMPANY

HEREIN CALLED THE COMPANY

The Company insures the insured against loss which the insured shall sustain by reason of damage to existing improvements, including lawns, shrubbery or trees resulting from the exercise of any right to use the surface of the land for the extraction or development of the minerals excepted from the description of the land or shown as a reservation in Schedule B.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Signed under seal for the Company, but this Endorsement is to be valid only when it bears an authorized countersignature, this the 13th day of January, 2011.

STEWART TITLE
GUARANTY COMPANY

Stewart Morris Jr.
Chairman of the Board

STEWART TITLE GUARANTY CO. INCORPORATED 1908 TEXAS

Malcolm S. Morris
President

Countersigned

Sandra S. Jack
Authorized Countersignature

Stewart Title Company - TN Overhead
Company

1630 NW Broad St., Ste 100
Murfreesboro, Tennessee 37129
City, State

SUPPLEMENTAL #1

May 22, 2015
11:56 am

ALTA Aggregation Endorsement 12

LOAN POLICY AGGREGATION ENDORSEMENT FORM 12

ATTACHED TO POLICY NO. PRO FORMA

Issued By

STEWART TITLE GUARANTY COMPANY

The following policies are issued in conjunction with one another:

See attached Exhibit B

Notwithstanding the provisions of Section 7(a)(i) of the Conditions and Stipulations of this policy, the Amount of Insurance available to cover the Company's liability for loss or damage under this policy at the time of Payment of Loss hereunder shall be the aggregate of the Amount of Insurance under this policy and the other policies identified above. At no time shall the Amount of Insurance under this policy and the other policies identified above exceed, in the aggregate, **$187,386,600.00.** Subject to the provisions of Section 9(a) of the Conditions and Stipulations of the policies, all payments made by the Company under this policy or any of the other policies identified above, except the payments made for costs, attorney's fees and expenses, shall reduce the aggregate Amount of Insurance pro tanto.

This endorsement is made a part of the policy and is subject to all of the terms and provisions thereof and of any prior endorsements thereto. Except to the extent expressly stated, it neither modifies any of the terms and provisions of the policy and any prior endorsements, nor does it extend the effective date of the policy and any prior endorsements.

Stewart Title Guaranty Company

By: _____

Cluster F

SUPPLEMENTAL #1

May 22, 2015
11:56 am

EXHIBIT B

BOS FILE NO.	LOCAL FILE NO.	FACILITY	ADDRESS	CITY	COUNTY	ST	Liability Amount
10070805	331008	Southwest Healthcare	36485 Inland Valley Drive	Wildomar/ Murietta	Riverside	CA	19,015,910.00
10070835	20101194	Brentwood Hospital	1006 Highland Avenue	Shreveport	Caddo	LA	12,568,354.00
10070840		Brynn Marr Behavioral Heath Care System	192 Village Drive	Jacksonville	Onslow	NC	13,653,983.00
10070839	10070839	Old Vineyard Behavioral Health Services	3637 Old Vineyard Road	Winston-Salem	Forsythe	NC	10,643,000.00
10070848	10090148	Saint Mary's Hospital	305 South 5th	Enid	Garfield	OK	17,608,000.00
10070849	10090157	Shadow Mountain Behavioral Health System	6262 South Sheridan Road	Tulsa	Tulsa	OK	14,963,696.00
10070858	10-045	Aiken Regional Medical Center	302 University Parkway	Aiken	Aiken	SC	42,937,000.00
10070859	10-044	Three Rivers Behavioral Health	2900 Sunset Boulevard West	West Columbia	Lexington	SC	14,197,283.00
10070861	210090074	Rolling Hills Hospital	2014 Quail Hollow Circle	Franklin	Williamson	TN	27,299,374.00
10070860	210090075	Lakeside BHS	2911-3015 Brunswick Road	Memphis	Shelby	TN	14,500,000.00

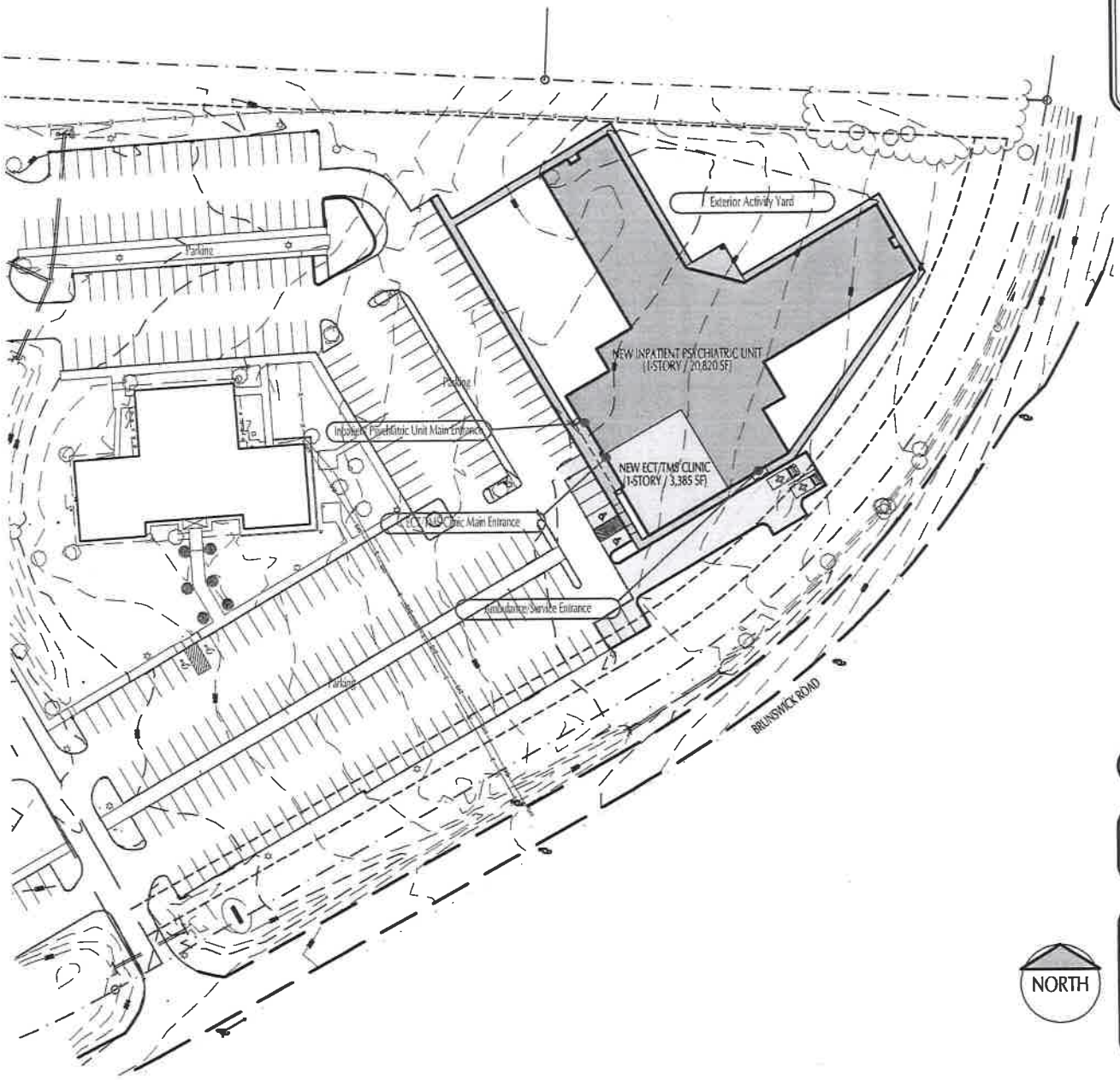
Cluster F

SUPPLEMENTAL #1
May 22, 2015
11:56 am

Supplemental – 1
CN1505-019

Section B III. A.

Plot Plan



LEGEND	
New Building Area - Inpatient Psychiatric Unit	20,820 sf
New Building Area - ECT/TMS Clinic	3,385 sf
TOTAL NEW BUILDING AREA	24,205 sf
Circulation Area - Horizontal	

NORTH

48 INPATIENT PSYCHIATRIC BEDS

GRAPHIC SCALE

0' 50' 100' 200'

SCHEMATIC SITE PLAN

SEE GRAPHIC SCALE

NEW GERIATRIC PSYCHIATRIC BUILDING
LAKESIDE BEHAVIORAL HEALTH SYSTEM
MEMPHIS, TENNESSEE

UHS1507

SD01-01

18 MARCH 2015

STENGEL-HILL ARCHITECTURE

613 WEST MAIN STREET LOUISVILLE, KENTUCKY 40202 502.895.1875 502.895.1876 fax

REVISED 05.20.15

May 22, 2015
11:56 am

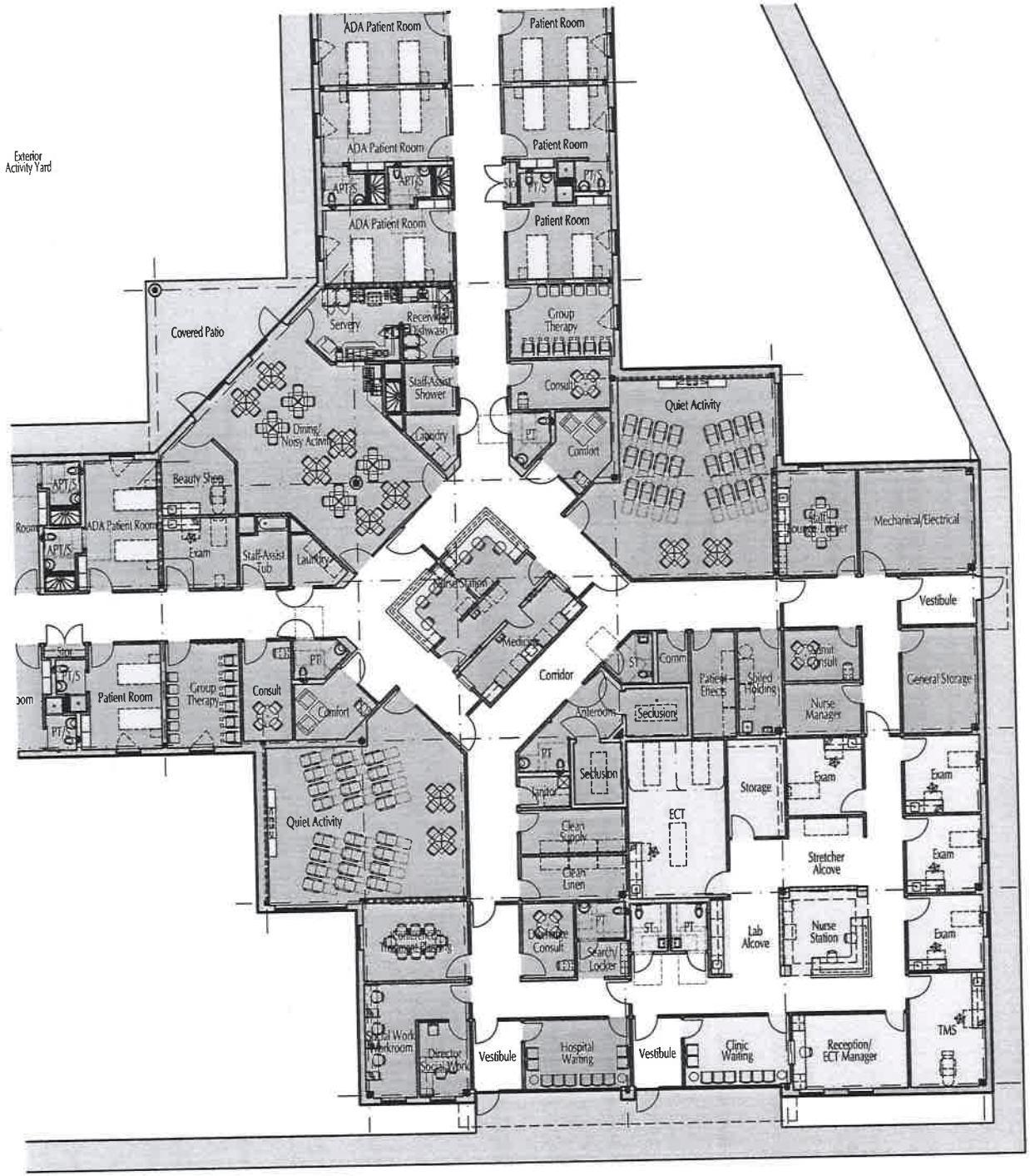
SUPPLEMENTAL #1

SUPPLEMENTAL #1
May 22, 2015
11:56 am

Supplemental – 1
CN1505-019

Section B. IV.

Floor Plan



LEGEND

New Building Area - Inpatient Psychiatric Unit	20,820 sf
New Building Area - ECT/TMS Clinic	3,385 sf
TOTAL NEW BUILDING AREA	24,205 sf
Circulation Area - Horizontal	

48 INPATIENT PSYCHIATRIC BEDS

GRAPHIC SCALE

0' 12.5' 25' 50'

SCHEMATIC FLOOR PLAN

SEE GRAPHIC SCALE

NEW GERIATRIC PSYCHIATRIC BUILDING
LAKESIDE BEHAVIORAL HEALTH SYSTEM
MEMPHIS, TENNESSEE

UHS1507

SD01-02a

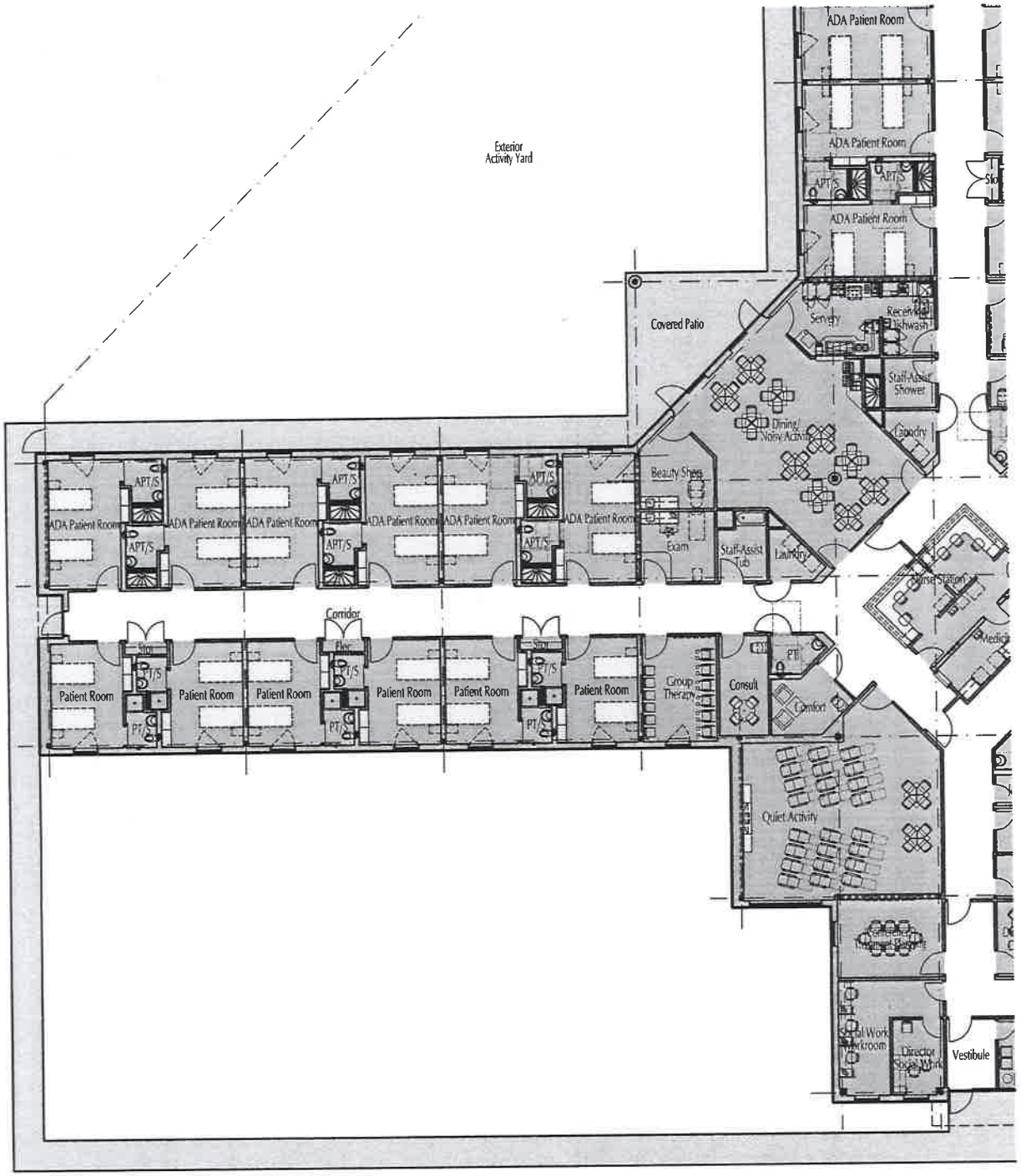
18 MARCH 2015

STENGEL-HILL ARCHITECTURE
613 WEST MAIN STREET LOUISVILLE, KENTUCKY 40202 502.893.1875 502.893.1876 fax

May 22, 2015
11:56 am

SUPPLEMENTAL #1

REVISED 05.20.15



LEGEND	
New Building Area - Inpatient Psychiatric Unit	20,820 sf
New Building Area - ECT/TMS Clinic	3,385 sf
TOTAL NEW BUILDING AREA	24,205 sf
Circulation Area - Horizontal	

48 INPATIENT PSYCHIATRIC BEDS

GRAPHIC SCALE

0' 12.5' 25' 50'

May 22, 2015
11:56 am

SCHEMATIC FLOOR PLAN
SEE GRAPHIC SCALE

NEW GERIATRIC PSYCHIATRIC BUILDING
LAKESIDE BEHAVIORAL HEALTH SYSTEM
MEMPHIS, TENNESSEE

SD01-02b

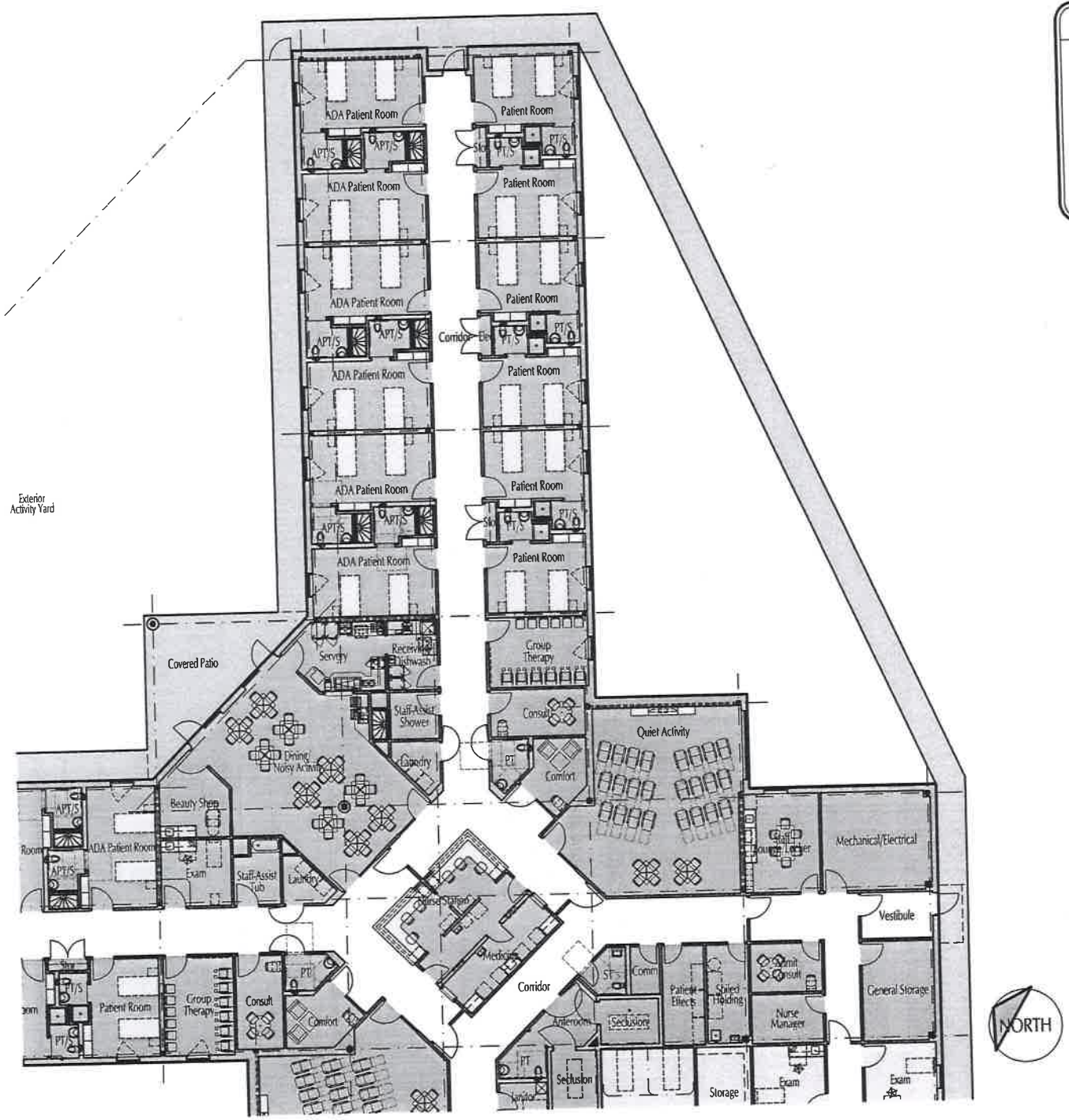
UHS1507

18 MARCH 2015

STENGEL-HILL ARCHITECTURE
613 WEST MAIN STREET LOUISVILLE, KENTUCKY 40202 502.893.1875 502.893.1876 fax

REVISED 05.20.15

SUPPLEMENTAL #1



LEGEND

New Building Area - Inpatient Psychiatric Unit	20,820 sf
New Building Area - ECT/TMS Clinic	3,385 sf
TOTAL NEW BUILDING AREA	24,205 sf
Circulation Area - Horizontal	

48 INPATIENT PSYCHIATRIC BEDS

GRAPHIC SCALE

0' 12.5' 25' 50'

SCHEMATIC FLOOR PLAN

SEE GRAPHIC SCALE

NEW GERIATRIC PSYCHIATRIC BUILDING
LAKESIDE BEHAVIORAL HEALTH SYSTEM
MEMPHIS, TENNESSEE

UHS1507

SD01-02c

18 MARCH 2015

STENGEL-HILL ARCHITECTURE
413 WEST MAIN STREET LOUISVILLE, KENTUCKY 40202 502.893.1875 502.893.1874 fax

REVISED 05.20.15

May 22, 2015
11:56 am

SUPPLEMENTAL #1

SUPPLEMENTAL #1
May 22, 2015
11:56 am

Supplemental – 1
CN1505-019

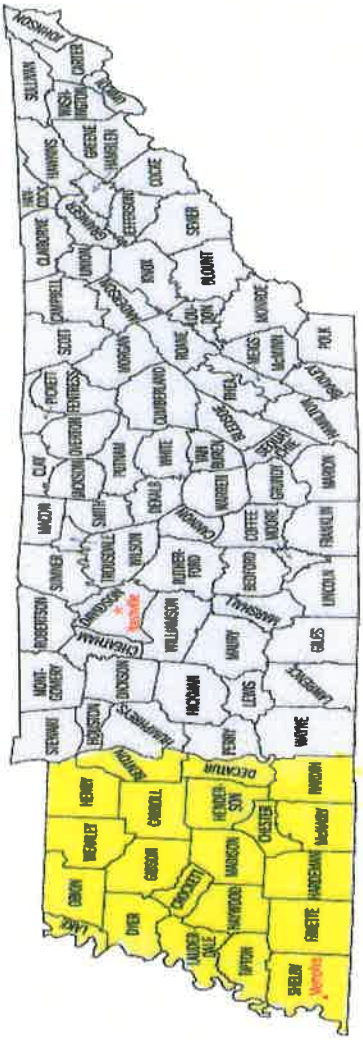
Section C. (Need) 3.

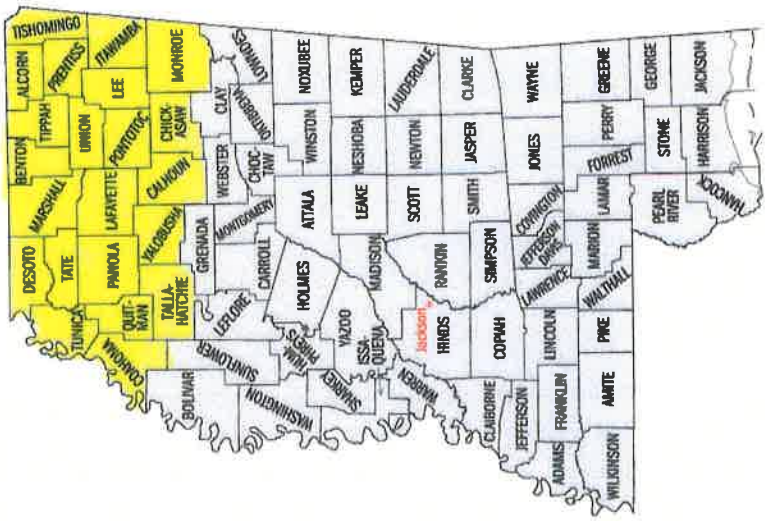
Service Area County Level Map

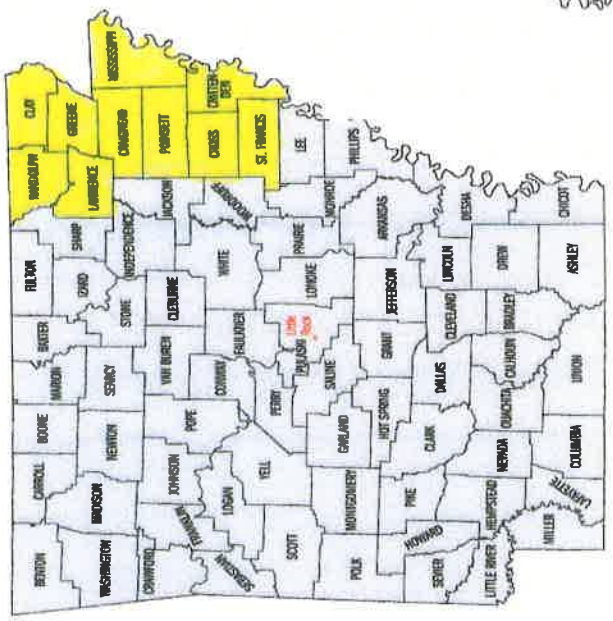
SUPPLEMENTAL #1

May 22, 2015

11:56 am







SUPPLEMENTAL #1
May 22, 2015
11:56 am

Supplemental – 1
CN1505-019

Section C. (Need) Item 4.A

Population Data Table

Demograhic Characteristics of Tennessee Service area - Ages 65 and up
Lakeside Behavioral Health System
2014 Current - 2016 Projected Year

Demographic	Benton County	Carroll County	Chester County	Crockett County	Decater County	Dyer County	Fayette County	Gibson County	Hardeman County	Hardin County	Haywood County
STATE OF TENNESSEE											
Current Year (CY) Age 65+	3,207	4,837	2,378	2,227	2,258	5,283	5,589	7,571	3,583	4,535	2,508
Projected Year (PY) Age 65+	3,805	5,695	2,855	2,602	2,603	6,550	7,561	8,990	4,396	5,650	2,871
Age 65+,% Change	18.6%	17.7%	20.0%	16.8%	15.2%	23.9%	35.3%	18.7%	22.6%	24.5%	14.4%
Age 65+, % Total (PY)	19.4%	16.6%	14.3%	15.0%	18.6%	15.7%	21.9%	17.5%	13.9%	19.6%	14.0%
CY, Total Population	16,489	28,522	17,131	14,586	11,757	38,335	29,413	49,683	27,253	26026	18787
PY, Total Population	19,578	34,295	19,892	17,267	13,941	41,617	34,419	51,248	31,456	28,808	20,474
Total Population % Change	18.7%	20.2%	16.1%	18.4%	18.6%	8.6%	17.0%	3.1%	15.4%	10.7%	9.0%
TennCare Enrollees	3,833	7,369	3,684	3,807	2,714	10,067	6,604	12,589	6,781	6,825	5,637
TennCare Enrollees as a % of Total Population	0.06%	0.12%	0.06%	0.06%	0.04%	0.16%	0.10%	0.20%	0.11%	0.11%	0.09%
Median Age	45	42	36	39	44	39	41	39	39	43	39
Median Household Income	$33,033	$35,049	$41,875	$36,066	$36,258	$38,953	$56,618	$38,343	$30,973	$33,622	$34,542
Population % Below Poverty Level	23.0%	19.2%	19.4%	21.1%	19.6%	17.7%	16.4%	19.8%	27.3%	21.4%	21.9%

2014 Current - 2016 Projected Year

Demographic	Henderson County	Henry County	Lake County	Lauderdale County	Madison County	McNairy County	Obion County	Shelby County	Tipton County	Weakley County	Service Area	Tennessee
STATE OF TENNESSEE												
Current Year (CY) Age 65+	3,990	6,119	889	3,314	12,205	4,307	5,124	92,405	6,548	5,035	417,918	823,104
Projected Year (PY) Age 65+	4998	7,144	1,183	4,007	15,075	5,301	6,101	116,675	8,743	6,020	488,242	1,042,071
Age 65+,% Change	25.20%	16.7%	33.0%	20.9%	23.5%	23.0%	19.1%	26.2%	33.5%	19.6%	16.8%	26.6%
Age 65+, % Total (PY)	15.9	19.2%	14.1%	13.7%	13.3%	18.4%	17.2%	11.4%	14.1%	15.4%	28.4%	15.5%
CY, Total Population	27,769	23,330	7,832	27,815	98,294	26,075	31,807	927,644	61,081	38,522	1,548,151	6,346,105
PY, Total Population	31,281	37,065	8,409	29,098	112,639	28,803	35,545	1,021,875	62,179	39,030	1,718,919	6,710,579
Total Population % Change	12.6%	58.9%	7.4%	4.6%	14.6%	10.5%	11.8%	10.2%	1.8%	1.3%	11.0%	5.7%
TennCare Enrollees	6,782	7,595	2,124	7,555	23,213	7,331	7,399	251,186	12,808	7,039	402,942	1,361,781
TennCare Enrollees as a % of Total Population	24.4%	32.6%	27.1%	27.2%	23.6%	28.1%	23.3%	27.1%	21.0%	18.3%	26.0%	21.5%
Median Age	39	44	38	36	36	41	41	34	36	37	39	38
Median Household Income	$38,280	$36,950	$27,115	$32,326	$41,617	$33,452	$39,467	$46,250	$52,423	$35,273	$38,023	$44,298
Population % Below Poverty Level	19.1%	19.2%	44.8%	28.7%	18.4%	21.5%	19.7%	21.8%	14.3%	21.0%	21.5%	17.8%

Source: 1) Surburban Stats.org/Tennessee Population by County/Age 2) TN Advisory Commission on Intergovernmental Relations 3) US Census Bureau 2009-2013 5-Year American Community Survey 4) TN Dept. of Health Statistics Web Page

SUPPLEMENTAL #1
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Demographic Characteristics of Mississippi Service Area - Ages 65 and up

Lakeside Behavioral Health System

2014 Current - 2016 Projected Year (2016 PY Data Unavailable - 2020 Data Presented as Census data in 5-year increments)

Demographic	Alcorn County	Benton County	Calhoun County	Chickasaw County	Coahoma County	DeSoto County	Itawamba County	Lafayette County	Monroe County	Lee County	Marshall County
STATE OF MISSISSIPPI											
Current Year (CY), Age 65+	5,681	1,298	3,042	2,390	3,042	16,043	3,494	5,568	5,568	10,189	4573
Projected Year (PY) Age 65+	8,047	1,780	3,224	3,394	4,089	28,107	4,929	7,272	7,835	15,362	7,183
Age 65+, % Change	41.6%	37.1%	6.0%	42.0%	34.4%	75.2%	41.1%	30.6%	40.7%	50.8%	57.1%
Age 65+, % Total (PY)	20.8%	20.3%	22.2%	20.4%	17.6%	13.2%	20.9%	14.2%	21.7%	17.1%	18.2%
CY, Total Population	37,057	8,729	14,962	17,392	26,151	161,252	23,401	47,351	36,989	82,910	37,144
PY, Total Population	38,711	8,759	14,543	16,604	23,252	212,747	23,639	51,188	36,155	89,871	39,513
Total Population % Change	4.5%	0.3%	-2.8%	-4.5%	-11.1%	31.9%	1.0%	8.1%	-2.3%	8.4%	6.4%
TennCare Enrollees	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TennCare Enrollees as a % of Total Population	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Median Age	39	39	39	37	32	35	38	27	36	36	38
Median Household Income	$33,600	$31,060	$30,000	$31,061	$26,407	$58,505	$36,073	$43,328	$36,308	$42,074	$36,022
Population % Below Poverty Level	22.2%	27.4%	22.5%	24.8%	36.5%	10.8%	19.6%	21.9%	21.7%	19.5%	27.3%

2014 Current - 2016 Projected Year (2016 PY Data Unavailable - 2020 Data Presented as Census data in 5-year increments)

Demographic	Panola County	Pontotoc County	Prentiss County	Quitman County	Tallahatchie County	Tate County	Tippah County	Tishomingo County	Tunica County	Union County	Yalobusha County	Service Area	Mississippi
STATE OF MISSISSIPPI													
Current Year (CY), Age 65+	4,360	3,680	3,819	1,106	1,761	3,463	3,179	3,381	979	3,774	1,998	92,388	365,651
Projected Year (PY) Age 65+	6,384	5,555	5,278	1,518	2,376	5,486	4,489	4,698	1,651	5,472	2,965	137,094	550,760
Age 65+, % Change	46.4%	51.0%	38.2%	37.3%	34.9%	58.4%	41.2%	39.0%	68.6%	45.0%	48.4%	48.4%	50.6%
Age 65+, % Total (PY)	17.5%	17.3%	20.9%	22.4%	17.7%	17.9%	19.4%	23.8%	13.4%	19.0%	21.9%	17.2%	18.3%
CY, Total Population	37,707	29,957	25,276	8,223	15,378	28,886	22,232	19,593	10,778	27,134	12,678	731,180	2,967,297
PY, Total Population	36,488	32,069	25,240	6,777	13,456	30,711	23,095	19,770	12,330	28,856	13,514	797,288	3,014,409
Total Population % Change	-3.2%	7.1%	-0.1%	-17.6%	-12.5%	6.3%	3.9%	0.9%	14.4%	6.3%	6.6%	9.0%	1.6%
TennCare Enrollees	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TennCare Enrollees as a % of Total Population	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Median Age	39	36	38	37	35	36	38	42	32	37	40	37	36
Median Household Income	$35,715	$39,899	$32,503	$22,863	$29,853	$41,494	$34,636	$32,592	$31,446	$38,373	$32,930	$35,306	$39,0[illegible]
Population % Below Poverty Level	27.0%	18.0%	22.7%	38.3%	38.4%	18.0%	22.0%	19.7%	31.4%	18.0%	22.5%	24.1%	17.8%

Source: 1) Surburban Stats.org/Mississippi Population by County/Age 2) US Census Bureau 2009-2013 5-Year American Community Survey 3) Mississippi.edu/urc/downloads/PopProjections/PopulationProjections.pdf

NOTE: 2016 Projected Year Data not available. Census data available in 5 year increments

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SUPPLEMENTAL #1

Demographic Characteristics of Arkansas Service Area - Ages 65 and up

Lakeside Behavioral Health System

2014 Current - 2016 Projected Year (2016 PY Data Unavailable - 2020 Data Presented as Census data in 5-year increments)

Demographic	Clay County	Craighead County	Crittenden County	Cross County	Greene County	Lawrence County	Mississippi County	Poinsett County	Randolph County	St. Francis County	Service Area	Arkansas
STATE OF ARKANSAS												
Current Year (CY), Age 65+	3,125	12,748	5,646	2,785	6,394	3,158	5,384	3,983	3,477	3,402	50,102	440,840
Projected Year (PY) Age 65+	2,989	14,625	5,972	2,851	7,059	3,160	4,902	4,140	3,721	3,324	52,743	480,942
Age 65+, % Change	-4.4%	14.7%	5.8%	2.4%	10.4%	0.1%	-9.0%	3.9%	7.0%	-2.3%	5.3%	9.1%
Age 65+, % Total (PY)	20.6%	12.7%	11.7%	17.6%	14.7%	18.6%	12.0%	17.6%	21.0%	12.3%	14.2%	14.6%
CY, Total Population	15,475	103,258	50,917	17,209	44,292	17,265	44,323	24,157	17,874	27,815	362,585	3,042,351
PY, Total Population	14,524	115,519	50,943	16,174	48,173	17,020	40,986	23,473	17,718	27,100	371,630	3,286,838
Total Population % Change	-6.1%	11.9%	0.1%	-6.0%	8.8%	-1.4%	-7.5%	-2.8%	-0.9%	-2.6%	2.5%	8.0%
TennCare Enrollees	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TennCare Enrollees as a % of Total Population	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Median Age	43	33	34	39	37	40	34	39	41	37	38	37
Median Household Income	$31,502	$41,393	$37,751	$38,085	$38,413	$32,239	$36,428	$32,089	$34,418	$30,873	$35,319	$40,768
Population % Below Poverty Level	22.4%	17.6%	24.0%	19.9%	19.4%	25.0%	25.6%	27.9%	21.6%	32.3%	23.6%	14.4%

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Section C (Economic Feasibility) Item 4

Projected Data Chart
Gero and Hospital

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PROJECTED DATA GERIATRIC - Volume Growth

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

Financial Data in Thousands			Year One	Year Two
A. Utilization Data (Specify unit of measure) Pt I		Pt Days	730	2,190
B. Revenue from Services to Patients				
1 Inpatient Services			$1,008.7	$3,059.6
2 Outpatient Services			$0.0	$0.0
3 Emergency Services				
4 Other Operating Revenue (Specify)				
	Gross Operating Revenue		$1,008.7	$3,059.6
C. Deductions from Gross Operating Revenue				
1 Contractual Adjustments			$503.8	$1,527.8
2 Provision for Charity Care			$0.0	$0.0
3 Provisions for Bad Debt			$5.4	$17.5
	Total Deductions		$509.2	$1,545.3
NET OPERATING REVENUE			$499.5	$1,514.3
D. Operating Expenses				
1 Salaries and Wages			$75.3	$150.8
2 Physician's Salaries and Wages				
3 Supplies			$27.7	$83.2
4 Taxes				
5 Depreciation			$493.0	$493.0
6 Rent			$6.0	$6.0
7 Interest, other than Capital				
8 Management Fees:				
a.	Fees to Affiliates		$0.0	$0.0
b.	Fees to Non-Affiliates			
9 Other Expenses (Specify) Professional Fees, Purchased Services, Maintenance, Travel, Insurance			$327.2	$377.9
	Total Operating Expenses		$929.2	$1,110.9
E. Other Revenue (Expenses) – Net (Specify)			$0.0	$0.0
NET OPERATING INCOME (LOSS)			($429.7)	$403.4
F. Capital Expenditures				
1 Retirement of Principal				
2 Interest				
	Total Capital Expenditures		$0.0	$0.0
NET OPERATING INCOME (LOSS)			($429.7)	$403.4

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PROJECTED DATA HOSPITAL

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

***Financial Data in Thousands**			Year One	Year Two
A. Utilization Data (Specify unit of measure) Pt I		Pt Days	83,986	85,446
B. Revenue from Services to Patients				
1 Inpatient Services			$116,731.7	$118,782.6
2 Outpatient Services			$947.0	$947.0
3 Emergency Services			$0.0	$0.0
4 Other Operating Revenue (Specify)			$0.0	$0.0
	Gross Operating Revenue		$117,678.7	$119,729.6
C. Deductions from Gross Operating Revenue				
1 Contractual Adjustments			$59,987.8	$61,011.8
2 Provision for Charity Care			$1,221.0	$1,221.0
3 Provisions for Bad Debt			$2,192.4	$2,204.5
	Total Deductions		$63,401.2	$64,437.3
NET OPERATING REVENUE			$54,277.5	$55,292.3
D. Operating Expenses				
1 Salaries and Wages			$23,522.3	$23,597.8
2 Physician's Salaries and Wages			$0.0	$0.0
3 Supplies			$3,338.7	$3,394.2
4 Taxes			$0.0	$0.0
5 Depreciation			$1,456.0	$1,456.0
6 Rent			$257.0	$257.0
7 Interest, other than Capital			$0.0	$0.0
8 Management Fees:			$0.0	$0.0
a.	Fees to Affiliates		$1,211.0	$1,211.0
b.	Fees to Non-Affiliates		$0.0	$0.0
9 Other Expenses (Specify) Professional Fees, Purchased Services, Maintenance, Travel, Insurance			$9,036.2	$9,086.9
	Total Operating Expenses		$38,821.2	$39,002.9
E. Other Revenue (Expenses) – Net (Specify)			$0.0	$0.0
NET OPERATING INCOME (LOSS)			$15,456.3	$16,289.4
F. Capital Expenditures				
1 Retirement of Principal				
2 Interest				
	Total Capital Expenditures		$0.0	$0.0
NET OPERATING INCOME (LOSS)			$15,456.3	$16,289.4

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Section C. (Economic Feasibility)
Item 10

Parent Company, UHS, Inc.
2014 Published Annual Report

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THIRTY-FIVE YEARS OF LEADERSHIP EXCELLENCE
UNIVERSAL HEALTH SERVICES, INC.

2014 Annual Report

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"I am wearing an American Flag lapel pin in solidarity with and support of our troops in the Middle East and around the world. I urge you to do the same."

UNIVERSAL HEALTH SERVICES, INC.

Our mission is to provide superior quality healthcare services that patients recommend to family and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term returns.

We believe hospitals will remain the focal point of the healthcare delivery system. We have built our success by remaining committed to a program of rational growth around our core businesses and seeking opportunities complementary to them with a prudent level of debt. The future of our industry remains bright for those whose focus is providing quality healthcare on a cost-effective basis.

2014 was an exceptional year for Universal Health Services, Inc. (NYSE: UHS).

It was a year in which the company celebrated its 35th Anniversary, a milestone that is exceedingly rare in this age of mergers and acquisitions. It was a year in which the company's net revenue reached $8.07 billion, the highest in its history. And, it was a year in which UHS was recognized both for the quality of medical care it provides and for its financial performance over the past three-and-a-half decades.

It was also a year of dramatic change for the healthcare industry, with the Patient Protection and Affordable Care Act (ACA) bringing insurance coverage to eight million Americans who had been previously uninsured. Along with the increased coverage, the ACA also brought stricter care and reimbursement requirements for healthcare providers.

UHS's results position it as one of the premier hospital management companies in the United States. Net revenue increased 10.7 percent, to $8.07 billion in 2014 compared to $7.28 billion in 2013. Adjusted net income attributable to UHS in 2014 increased 29 percent to $581.8 million, compared to $452.1 million in 2013.

The company's stock price appreciated 37 percent during the year, closing 2014 at $111.26 per share. In 2013, the company's stock price had appreciated 68 percent and closed at $81.26 per share.

ACUTE CARE: PREPARING FOR THE FUTURE

Our Acute Care Division performed well in 2014 as it worked to successfully meet a number of challenges as we move into a future that will see reimbursement rates increasingly tied to quality measures and patient satisfaction scores.

Through process improvement programs, developing best practices and adopting new technology, we have successfully introduced a number of programs that have increased the quality of care and patient satisfaction. We completed the successful implementation of Phase 2 of UHS FUSION, our electronic health records initiative, and we are well on the way toward completing the next phase.

The company continues to invest in the growth of the Acute Care Division. The 140-bed Temecula Valley Hospital opened last year and is progressing well. The division broke ground for construction of Henderson Hospital in Henderson, Nevada. The new 142-bed acute care facility is slated for completion in 2016 and will be the sixth UHS acute care facility in the Las Vegas region. The division also began construction on three freestanding emergency departments in Texas, one in Laredo and two in the Rio Grande Valley, to make quality medical care more accessible to residents of the region. In Denison, Texas, the company built out the previously unused eighth floor of Texoma Medical Center to add 38 beds.

The Acute Care Division implemented several programs designed to increase quality and improve patient satisfaction. Process improvement programs in our surgery departments have allowed us to virtually eliminate same-day surgery cancellations and reduce the amount of time it takes to prepare an operating room for its next patient to 28 minutes. New procedures in our emergency departments are reducing delays so that we can now meet our objective of 150 minutes from the time a patient is checked in to when he or she is discharged.

UHS acquired Prominence Health Plan in 2014 to help prepare for narrow networks, which may evolve in the future as a way to reduce costs by limiting doctors and hospitals available to insurance subscribers. The new health plan offers a Medicare Advantage option in Nevada and Texas, as well as a commercial insurance product through the Nevada Health Care Exchange. Through its affiliations with Northern Nevada Medical Center, South Texas Health System and Northwest Texas Healthcare System, Prominence Health Plan continues to expand its care management programs.

BEHAVIORAL HEALTH: ACQUISITION AND GROWTH

In September 2014, UHS acquired Cygnet Health Care Limited, one of the largest independent providers of behavioral health services in the United Kingdom. Through this acquisition, we added a total of 17 facilities and 1,450 employees throughout the UK.

As demand for inpatient care continued to grow in the U.S., the Behavioral Health Division acquired two facilities, one in Washington, DC, and one in Tucson, Arizona.

The Behavioral Health Division responded to the continuing demand for more acute inpatient beds brought on by healthcare reform, which requires that mental health services are covered by insurance and are treated equitably with medical and surgical services. To meet that need, the division added beds to existing facilities or converted existing residential beds for a total of more than 600 new acute inpatient psychiatric beds.

RECOGNIZED FOR QUALITY AND PERFORMANCE

Fortune magazine consistently lists UHS among the ***World's Most Admired Companies***, a respected report card on corporate reputation. Through hard work, dedication and service excellence, in 2014, UHS was ranked as the World's Most Admired Company in the healthcare management industry, topping all of its competitors and second among all healthcare/medical facilities.

In November, The Joint Commission released its list of *Top Performers on Key Quality Measures®* for 2013 and 46 UHS acute care and behavioral health facilities were on the list. This recognition, together with the number of patients who leave our facilities extremely satisfied with the treatment they received, is an important achievement for everyone who works at UHS.

UHS was also recognized for its excellent financial performance. The company was included in the Standard & Poor's 500 index, which tracks the 500 most widely held stocks on the New York Stock Exchange, and is one of the world's most followed stock market indices.

The company also appeared on the list of ***Historical Extreme Winners*** in J.P. Morgan's "Eye On The Market," a historical perspective of the stock performance of companies on the Russell 3000 Index, which measures the performance of 3,000 of the largest publicly held U.S. companies. As part of that recognition, UHS was named as a stock that generated one of the highest excess lifetime returns over its 35-year history.

35 YEARS OF SUCCESS

UHS built its success by remaining committed to rational growth around core businesses and seeking opportunities to complement those businesses, such as health insurance plans to supplement the Acute Care Division and acquiring behavioral assets in the UK.

UHS will continue to focus on long-term goals and will take calculated risks to achieve them. The company will continue to cultivate new leaders who have high ethical standards, experience and are highly motivated to succeed. Those leaders will direct the company toward continued success, no matter what changes occur in the industry and will not waver from the company's core commitment to provide superior quality healthcare to the patients and communities it serves.

Our management team is confident that we will continue our record of success and believes that the initiatives being put into place now will provide the base for excellent performance for years to come.

No doubt UHS will continue to perform as an industry leader. I greatly appreciate the efforts of our entire team as we provide patients with the highest possible quality of care.

Sincerely,

Alan B. Miller
Chairman of the Board
Chief Executive Officer

FINANCIAL HIGHLIGHTS

SUPPLEMENTAL #1

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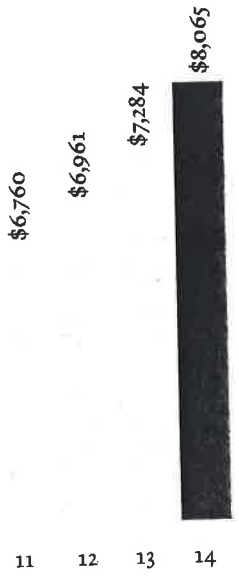
Year Ended December 31	2014	2013	Percentage Increase	2012
Net revenues	$8,065,326,000	$7,283,822,000	11%	$6,961,400,000
Adjusted net income attributable to UHS (1)	$581,753,000	$452,103,000	29%	$406,419,000
Adjusted diluted earnings per share attributable to UHS (1)	$5.78	$4.55	27%	$4.15

Year Ended December 31	2014	2013	Percentage Increase	2012
Patient days	6,686,386	6,466,875	3%	6,308,590
Admissions	677,675	647,725	5%	618,671
Average number of licensed beds	26,007	25,592	2%	24,821

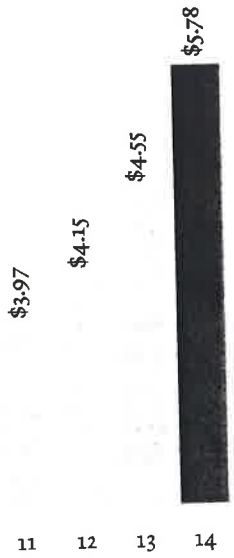
(1) Calculation of Adjusted Net Income Attributable to UHS (in thousands except per share amounts)	2014 Amount	2014 Per Diluted Share	2013 Amount	2013 Per Diluted Share	2012 Amount	2012 Per Diluted Share	2011 Amount	2011 Per Diluted Share
Net income attributable to UHS	$545,343	$5.42	$510,733	$5.14	$443,446	$4.53	$398,167	$4.04
Other combined adjustments	36,410	0.36	(58,630)	(0.59)	(37,027)	(0.38)	(6,477)	(0.07)
Adjusted net income attributable to UHS	$581,753	$5.78	$452,103	$4.55	$406,419	$4.15	$391,690	$3.97

The "Other combined adjustments" neutralize the effect of items in each year that are nonrecurring or non-operational in nature including items such as: the cost incurred and incentive income recorded in connection with the implementation of electronic health records applications; adjustments to our reserves relating to prior years for self-insured professional & general liability and workers' compensation claims; gains and losses on sales of assets and businesses; reserves for settlements and legal judgments, and; other amounts that may be reflected in a given year that relate to prior years. Since "adjusted net income attributable to UHS" is not computed in accordance with generally accepted accounting principles ("GAAP"), investors are encouraged to use GAAP measures when evaluating our financial performance. To obtain a complete understanding of our financial performance the information provided above should be examined in connection with our consolidated financial statements and notes thereto, as contained in this report.

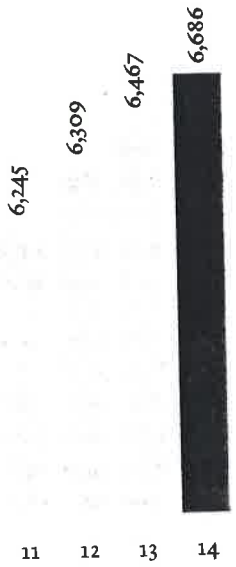
Net revenues
(in millions)



Adjusted net income per diluted share attributable to UHS (1)



Hospital patient days
(in thousands)



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For a full state-by-state list of Universal Health Services, Inc. facilities, please visit us at our website: **www.uhsinc.com**

UHS is a registered trademark of UHS of Delaware, Inc., the management company for Universal Health Services, Inc. and a wholly owned subsidiary of Universal Health Services. 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. Any reference to "UHS or UHS facilities" including any statements, articles or other publications contained herein which relates to healthcare or management operations is referring to Universal Health Services' subsidiaries including UHS of Delaware. Further, the terms "we," "us," "our" or "the company" in such context similarly refer to the operations of Universal Health Services' subsidiaries including UHS of Delaware. Any reference to employment at UHS or employees of UHS refers to employment with one of the subsidiaries of Universal Health Services, Inc., including its management company, UHS of Delaware, Inc.

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SUPPLEMENTAL #1

May 22, 2015
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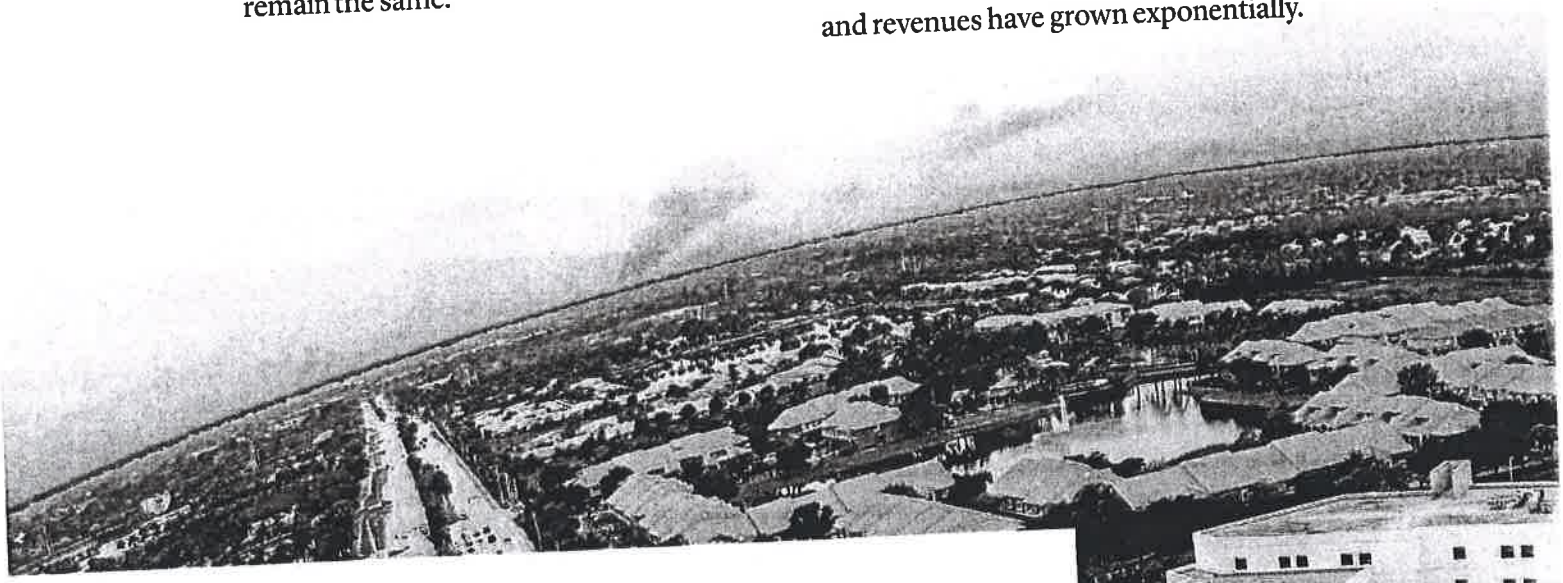
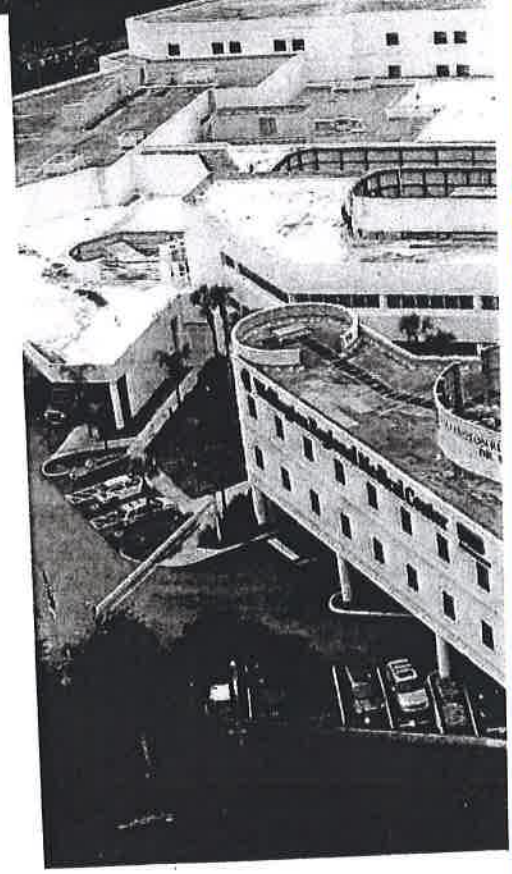
UHS | Thirty-five years of leadership excellence

Universal Health Services, Inc. (UHS) is dramatically larger and more diverse than it was when it was founded in 1979 but our core values, integrity, perseverance and talent for capturing growth opportunities remain the same.

For 35 years, UHS has provided patients with high quality healthcare, physicians with the finest equipment and optimal environments to practice medicine and shareholders with exceptional returns on their investment. Our facilities, services, number of employees and revenues have grown exponentially.





Wellington Regional Medical Center opened in 1986 and has continued to expand in size to serve residents of the rapidly growing community. The most recent expansion was the construction and opening of the Alan B. Miller Pavilion in 2012. The photo above was taken in December 1984 and shows the fields on which the hospital was built, compared to the latest photo of the 50-acre Wellington Regional Medical Center campus, taken in January 2015.

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From the classic start up of an idea but no actual business, today UHS employs more than 70,000 people and we operate more than 235 hospitals in 37 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and the United Kingdom. Throughout the past three-and-a-half decades, amid constant change, UHS has consistently turned challenges into golden opportunities.

Our company's success is grounded in a clear, effective philosophy: Build or acquire high quality hospitals in strong growth markets then invest in the people and equipment most needed in each community that will allow the facility to thrive and become the dominant healthcare provider in the region. This philosophy has served the company well for 35 years and it will continue to guide us long into the future.

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Focusing on quality, growth and operations means constantly identifying new opportunities to enhance the quality of care UHS hospitals provide, like at the George Washington University Hospital in Washington, DC, where a new comprehensive breast care center opened in 2014 and specialty programs like the cancer program received a national achievement award from the Commission on Cancer of the American College of Surgeons.

UHS ACUTE CARE DIVISION

Dedication to quality care and clinical excellence

UHS acute care hospitals serve people at a time when they are most vulnerable. How we respond leaves an indelible impression on our patients, their families and the communities we serve.

It is the dedication employees have to providing quality care and clinical excellence that sets UHS hospitals apart. In a year of significant change brought on by the implementation of the Patient Protection and Affordable Care Act (ACA), accompanied by more stringent reimbursement policies that tie payments to quality of care, readmission rates and patient satisfaction scores, the UHS Acute Care Division realized impressive results in 2014. Quality and patient satisfaction improved significantly. Readmissions decreased markedly. Productivity and efficiency dramatically increased. And, the Acute Care Division grew, entering new markets and adding services to ensure that UHS is well positioned for the future.

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FOCUS ON QUALITY, GROWTH AND LEAN OPERATIONS

The success of the Acute Care Division is based on three pillars that are the foundation for patient care, quality and service, growth and development and lean operations. When we focus on the pillars we will continue to succeed and be the provider of choice in our markets.

2014 was a good example of how these pillars helped UHS improve quality, patient outcomes and patient satisfaction, even as significant changes affected the healthcare industry. The implementation of the ACA made it possible for an additional eight million Americans to have health insurance in 2014. But it also meant UHS facilities faced more stringent guidelines and regulations to receive reimbursement.

Additional changes came with federal indigent funding programs, like one available in Texas called Delivery System Reform Incentive Payment Program (DSRIP). The goal of the program was to make quality care for under-served populations more accessible.

Our leadership team in Texas identified and developed projects that qualified for significant DSRIP reimbursement. One of the projects was a mobile medical clinic that is equipped and staffed to deliver primary care services to residents in the Rio Grande Valley in South Texas who cannot get to a doctor's office.

THE CHANGING FACE OF HEALTHCARE

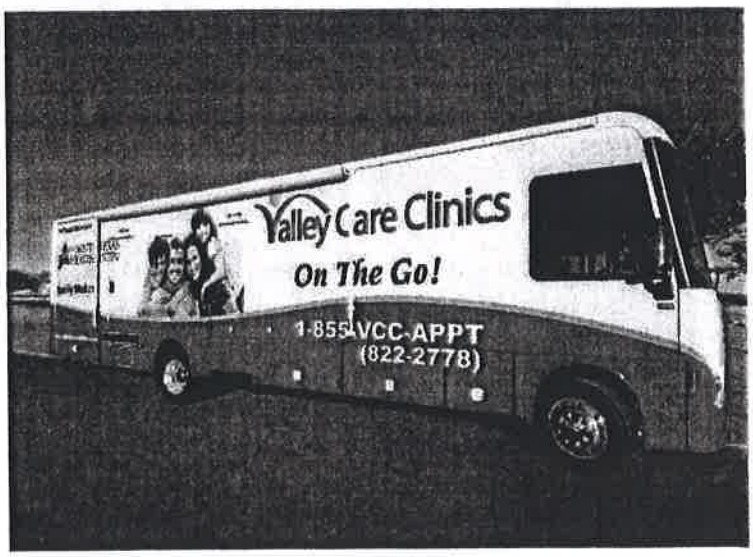
While the ACA meant millions more Americans had health insurance, it also brought new, more stringent reimbursement guidelines and regulations. The UHS Acute Care Division responded well and improved metrics for lean operations and met clinical and productivity benchmarks by establishing best practices and process improvement initiatives.

UHS moved to a new group purchasing organization in 2013 and realized significant savings and quality improvements, like standardizing clinical vendors and procedures to improve quality and patient safety and use best practice suppliers that are more cost effective.

Process improvement projects helped the division achieve greater patient satisfaction and outcomes. One of our goals was to reduce the number of patients who leave our emergency departments without being seen. In 2014, the division realized significant improvement in this metric and improved our patients' experience.

The division also launched a program to reduce the wait time in the emergency department from hours to minutes. The initial program was so successful at The Valley Health System in Las Vegas, that it has been duplicated at the South Texas Health System, Inland Valley Medical Center, Rancho Springs Medical Center and Temecula Valley Hospital in California, and at Aiken Regional Medical Centers in South Carolina. The program will be implemented at other UHS hospitals in 2015.

Another significant process improvement that is positively affecting operations and the patient experience is a project to optimize the operating room efficiency by reducing the same day surgery cancellation rate. During 2014, the division virtually eliminated same day cancellations.



Residents in South Texas now have access to primary care and specialty care services without having to travel to our hospitals, thanks to the Valley Care Clinics On-the-Go mobile care unit. The unit makes quality healthcare services available to under-served populations.

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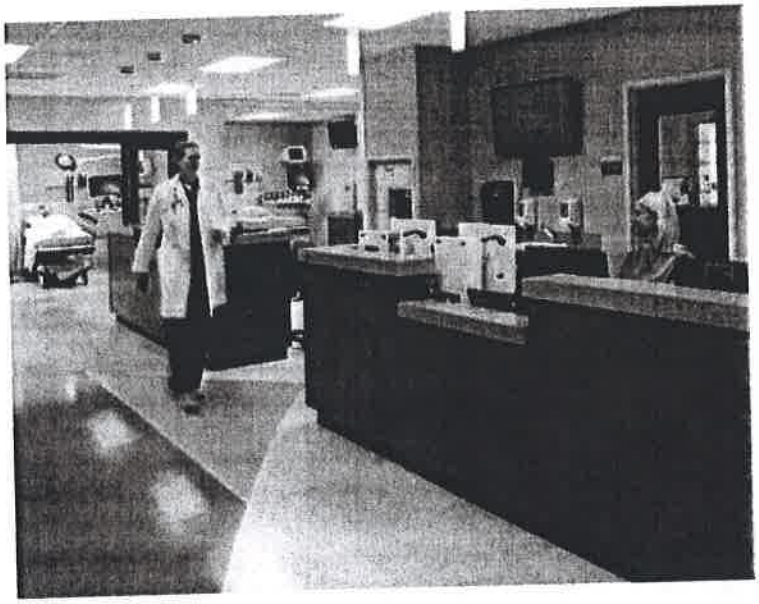
Another 2014 process improvement initiative focused on cleaning and equipping operating rooms faster and more efficiently for the next procedure. The national standard for operating room turnover is 28 minutes. After onsite visits, new procedures were developed to ensure hospitals met the national metric and as a result, 20 hospitals achieved the 28-minute metric and saw significant improvement in on-time starts.

A YEAR OF GROWTH FOR THE ACUTE CARE DIVISION

Significant growth occurred in the division, thanks to new services, new programs and new facilities.

One of the first hospitals UHS acquired 36 years ago was Valley Hospital in Las Vegas. Since then, the company's presence in that city has expanded significantly with five acute care hospitals. In 2014, UHS broke ground for Henderson Hospital, the sixth Valley Health System hospital.



Temecula Valley Hospital in California completed its first full year of operation, with more than 26,000 emergency department visits and 3,300 inpatient admissions. The hospital also launched a program to reduce the wait time in the emergency department to improve the patient experience and patient satisfaction.

The new facility will be the anchor for a new master-planned community in Henderson, the second largest city in the Las Vegas metropolitan area. Success in Las Vegas is further evidenced by the approval and construction of a new bed tower for Spring Valley Hospital. UHS hospitals in Nevada continue to prosper and add needed services and programs for an increasing number of residents and visitors.

Another expansion took place at Texoma Medical Center in Texas, where shelled space on the top floor of the main hospital was completed. This was the second expansion project at the hospital since it opened and is the direct result of volume growth and the need for quality healthcare services there.

Growth and community outreach also occurred in South Texas. UHS is bringing emergency and outpatient services to residents of Weslaco and Mission as a result of the construction of two new freestanding emergency departments that will provide new patient access sites for our South Texas Health System facilities.

In addition, ground was broken for a new freestanding emergency department in South Laredo. These new facilities will be open 24 hours a day, seven days a week and will provide emergency and outpatient services, including imaging, laboratory and pharmacy services.

In California, Temecula Valley Hospital completed its first full year of operation, with more than 26,000 emergency department visits and 3,300 inpatient admissions. The hospital also established a clinical collaboration and affiliation with UC San Diego Health System, implemented a coronary intervention program, earned designation as a Stroke Ready Center and a STEMI Receiving Center for meeting or exceeding national standards and surgeons performed the first open-heart surgery in April.

The success of the affiliation prompted a similar collaboration between Corona Regional Medical Center and UC Irvine Health, which will enhance the depth and variety of specialty services for residents of western Riverside County, including stroke telemedicine, oncology, urology and maternal and fetal medicine.

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For UHS employees and clinicians patients always come first and delivering quality care is personal. Our employees, like the cardiac care nurses at Aiken Regional Medical Centers in Aiken, South Carolina, go above and beyond to continually improve patient outcomes and patient satisfaction.

Corona Regional Medical Center also announced plans to expand its emergency department, which will be twice the size of the current facility and will include two floors designated for future expansion.

The year also saw the expansion of specialty services. Among them were women's health services, including comprehensive breast care centers and advanced neonatal intensive care units. Specialty outpatient programs added were wound care, diabetes, sleep studies, cardiac rehabilitation and physical rehabilitation programs. The growth and expansion of these programs helped increase patient volume significantly, specifically outpatient visits at UHS acute care hospitals totaled more than one million in 2014, a nine percent increase over the prior year.

All signs point to continued growth in outpatient and ambulatory care over the next five to 10 years. The Acute Care Division is responding with new ambulatory surgery centers, home healthcare, retail pharmacies and telehealth services.

VOLUME TO VALUE AND POPULATION HEALTH

Last year we began to address the changing direction of healthcare from volume to value or population health. This transition means achieving clinical benchmarks, improving outcomes and quality of care and enhancing the patient experience, at a reasonable cost. Population health will result in the creation of narrow networks, the insurance industry's way to reduce costs by limiting the doctors and hospitals available to subscribers.

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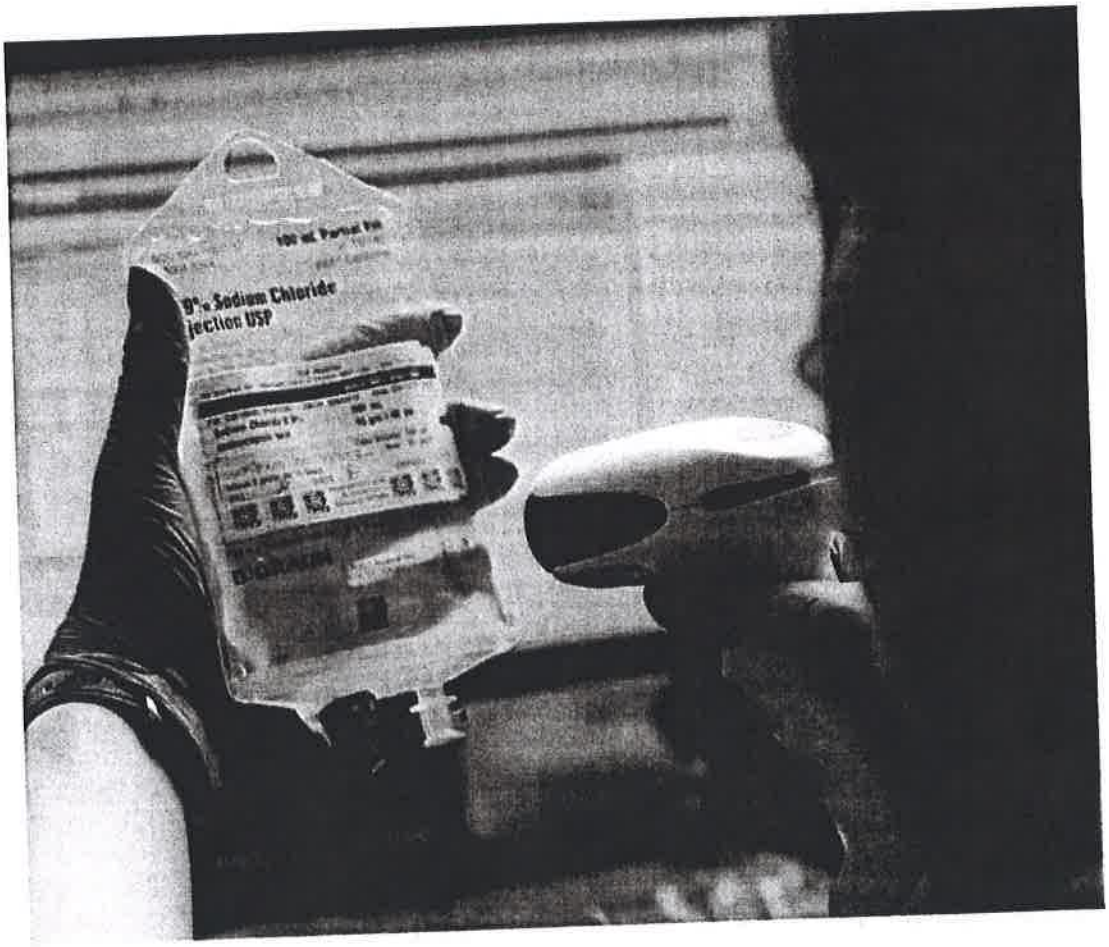

Being a leader in healthcare also means being at the forefront with the latest technology, including advanced information system capabilities that will help improve quality and outcomes. UHS FUSION, implemented at all of the acute care hospitals, includes specialty bar code administration technology available at the patient's bedside to improve safety, outcomes and quality of care.

In July, UHS acquired Prominence Health Plan. The health insurance plan offered group health insurance, health exchange products and a new Medicare Advantage plan in Nevada and Texas. In its first year, Prominence Health Plan enrolled more than 5,500 new members, including 2,000 for Medicare Advantage programs, and more than 3,500 people in its commercial product through the Nevada Health Care Exchange. Prominence Health Plan and its affiliations with Northern Nevada Medical Center in Reno, Nevada, South Texas Health System in the Rio Grande Valley and Northwest Texas Healthcare System in Amarillo are important as UHS prepares for the future of narrow networks and population health in these markets.

Physicians play a significant role in the development and success of a narrow network, which is why 2014 saw significant growth and expansion in physician relationships. Independence Physician Management, or IPM, employs more than 350 physicians. As employees, IPM physicians focus on clinical excellence and UHS focuses on business operations and identifies ways to improve quality, service and patient satisfaction.

Unique physician relationships were developed through the Physician Relationship Management (PRM) program. PRM specialists work with physicians to improve their practices and utilization of UHS services and programs.

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A good example of a population healthcare initiative was implemented in South Texas where McAllen Heart Hospital and physicians at The Heart Clinic in South Texas opened the South Texas Advanced Cardiology Clinic. This clinic makes specialty cardiac services more accessible to patients. When cardiac patients are discharged from McAllen Heart Hospital they are referred to the clinic. The Heart Clinic physicians provide follow-up care, telemedicine and home monitoring. This makes it easier for patients to get follow-up care and it helps prevent readmissions.

A CONTINUED FOCUS ON QUALITY

Guidelines from CMS dictate that we must focus on improving quality measures and patient satisfaction, while reducing readmissions. Providing the highest quality care in each facility is key to meeting CMS mandates, maintaining beneficial reimbursement and satisfying patients' needs.

Clinical excellence will help UHS succeed and the electronic health record infrastructure now in place at all UHS acute care hospitals will ensure success. The focus in 2014 was to incorporate computerized physician order entry (CPOE) into FUSION, the UHS electronic health record, and we were successful in all acute care facilities. UHS has one of the highest utilization rates in the industry with 70 to 90 percent of physicians in our hospitals using CPOE.

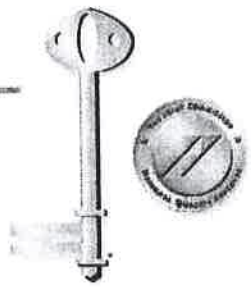
Implementation of the next phase of FUSION began in December and integrates voice recognition and clinical decision support to reduce variability in care. UHS is working closely with interdisciplinary teams in our hospitals to customize FUSION and help create electronic care plans that follow best practices.

Clinical excellence and quality also were the topics at the second UHS Quality Management Summit. With more than 140 chief medical officers, physicians, chief nursing officers, risk managers and infection control specialists in attendance, the event was dedicated to ensuring the integration of quality improvement and clinical excellence programs at the hospital level and driving patient safety policies and protocols.

Being recognized for providing the highest possible care is important. In 2014, The Joint Commission recognized 9 UHS acute care hospitals as *Top Performers on Key Quality Measures®*. Such recognition will continue to be important as the government and insurance plans put more quality and cost constraints in place, while they expand the use of narrow provider networks through state or federal healthcare exchanges.

UHS acute care hospitals strive to be the provider of choice in each of our markets and continuously work to meet and exceed quality standards, provide high quality care at a reasonable cost and build relationships with physicians that focus on best practice quality initiatives. The Acute Care Division has the clinical leadership and expertise to continue to meet quality standards, to raise the bar in quality and patient experience and ensure that UHS acute care services are at the center of the healthcare delivery model.

There were 46 facilities recognized by The Joint Commission as *Top Performers on Key Quality Measures®* for 2013, including 37 behavioral health facilities and 9 acute care hospitals. The program identifies hospitals that improve performance and outcomes using evidence-based practices.



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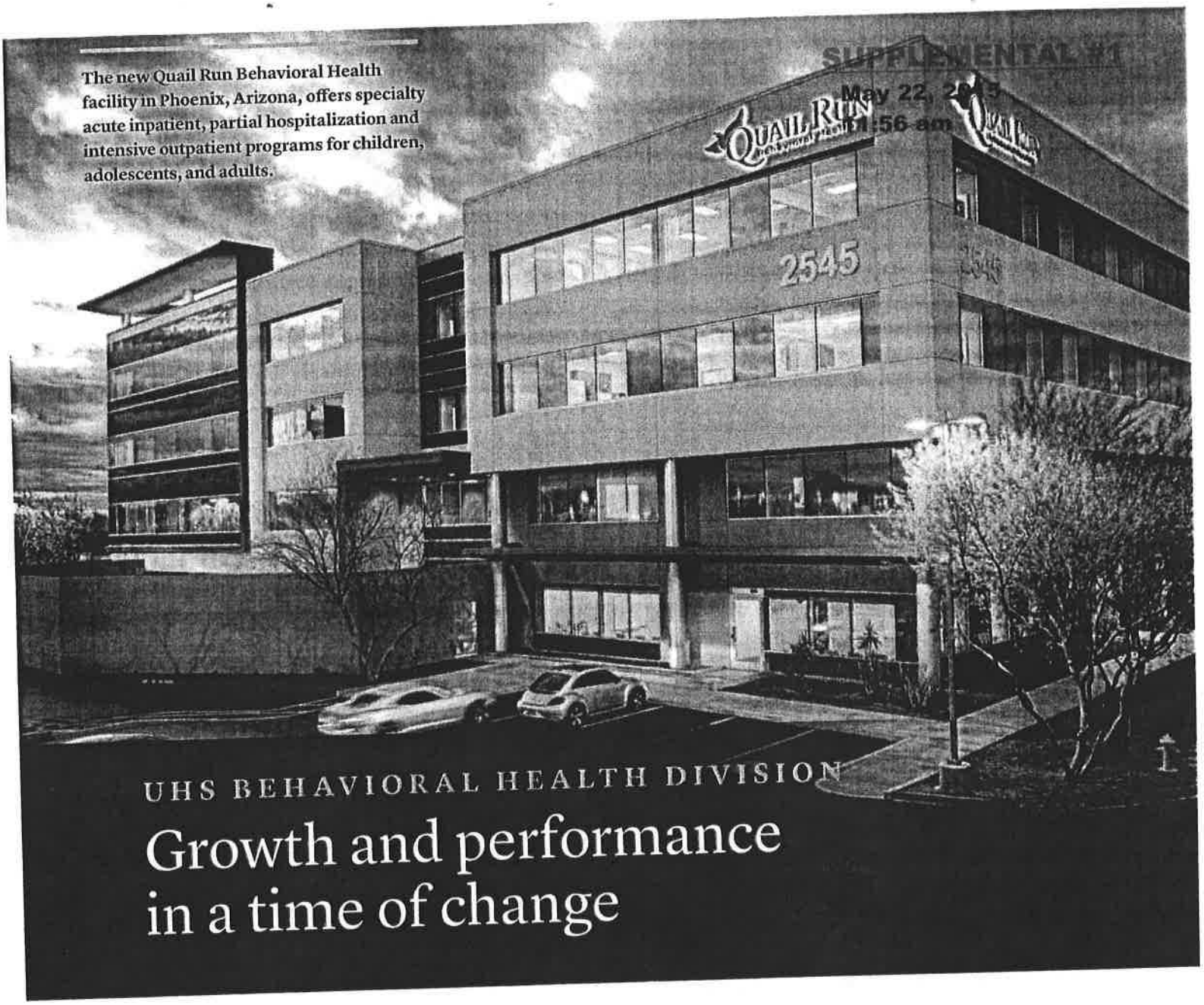

The new Quail Run Behavioral Health facility in Phoenix, Arizona, offers specialty acute inpatient, partial hospitalization and intensive outpatient programs for children, adolescents, and adults.

UHS BEHAVIORAL HEALTH DIVISION

Growth and performance in a time of change

The Behavioral Health Division of Universal Health Services (UHS) recorded another year of high quality of patient care measures, excellent financial performance, continued growth in the USA and an acquisition that expanded mental health services into the United Kingdom for the first time.

The division's success was not by accident but was the result of strategic planning, based on its commitment to the company's mission, the competitive realities of the marketplace and leadership's ability to adapt to the rapid changes taking place in the behavioral health industry.

Through dedicated employees, physicians and clinical staff, the division continues every day to give hope to patients and families who struggle with mental health challenges and positively impact hundreds of thousands of lives each year.

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AN EMPHASIS ON QUALITY

The UHS Behavioral Health Division's dedication to quality remains as strong as ever. The division continued to outperform the industry in several quality measures. This year 37 UHS behavioral health facilities were recognized as *Top Performers on Key Quality Measures®* for 2013 by The Joint Commission. UHS facilities made up more than a quarter of all the freestanding psychiatric facilities in the nation that achieved this recognition. In addition, UHS facilities score more favorably than the industry in quality surveys by The Joint Commission. The division's inpatient psychiatric facilities exceeded national averages for specific quality indicators in new measures reported to the federal Centers for Medicare & Medicaid Services (CMS).

One hundred percent of UHS behavioral health facilities measure patient outcomes as an additional way to determine the effectiveness of their treatment programs. More than 300,000 patients, or 69 percent of the total number of patients served by UHS facilities, participated in the division's patient satisfaction survey. Those respondents gave UHS an overall score of 4.6 on a scale of one to five, indicating that they are better after receiving care at one of the division's facilities.

ENTERING THE UNITED KINGDOM, GROWTH IN THE USA

The Behavioral Health Division completed its first acquisition outside the USA and its territories when it acquired Cygnet Health Care Limited (Cygnet), one of the largest independent providers of behavioral health services in the United Kingdom. Cygnet provides services for adolescents and adults with acute mental health conditions, eating disorders, chemical dependence, personality disorders and autism.

The acquisition added 17 facilities located throughout the UK, including 15 inpatient behavioral health hospitals and two nursing homes, with a total of 723 beds.

In addition to acquiring Cygnet, the UHS Behavioral Health Division acquired two facilities in the USA during 2014. One was Psychiatric Institute of Washington, a 124-bed facility that is the only freestanding, private, psychiatric hospital in the District of Columbia.

The division also moved into the Tucson, Arizona market when it acquired Palo Verde Behavioral Health. Palo Verde Behavioral Health is a 48-bed hospital that has already broken ground to add an additional 36 inpatient psychiatric beds to bring its total capacity to 84 beds.

During 2014, the Behavioral Health Division also added more than 600 new acute inpatient psychiatric beds to existing facilities through expansion projects and by converting existing residential beds to acute psychiatric inpatient beds. In Bradenton, Florida, the division converted a 60-bed residential treatment facility into an acute inpatient psychiatric hospital that reopened as Suncoast Behavioral Health Center, an acute psychiatric treatment facility for children, adolescents and adults.

In addition, the division also opened two de novo facilities. Holly Hill Children's Hospital, an 80-bed facility in Raleigh, North Carolina, is the state's first private, stand-alone hospital dedicated to treating children and adolescents.

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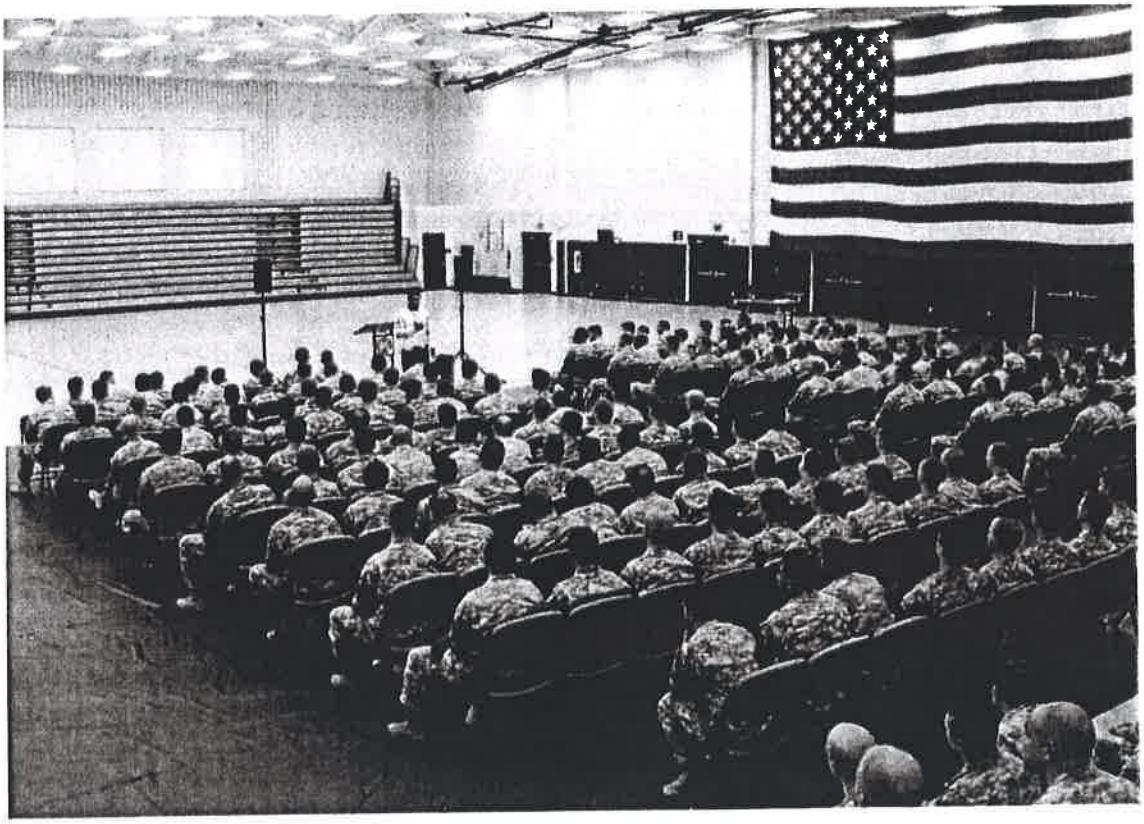

As the national spokesman for the UHS Patriot Support Programs, Herschel Walker visits military installations and speaks to service men and women and their families about the importance of seeking help for behavioral health disorders.

In Phoenix, Arizona, UHS acquired an office building and converted it into Quail Run Behavioral Health, a facility that is licensed for 102 inpatient psychiatric beds, and provides a broad range of acute behavioral health services for children, adolescents and adults.

By the end of 2014, the UHS Behavioral Health Division had grown to 217 facilities in 37 states, Washington DC, Puerto Rico, the U.S. Virgin Islands and the United Kingdom.

THE TREND TOWARD INTEGRATION

Healthcare reform encourages increased consolidation among health service providers, including integrating behavioral health services in all types of treatment settings. As a result, general healthcare systems are increasingly looking to leaders in the behavioral field for ideas on better integrating physical and mental care, and for managing healthcare for specific populations.

For example, to help reduce Emergency Department stays and treat patients in the underserved area of Snohomish County in the state of Washington, Fairfax Hospital partnered with a major acute care hospital to provide a voluntary and involuntary acute inpatient psychiatric care program for adults in Everett, Washington.

The division will continue to evaluate potential partnerships with health systems around the country to lower readmissions, cut unnecessary emergency department use and improve outcomes and patient satisfaction.

As the stigma associated with mental illness continues to diminish in society, more people are seeking and receiving treatment. The demand for behavioral health services continues to exceed capacity, so improving care integration is vital to managing the growing need for mental health services.

AN UNWAVERING COMMITMENT

In 2014, the UHS Behavioral Health Division served more than 420,000 patients. While this is a large number, the division did not waver in its philosophy of caring for each individual with kindness, dignity and respect.

Recent legislation, such as the Patient Protection and Affordable Care Act, and the Mental Health Parity Law, show greater recognition that mental health disorders should be treated like any other illness. Additionally, they are leading to improvements in access and coverage for mental health and addiction services.

The division's core business is comprehensive inpatient and outpatient mental health and substance abuse services but leadership continues to look for ways to expand and enhance specialty programs and create innovative ways to deliver quality care in a cost-effective manner.

The Behavioral Health division currently provides nationally recognized specialty programs, in numerous areas such as eating disorders, sexual trauma, autism and neuropsychiatry, and is working to expand other unique behavioral health programs dealing with women's services and pain management.

The UHS Patriot Support Program and the services the company provides to active duty service members, veterans, TRICARE® beneficiaries and their families are very important to the Behavioral Health Division. Through dedicated Centers of Excellence, the Patriot Support Program currently serves more than 160 military installations in the United States, and 20 bases and installations overseas.

Since October 2001, approximately 2.5 million U.S. troops have been deployed to support Operations in Afghanistan and Iraq. The UHS Patriot Support treatment programs are geared to help manage the effects of combat stress, post-traumatic stress (PTSD), Military depression, Military substance abuse, and other post-deployment adjustment related issues.

The Behavioral Health Division formed the UHS Patriot Support Advisory Board in 2014. The advisory board members include seven distinguished representatives of top-level leadership from all branches of the United States military who are retired but remain involved with processes and policy development for active duty service members, TRICARE® beneficiaries and veterans.

The Chairman of UHS Patriot Support Advisory Board is retired United States Army Lieutenant General Ronald R. Blanck, who is a physician and served as the Surgeon General of the United States Army from 1996 to 2000. Through General Blanck's leadership and the support of the other board members, the UHS Behavioral Health Division will continue to work to ensure that military service men and women and their families receive the care they need and deserve.

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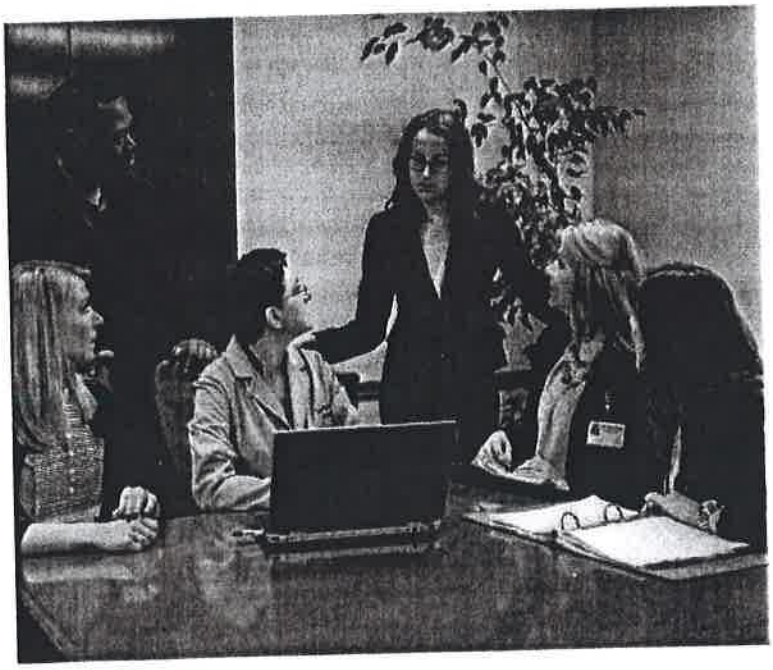
TELEPSYCHIATRY EXPANDS ACCESS TO CARE

Telepsychiatry is helping address the lack of access to care due to the shortage of psychiatrists and large demand for services in rural areas of the country. The Indiana Rural Health Association and Chamber of Commerce recently recognized Bloomington Meadows Hospital, a UHS facility, for its innovative use of telepsychiatry.

A number of UHS behavioral health facilities have implemented telepsychiatry programs to expedite psychiatric assessment, diagnosis and treatment of patients. This includes immediate emergency psychiatric assessments and interventions for emergency departments in acute care hospitals.

In the future, telepsychiatry will continue to make a significant impact on the delivery of mental health services, and the Behavioral Health Division of UHS will continue to look for innovative ways to expand the use of that technology to broaden its capacity to provide care in different settings and better serve its patients.



COMMUNITY INVOLVEMENT

The division has long worked to be an active member of every community it serves, and a key contributor to important causes. In 2014, the division remained steadfast in its dedication to giving back to its communities and being an advocate for patients and their families.

The division works vigorously at the local, state and national levels with the National Alliance on Mental Illness (NAMI). Through UHS's corporate sponsorship of NAMI, the division last year helped create and launch the NAMI Homefront program which is geared to meet the unique needs of military families and veterans who are living with mental illness.

The UHS Behavioral Health Division remains dedicated to suicide prevention. In 2014, Debra K. Osteen, president of the Behavioral Health Division, joined the Executive Committee of the National Action Alliance for Suicide Prevention to help advance the National Strategy for Suicide Prevention.

UHS continues to collaborate with the Action Alliance on its Zero Suicide initiative, which is building a universally accepted, evidence-based approach to suicide prevention in healthcare settings. The division's goal is to leverage its size and scope to be a voice in reducing the stigma of mental illness, encouraging people to seek assistance and ultimately eliminating the tragic event of suicide.

UHS is the first in the industry to place significant emphasis on patient outcomes measurements and to show how our programs improve the lives of patients. Our strong focus on a multidisciplinary approach to care includes team meetings that bring clinicians together to review patients' needs and progress, like the team at Hartgrove Hospital in Chicago, Illinois.

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Holly Hill Hospital in Raleigh, North Carolina, opened the state's first private, stand-alone hospital specifically dedicated to treat the behavioral healthcare needs of children and adolescents. The new facility helps fill a growing need for inpatient psychiatric beds.

WELL POSITIONED FOR THE FUTURE

The UHS Behavioral Health Division is committed to expanding into markets that are currently underserved, establishing new treatment services and continuing to invest in existing facilities and its employees. By working closely with academic partners from highly respected colleges and universities, we seek to attract the best talent from around the country.

The division has the clinical expertise and established programs to position it well for future growth. Leadership of the division has pledged its commitment to continue tailoring programs and services to meet the needs of the populations it serves, and to provide quality treatment and compassionate care to its patients every day. The UHS Behavioral Health Division has the distinction of being the largest facility-based provider of mental health services in the country, with more than 21,000 beds.

But what has truly made the division successful and what will continue to drive its success is that everyone in the division – from corporate leadership to employees at each facility – never lose sight of its primary objectives of taking care of patients first, treating people with respect and doing things the right way. That operational philosophy is the reason the UHS Behavioral Health Division has accomplished so much in the past and it will continue to fuel its success in the future.

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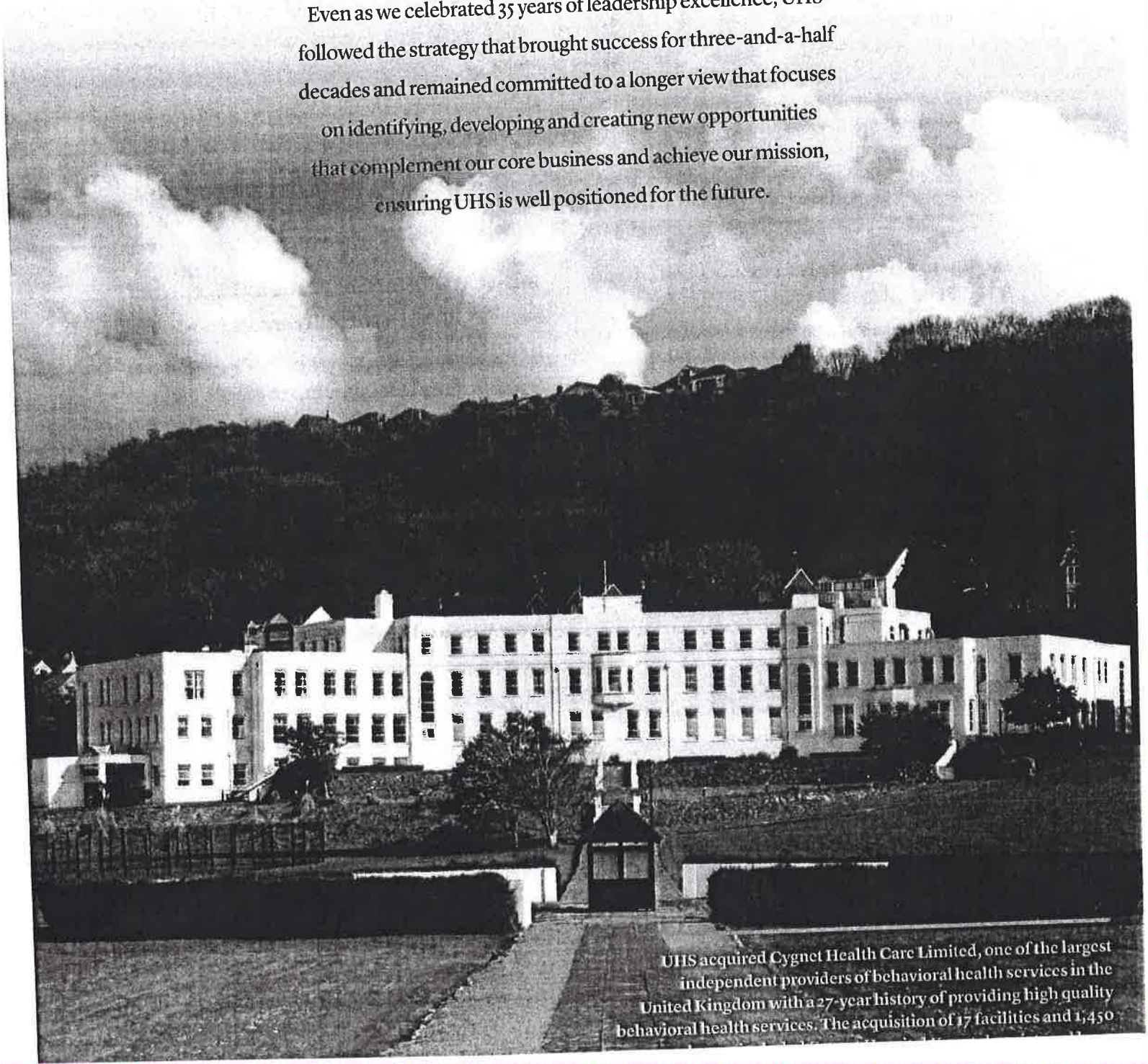
UHS

Building for the future

2014 could have passed simply as a celebratory year for UHS, a year for employees to look back and reminisce about growth and success over 35 years. But business moved forward and it was focused on the future, as it always has been.

Even as we celebrated 35 years of leadership excellence, UHS followed the strategy that brought success for three-and-a-half decades and remained committed to a longer view that focuses on identifying, developing and creating new opportunities that complement our core business and achieve our mission, ensuring UHS is well positioned for the future.



UHS acquired Cygnet Health Care Limited, one of the largest independent providers of behavioral health services in the United Kingdom with a 27-year history of providing high quality behavioral health services. The acquisition of 17 facilities and 1,450

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

FORM 10-K

(MARK ONE)

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

For the fiscal year ended December 31, 2014

OR

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

For the transition period from _____ to _____

Commission File No. 1-10765

UNIVERSAL HEALTH SERVICES, INC.

(Exact name of registrant as specified in its charter)

Delaware **(State or other jurisdiction of incorporation or organization)**	**23-2077891** **(I.R.S. Employer Identification Number)**
UNIVERSAL CORPORATE CENTER **367 South Gulph Road** **P.O. Box 61558** **King of Prussia, Pennsylvania** **(Address of principal executive offices)**	**19406-0958** **(Zip Code)**

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

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

Title of each Class	Name of each exchange on which registered
Class B Common Stock, $.01 par value	New York Stock Exchange

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

Class D Common Stock, $.01 par value
(Title of each Class)

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act. Yes ☐ No ☒

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

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

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

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

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

The aggregate market value of voting stock held by non-affiliates at June 30, 2014 was $8.7 billion. (For the purpose of this calculation, it was assumed that Class A, Class C, and Class D Common Stock, which are not traded but are convertible share-for-share into Class B Common Stock, have the same market value as Class B Common Stock. Also, for purposes of this calculation only, all directors are deemed to be affiliates.)

The number of shares of the registrant's Class A Common Stock, $.01 par value, Class B Common Stock, $.01 par value, Class C Common Stock, $.01 par value, and Class D Common Stock, $.01 par value, outstanding as of January 31, 2015, were 6,595,708; 91,656,482; 664,000 and 28,111, respectively.

DOCUMENTS INCORPORATED BY REFERENCE:

Portions of the registrant's definitive proxy statement for our 2015 Annual Meeting of Stockholders, which will be filed with the Securities and Exchange Commission within 120 days after December 31, 2014 (incorporated by reference under Part III).

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UNIVERSAL HEALTH SERVICES, INC.
2014 FORM 10-K ANNUAL REPORT

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This Annual Report on Form 10-K is for the year ended December 31, 2014. This Annual Report modifies and supersedes documents filed prior to this Annual Report. Information that we file with the Securities and Exchange Commission (the "SEC") in the future will automatically update and supersede information contained in this Annual Report.

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

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PART I

ITEM 1. *Business*

Our principal business is owning and operating, through our subsidiaries, acute care hospitals, behavioral health centers, surgical hospitals, ambulatory surgery centers and radiation oncology centers. As of February 26, 2015, we owned and/or operated 24 acute care hospitals and 216 behavioral health centers located in 37 states, Washington, D.C., the United Kingdom, 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.

Net revenues from our acute care hospitals, surgical hospitals, surgery centers and radiation oncology centers accounted for 51% of our consolidated net revenues in 2014, 49% in 2013 and 50% in 2012. Net revenues from our behavioral health care facilities accounted for 49% of our consolidated net revenues in 2014 and 50% during each of 2013 and 2012.

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.

2014 Acquisition and Divestiture Activity:

Acquisitions of Assets and Businesses:

During 2014, we spent approximately $431 million to: (i) acquire the stock of Cygnet Health Care Limited which consists of 17 facilities located throughout the United Kingdom including 15 inpatient behavioral health hospitals and 2 nursing homes with a total of 723 beds (during the third quarter); (ii) acquire and fund the required capital reserves related to Prominence Health Plan, a commercial health insurer headquartered in Reno, Nevada (during the second quarter); (iii) acquire the Psychiatric Institute of Washington ("PIW"), a 124-bed behavioral health care facility and outpatient treatment center located in Washington, D.C. (during the second quarter); (iv) acquire the operations of Palo Verde Behavioral Health, a 48-bed behavioral health facility in Tucson, Arizona; (v) acquire the real property of The Bridgeway, a 103-bed behavioral health care facility located in North Little Rock, Arkansas, that was previously leased from Universal Health Realty Income Trust; (vi) acquire the previously leased real property of Cygnet Hospital-Harrow, a 44-bed behavioral health care facility, the operations of which were acquired by us as part of the Cygnet Health Care Limited acquisition, and; (vii) acquire physician practices. As part of the acquisition of PIW, we also acquired the Arbor Group, L.L.C., which operates three facilities pursuant to management contracts covering 66 beds in the Washington, D.C. and Maryland market.

2015 Acquisition:

In February, 2015, we acquired the Orchard Portman House Hospital (now called Cygnet Hospital-Taunton), a 46-bed behavioral health care facility located near Taunton, United Kingdom.

Divestitures:

During 2014, we received approximately $15 million of cash proceeds for the divestiture of a non-operating investment sold during the first quarter of 2014 and the real property of a closed behavioral health facility sold during the second quarter of 2014. In connection with these transactions, our 2014 consolidated results of operations included a net pre-tax gain of $8 million.

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Available Information

We are a Delaware corporation that was organized in 1979. Our principal executive offices are located at Universal Corporate Center, 367 South Gulph Road, P.O. Box 61558, King of Prussia, PA 19406. Our telephone number is (610) 768-3300.

Our website is located at http://www.uhsinc.com. Copies of our annual, quarterly and current reports that we file with the SEC, and any amendments to those reports, are available free of charge on our website. The information posted on our website is not incorporated into this Annual Report. Our Board of Directors' committee charters (Audit Committee, Compensation Committee and Nominating & Governance Committee), Code of Business Conduct and Corporate Standards applicable to all employees, Code of Ethics for Senior Financial Officers, Corporate Governance Guidelines and our Healthcare Code of Conduct, Corporate Compliance Manual and Compliance Policies and Procedures are available free of charge on our website. Copies of such reports and charters are available in print to any stockholder who makes a request. Such requests should be made to our Secretary at our King of Prussia, PA corporate headquarters. We intend to satisfy the disclosure requirement under Item 5.05 of Form 8-K relating to amendments to or waivers of any provision of our Code of Ethics for Senior Financial Officers by promptly posting this information on our website.

In accordance with Section 303A.12(a) of the New York Stock Exchange Listed Company Manual, we submitted our CEO's certification to the New York Stock Exchange in 2014. Additionally, contained in Exhibits 31.1 and 31.2 of this Annual Report on Form 10-K, are our CEO's and CFO's certifications regarding the quality of our public disclosures under Section 302 of the Sarbanes-Oxley Act of 2002.

Our Mission

Our mission and objective is to provide superior healthcare services that patients recommend to families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. To achieve this, we have a commitment to:

- service excellence
- continuous improvement in measurable ways
- employee development
- ethical and fair treatment
- teamwork
- compassion
- innovation in service delivery

Business Strategy

We believe community-based hospitals will remain the focal point of the healthcare delivery network and we are committed to a philosophy of self-determination for both the company and our hospitals.

Acquisition of Additional Hospitals. We selectively seek opportunities to expand our base of operations by acquiring, constructing or leasing additional hospital facilities. We are committed to a program of rational growth around our core businesses, while retaining the missions of the hospitals we manage and the communities we serve. Such expansion may provide us with access to new markets and new healthcare delivery capabilities. We also continue to examine our facilities and consider divestiture of those facilities that we believe do not have the potential to contribute to our growth or operating strategy.

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Improvement of Operations of Existing Hospitals and Services. We also seek to increase the operating revenues and profitability of owned hospitals by the introduction of new services, improvement of existing services, physician recruitment and the application of financial and operational controls.

We are involved in continual development activities for the benefit of our existing facilities. From time to time applications are filed with state health planning agencies to add new services in existing hospitals in states which require certificates of need, or CONs. Although we expect that some of these applications will result in the addition of new facilities or services to our operations, no assurances can be made for ultimate success by us in these efforts.

Quality and Efficiency of Services. Pressures to contain healthcare costs and technological developments allowing more procedures to be performed on an outpatient basis have led payors to demand a shift to ambulatory or outpatient care wherever possible. We are responding to this trend by emphasizing the expansion of outpatient services. In addition, in response to cost containment pressures, we continue to implement programs at our facilities designed to improve financial performance and efficiency while continuing to provide quality care, including more efficient use of professional and paraprofessional staff, monitoring and adjusting staffing levels and equipment usage, improving patient management and reporting procedures and implementing more efficient billing and collection procedures. In addition, we will continue to emphasize innovation in our response to the rapid changes in regulatory trends and market conditions while fulfilling our commitment to patients, physicians, employees, communities and our stockholders.

In addition, our aggressive recruiting of highly qualified physicians and developing provider networks help to establish our facilities as an important source of quality healthcare in their respective communities.

Hospital Utilization

We believe that the most important factors relating to the overall utilization of a hospital include the quality and market position of the hospital and the number, quality and specialties of physicians providing patient care within the facility. Generally, we believe that the ability of a hospital to meet the health care needs of its community is determined by its breadth of services, level of technology, emphasis on quality of care and convenience for patients and physicians. Other factors that affect utilization include general and local economic conditions, market penetration of managed care programs, the degree of outpatient use, the availability of reimbursement programs such as Medicare and Medicaid, and demographic changes such as the growth in local populations. Utilization across the industry also is being affected by improvements in clinical practice, medical technology and pharmacology. Current industry trends in utilization and occupancy have been significantly affected by changes in reimbursement policies of third party payors. We are also unable to predict the extent to which these industry trends will continue or accelerate. In addition, hospital operations are subject to certain seasonal fluctuations, such as higher patient volumes and net patient service revenues in the first and fourth quarters of the year.

The following table sets forth certain operating statistics for hospitals operated by us for the years indicated. Accordingly, information related to hospitals acquired during the five-year period has been included from the respective dates of acquisition, and information related to hospitals divested during the five year period has been included up to the respective dates of divestiture.

	2014	2013	2012	2011	2010
Average Licensed Beds:					
Acute Care Hospitals	5,776	5,652	5,682	5,726	5,689
Behavioral Health Centers	20,231	19,975	19,362	19,280	9,427
Average Available Beds (1):					
Acute Care Hospitals	5,571	5,429	5,457	5,424	5,383
Behavioral Health Centers	20,131	19,876	19,282	19,262	9,409

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	2014	2013	2012	2011	2010
Admissions:					
Acute Care Hospitals	251,165	246,160	251,099	258,754	264,470
Behavioral Health Centers	426,510	402,088	374,865	352,208	166,434
Average Length of Stay (Days):					
Acute Care Hospitals	4.6	4.5	4.5	4.4	4.4
Behavioral Health Centers	12.9	13.3	14.0	14.6	15.1
Patient Days (2):					
Acute Care Hospitals	1,167,726	1,112,541	1,122,557	1,151,183	1,155,984
Behavioral Health Centers	5,518,660	5,365,734	5,245,499	5,157,454	2,507,046
Occupancy Rate-Licensed Beds (3):					
Acute Care Hospitals	55%	54%	54%	55%	56%
Behavioral Health Centers	75%	74%	74%	73%	73%
Occupancy Rate-Available Beds (3):					
Acute Care Hospitals	57%	56%	56%	58%	59%
Behavioral Health Centers	75%	74%	75%	73%	73%

(1) "Average Available Beds" is the number of beds which are actually in service at any given time for immediate patient use with the necessary equipment and staff available for patient care. A hospital may have appropriate licenses for more beds than are in service for a number of reasons, including lack of demand, incomplete construction, and anticipation of future needs

(2) "Patient Days" is the sum of all patients for the number of days that hospital care is provided to each patient.

(3) "Occupancy Rate" is calculated by dividing average patient days (total patient days divided by the total number of days in the period) by the number of average beds, either available or licensed.

Sources of Revenue

We receive payments for services rendered from private insurers, including managed care plans, the federal government under the Medicare program, state governments under their respective Medicaid programs and directly from patients. See *Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Sources of Revenue* for additional disclosure. Other information related to our revenues, income and other operating information for each reporting segment of our business is provided in Note 11 to our Consolidated Financial Statements, *Segment Reporting*.

Regulation and Other Factors

Overview: The healthcare industry is subject to numerous laws, regulations and rules including, among others, those related to government healthcare participation requirements, various licensure and accreditations, reimbursement for patient services, health information privacy and security rules, and Medicare and Medicaid fraud and abuse provisions (including, but not limited to, federal statutes and regulations prohibiting kickbacks and other illegal inducements to potential referral sources, false claims submitted to federal health care programs and self-referrals by physicians). Providers that are found to have violated any of these laws and regulations may be excluded from participating in government healthcare programs, subjected to significant fines or penalties and/or required to repay amounts received from the government for previously billed patient services. Although we believe our policies, procedures and practices comply with governmental regulations, no assurance can be given that we will not be subjected to additional governmental inquiries or actions, or that we would not be faced with sanctions, fines or penalties if so subjected. Even if we were to ultimately prevail, a significant governmental inquiry or action under one of the above laws, regulations or rules could have a material adverse impact on us.

Licensing, Certification and Accreditation: All of our hospitals are subject to compliance with various federal, state and local statutes and regulations and receive periodic inspection by state licensing agencies to

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review standards of medical care, equipment and cleanliness. Our hospitals must also comply with the conditions of participation and licensing requirements of federal, state and local health agencies, as well as the requirements of municipal building codes, health codes and local fire departments. Various other licenses and permits are also required in order to dispense narcotics, operate pharmacies, handle radioactive materials and operate certain equipment.

All of our eligible hospitals have been accredited by The Joint Commission. All of our acute care hospitals and most of our behavioral health centers are certified as providers of Medicare and Medicaid services by the appropriate governmental authorities.

If any of our facilities were to lose its Joint Commission accreditation or otherwise lose its certification under the Medicare and Medicaid programs, the facility may be unable to receive reimbursement from the Medicare and Medicaid programs and other payors. We believe our facilities are in substantial compliance with current applicable federal, state, local and independent review body regulations and standards. The requirements for licensure, certification and accreditation are subject to change and, in order to remain qualified, it may become necessary for us to make changes in our facilities, equipment, personnel and services in the future, which could have a material adverse impact on operations.

Certificates of Need: Many of the states in which we operate hospitals have enacted certificates of need ("CON") laws as a condition prior to hospital capital expenditures, construction, expansion, modernization or initiation of major new services. Failure to obtain necessary state approval can result in our inability to complete an acquisition, expansion or replacement, the imposition of civil or, in some cases, criminal sanctions, the inability to receive Medicare or Medicaid reimbursement or the revocation of a facility's license, which could harm our business. In addition, significant CON reforms have been proposed in a number of states that would increase the capital spending thresholds and provide exemptions of various services from review requirements. In the past, we have not experienced any material adverse effects from those requirements, but we cannot predict the impact of these changes upon our operations.

Conversion Legislation: Many states have enacted or are considering enacting laws affecting the conversion or sale of not-for-profit hospitals to for-profit entities. These laws generally require prior approval from the attorney general, advance notification and community involvement. In addition, attorneys general in states without specific conversion legislation may exercise discretionary authority over these transactions. Although the level of government involvement varies from state to state, the trend is to provide for increased governmental review and, in some cases, approval of a transaction in which a not-for-profit entity sells a health care facility to a for-profit entity. The adoption of new or expanded conversion legislation and the increased review of not-for-profit hospital conversions may limit our ability to grow through acquisitions of not-for-profit hospitals.

Utilization Review: Federal regulations require that admissions and utilization of facilities by Medicare and Medicaid patients must be reviewed in order to ensure efficient utilization of facilities and services. The law and regulations require Peer Review Organizations ("PROs") to review the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, the validity of diagnosis related group ("DRG") classifications and the appropriateness of cases of extraordinary length of stay. PROs may deny payment for services provided, assess fines and also have the authority to recommend to the Department of Health and Human Services ("HHS") that a provider that is in substantial non-compliance with the standards of the PRO be excluded from participating in the Medicare program. We have contracted with PROs in each state where we do business to perform the required reviews.

Audits: Most hospitals are subject to federal audits to validate the accuracy of Medicare and Medicaid program submitted claims. If these audits identify overpayments, we could be required to pay a substantial rebate of prior years' payments subject to various administrative appeal rights. The federal government contracts with

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third-party "recovery audit contractors" ("RACs") and "Medicaid integrity contractors" ("MICs"), on a contingent fee basis, to audit the propriety of payments to Medicare and Medicaid providers. The Recovery Audit Prepayment Review demonstration program will enable RACs to review claims before they are paid to ensure that the provider complied with all Medicare payment rules. Currently, the demonstration program is targeting states with high populations of fraud- and error-prone providers. Similarly, Medicare zone program integrity contractors ("ZPICs") target claims for potential fraud and abuse. Additionally, Medicare administrative contractors ("MACs") must ensure they pay the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers. The Centers for Medicare and Medicaid Services ("CMS") announced its intent to consolidate many of these Medicare and Medicaid program integrity functions into new unified program integrity contractors ("UPICs"), though it remains unclear what effect, if any, this proposed consolidation may have. We have undergone claims audits related to our receipt of federal healthcare payments during the last three years, the results of which have not required material adjustments to our consolidated results of operations. However, potential liability from future federal or state audits could ultimately exceed established reserves, and any excess could potentially be substantial. Further, Medicare and Medicaid regulations also provide for withholding Medicare and Medicaid overpayments in certain circumstances, which could adversely affect our cash flow.

Self-Referral and Anti-Kickback Legislation

The Stark Law: The Social Security Act includes a provision commonly known as the "Stark Law." This law prohibits physicians from referring Medicare and Medicaid patients to entities with which they or any of their immediate family members have a financial relationship, unless an exception is met. These types of referrals are known as "self-referrals." Sanctions for violating the Stark Law include civil penalties up to $15,000 for each violation, up to $100,000 for sham arrangements, up to $10,000 for each day an entity fails to report required information and exclusion from the federal health care programs. There are a number of exceptions to the self-referral prohibition, including an exception for a physician's ownership interest in an entire hospital as opposed to an ownership interest in a hospital department unit, service or subpart. However, federal laws and regulations now limit the ability of hospitals relying on this exception to expand aggregate physician ownership interest or to expand certain hospital facilities. This recent regulation also places a number of compliance requirements on physician-owned hospitals related to reporting of ownership interest. There are also exceptions for many of the customary financial arrangements between physicians and providers, including employment contracts, leases and recruitment agreements that adhere to certain enumerated requirements.

We monitor all aspects of our business and have developed a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards. Nonetheless, because the law in this area is complex and constantly evolving, there can be no assurance that federal regulatory authorities will not determine that any of our arrangements with physicians violate the Stark Law.

Anti-kickback Statute: A provision of the Social Security Act known as the "anti-kickback statute" prohibits healthcare providers and others from directly or indirectly soliciting, receiving, offering or paying money or other remuneration to other individuals and entities in return for using, referring, ordering, recommending or arranging for such referrals or orders of services or other items covered by a federal or state health care program. However, recent changes to the anti-kickback statute have reduced the intent required for violation; one is no longer required to "have actual knowledge or specific intent to commit a violation of" the anti-kickback statute in order to be found in violation of such law.

The anti-kickback statute contains certain exceptions, and the Office of the Inspector General of the Department of Health and Human Services ("OIG") has issued regulations that provide for "safe harbors," from the federal anti-kickback statute for various activities. These activities, which must meet certain requirements, include (but are not limited to) the following: investment interests, space rental, equipment rental, practitioner recruitment, personnel services and management contracts, sale of practice, referral services, warranties, discounts, employees, group purchasing organizations, waiver of beneficiary coinsurance and deductible amounts, managed care arrangements, obstetrical malpractice insurance subsidies, investments in group

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practices, freestanding surgery centers, donation of technology for electronic health records and referral agreements for specialty services. The fact that conduct or a business arrangement does not fall within a safe harbor or exception does not automatically render the conduct or business arrangement illegal under the anti-kickback statute. However, such conduct and business arrangements may lead to increased scrutiny by government enforcement authorities.

Although we believe that our arrangements with physicians and other referral sources have been structured to comply with current law and available interpretations, there can be no assurance that all arrangements comply with an available safe harbor or that regulatory authorities enforcing these laws will determine these financial arrangements do not violate the anti-kickback statute or other applicable laws. Violations of the anti-kickback statute may be punished by a criminal fine of up to $25,000 for each violation or imprisonment, however, under 18 U.S.C. Section 3571, this fine may be increased to $250,000 for individuals and $500,000 for organizations. Civil money penalties may include fines of up to $50,000 per violation and damages of up to three times the total amount of the remuneration and/or exclusion from participation in Medicare and Medicaid.

Similar State Laws: Many of the states in which we operate have adopted laws that prohibit payments to physicians in exchange for referrals similar to the anti-kickback statute and the Stark Law, some of which apply regardless of the source of payment for care. These statutes typically provide criminal and civil penalties as well as loss of licensure. In many instances, the state statutes provide that any arrangement falling in a federal safe harbor will be immune from scrutiny under the state statutes. However, in most cases, little precedent exists for the interpretation or enforcement of these state laws.

These laws and regulations are extremely complex and, in many cases, we don't have the benefit of regulatory or judicial interpretation. It is possible that different interpretations or enforcement of these laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. A determination that we have violated one or more of these laws, or the public announcement that we are being investigated for possible violations of one or more of these laws (see Item 3. Legal Proceedings), could have a material adverse effect on our business, financial condition or results of operations and our business reputation could suffer significantly. In addition, we cannot predict whether other legislation or regulations at the federal or state level will be adopted, what form such legislation or regulations may take or what their impact on us may be.

If we are deemed to have failed to comply with the anti-kickback statute, the Stark Law or other applicable laws and regulations, we could be subjected to liabilities, including criminal penalties, civil penalties (including the loss of our licenses to operate one or more facilities), and exclusion of one or more facilities from participation in the Medicare, Medicaid and other federal and state health care programs. The imposition of such penalties could have a material adverse effect on our business, financial condition or results of operations.

Federal False Claims Act and Similar State Regulations: A current trend affecting the health care industry is the increased use of the federal False Claims Act, and, in particular, actions being brought by individuals on the government's behalf under the False Claims Act's qui tam, or whistleblower, provisions. Whistleblower provisions allow private individuals to bring actions on behalf of the government by alleging that the defendant has defrauded the Federal government.

When a defendant is determined by a court of law to have violated the False Claims Act, the defendant may be liable for up to three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 to $11,000 for each separate false claim. There are many potential bases for liability under the False Claims Act. Liability often arises when an entity knowingly submits a false claim for reimbursement to the federal government. The Fraud Enforcement and Recovery Act of 2009 ("FERA") has expanded the number of actions for which liability may attach under the False Claims Act, eliminating requirements that false claims be presented to federal officials or directly involve federal funds. FERA also clarifies that a false claim violation occurs upon the knowing retention, as well as the receipt, of overpayments. In addition, recent changes to the anti-kickback statute have made violations of that law punishable under the civil False Claims Act. Further, a

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number of states have adopted their own false claims provisions as well as their own whistleblower provisions whereby a private party may file a civil lawsuit on behalf of the state in state court. Recent changes to the False Claims Act require that federal healthcare program overpayments be returned within 60 days from the date the overpayment was identified, or by the date any corresponding cost report was due, whichever is later. Failure to return an overpayment within this period may result in additional civil False Claims Act liability.

Other Fraud and Abuse Provisions: The Social Security Act also imposes criminal and civil penalties for submitting false claims to Medicare and Medicaid. False claims include, but are not limited to, billing for services not rendered, billing for services without prescribed documentation, misrepresenting actual services rendered in order to obtain higher reimbursement and cost report fraud. Like the anti-kickback statute, these provisions are very broad.

Further, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") broadened the scope of the fraud and abuse laws by adding several criminal provisions for health care fraud offenses that apply to all health benefit programs, whether or not payments under such programs are paid pursuant to federal programs. HIPAA also introduced enforcement mechanisms to prevent fraud and abuse in Medicare. There are civil penalties for prohibited conduct, including, but not limited to billing for medically unnecessary products or services.

HIPAA Administrative Simplification and Privacy Requirements: The administrative simplification provisions of HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH"), require the use of uniform electronic data transmission standards for health care claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the health care industry. HIPAA also established federal rules protecting the privacy and security of personal health information. The privacy and security regulations address the use and disclosure of individual health care information and the rights of patients to understand and control how such information is used and disclosed. Violations of HIPAA can result in both criminal and civil fines and penalties.

We believe that we are in material compliance with the privacy regulations of HIPAA, as we continue to develop training and revise procedures to address ongoing compliance. The HIPAA security regulations require health care providers to implement administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of patient information. HITECH has since strengthened certain HIPAA rules regarding the use and disclosure of protected health information, extended certain HIPAA provisions to business associates, and created new security breach notification requirements. HITECH has also extended the ability to impose civil money penalties on providers not knowing that a HIPAA violation has occurred. We believe that we have been in substantial compliance with HIPAA and HITECH requirements to date. Recent changes to the HIPAA regulations may result in greater compliance requirements for healthcare providers, including expanded obligations to report breaches of unsecured patient data, as well as create new liabilities for the actions of parties acting as business associates on our behalf.

Red Flags Rule: In addition, the Federal Trade Commission ("FTC") Red Flags Rule requires financial institutions and businesses maintaining accounts to address the risk of identity theft. The Red Flag Program Clarification Act of 2010, signed on December 18, 2010, appears to exclude certain healthcare providers from the Red Flags Rule, but permits the FTC or relevant agencies to designate additional creditors subject to the Red Flags Rule through future rulemaking if the agencies determine that the person in question maintains accounts subject to foreseeable risk of identity theft. Compliance with any such future rulemaking may require additional expenditures in the future.

Patient Safety and Quality Improvement Act of 2005: On July 29, 2005, the Patient Safety and Quality Improvement Act of 2005 was enacted, which has the goal of reducing medical errors and increasing patient safety. This legislation establishes a confidential reporting structure in which providers can voluntarily report "Patient Safety Work Product" ("PSWP") to "Patient Safety Organizations" ("PSOs"). Under the system, PSWP

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is made privileged, confidential and legally protected from disclosure. PSWP does not include medical, discharge or billing records or any other original patient or provider records but does include information gathered specifically in connection with the reporting of medical errors and improving patient safety. This legislation does not preempt state or federal mandatory disclosure laws concerning information that does not constitute PSWP. PSOs are certified by the Secretary of the HHS for three-year periods and analyze PSWP, provide feedback to providers and may report non-identifiable PSWP to a database. In addition, PSOs are expected to generate patient safety improvement strategies.

Environmental Regulations: Our healthcare operations generate medical waste that must be disposed of in compliance with federal, state and local environmental laws, rules and regulations. Infectious waste generators, including hospitals, face substantial penalties for improper disposal of medical waste, including civil penalties of up to $25,000 per day of noncompliance, criminal penalties of up to $50,000 per day, imprisonment, and remedial costs. In addition, our operations, as well as our purchases and sales of facilities are subject to various other environmental laws, rules and regulations. We believe that our disposal of such wastes is in material compliance with all state and federal laws.

Corporate Practice of Medicine: Several states, including Florida, Nevada, California and Texas, have laws and/or regulations that prohibit corporations and other entities from employing physicians and practicing medicine for a profit or that prohibit certain direct and indirect payments or fee-splitting arrangements between health care providers that are designed to induce or encourage the referral of patients to, or the recommendation of, particular providers for medical products and services. Possible sanctions for violation of these restrictions include loss of license and civil and criminal penalties. In addition, agreements between the corporation and the physician may be considered void and unenforceable. These statutes and/or regulations vary from state to state, are often vague and have seldom been interpreted by the courts or regulatory agencies. We do not expect these state corporate practice of medicine proscriptions to significantly affect our operations. Many states have laws and regulations which prohibit payments for referral of patients and fee-splitting with physicians. We do not make any such payments or have any such arrangements.

EMTALA: All of our hospitals are subject to the Emergency Medical Treatment and Active Labor Act ("EMTALA"). This federal law generally requires hospitals that are certified providers under Medicare to conduct a medical screening examination of every person who visits the hospital's emergency room for treatment and, if the patient is suffering from a medical emergency, to either stabilize the patient's condition or transfer the patient to a facility that can better handle the condition. Our obligation to screen and stabilize emergency medical conditions exists regardless of a patient's ability to pay for treatment. There are severe penalties under EMTALA if a hospital fails to screen or appropriately stabilize or transfer a patient or if the hospital delays appropriate treatment in order to first inquire about the patient's ability to pay. Penalties for violations of EMTALA include civil monetary penalties and exclusion from participation in the Medicare program. In addition to any liabilities that a hospital may incur under EMTALA, an injured patient, the patient's family or a medical facility that suffers a financial loss as a direct result of another hospital's violation of the law can bring a civil suit against the hospital unrelated to the rights granted under that statute.

The federal government broadly interprets EMTALA to cover situations in which patients do not actually present to a hospital's emergency room, but present for emergency examination or treatment to the hospital's campus, generally, or to a hospital-based clinic that treats emergency medical conditions or are transported in a hospital-owned ambulance, subject to certain exceptions. EMTALA does not generally apply to patients admitted for inpatient services; however, CMS has recently sought industry comments on the potential applicability of EMTALA to hospital inpatients and the responsibilities of hospitals with specialized capabilities, respectively. CMS has not yet issued regulations or guidance in response to that request for comments. The government also has expressed its intent to investigate and enforce EMTALA violations actively in the future. We believe that we operate in substantial compliance with EMTALA.

Health Care Industry Investigations: We are subject to claims and suits in the ordinary course of business, including those arising from care and treatment afforded by our hospitals and are party to various

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government investigations and litigation. Please see *Item 3. Legal Proceedings* included herein for additional disclosure. In addition, currently, and from time to time, some of our facilities are subjected to inquiries and/or actions and receive notices of potential non-compliance of laws and regulations from various federal and state agencies. Providers that are found to have violated these laws and regulations may be excluded from participating in government healthcare programs, subjected to potential licensure, certification, and/or accreditation revocation, subjected to fines or penalties or required to repay amounts received from the government for previously billed patient services.

We monitor all aspects of our business and have developed a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards. Because the law in this area is complex and constantly evolving, governmental investigation or litigation may result in interpretations that are inconsistent with industry practices, including ours. Although we believe our policies, procedures and practices comply with governmental regulations, no assurance can be given that we will not be subjected to inquiries or actions, or that we will not be faced with sanctions, fines or penalties in connection with the investigations. Even if we were to ultimately prevail, the government's inquiry and/or action in connection with these matters could have a material adverse effect on our future operating results.

Our substantial Medicare, Medicaid and other governmental billings may result in heightened scrutiny of our operations. It is possible that governmental entities could initiate additional investigations or litigation in the future and that such matters could result in significant penalties as well as adverse publicity. It is also possible that our executives and/or managers could be included as targets or witnesses in governmental investigations or litigation and/or named as defendants in private litigation.

Revenue Rulings 98-15 and 2004-51: In March 1998 and May 2004, the IRS issued guidance regarding the tax consequences of joint ventures between for-profit and not-for-profit hospitals. As a result of the tax rulings, the IRS has proposed, and may in the future propose, to revoke the tax-exempt or public charity status of certain not-for-profit entities which participate in such joint ventures or to treat joint venture income as unrelated business taxable income to them. The tax rulings have limited development of joint ventures and any adverse determination by the IRS or the courts regarding the tax-exempt or public charity status of a not-for-profit partner or the characterization of joint venture income as unrelated business taxable income could further limit joint venture development with not-for-profit hospitals, and/or require the restructuring of certain existing joint ventures with not-for-profits.

State Rate Review: Some states where we operate hospitals have adopted legislation mandating rate or budget review for hospitals or have adopted taxes on hospital revenues, assessments or licensure fees to fund indigent health care within the state. In the aggregate, state rate reviews and indigent tax provisions have not materially, adversely affected our results of operations.

Medical Malpractice Tort Law Reform: Medical malpractice tort law has historically been maintained at the state level. All states have laws governing medical liability lawsuits. Over half of the states have limits on damages awards. Almost all states have eliminated joint and several liability in malpractice lawsuits, and many states have established limits on attorney fees. Many states had bills introduced in their legislative sessions to address medical malpractice tort reform. Proposed solutions include enacting limits on non-economic damages, malpractice insurance reform, and gathering lawsuit claims data from malpractice insurance companies and the courts for the purpose of assessing the connection between malpractice settlements and premium rates. Reform legislation has also been proposed, but not adopted, at the federal level that could preempt additional state legislation in this area.

Compliance Program: Our company-wide compliance program has been in place since 1998. Currently, the program's elements include a Code of Conduct, risk area specific policies and procedures, employee education and training, an internal system for reporting concerns, auditing and monitoring programs, and a means for enforcing the program's policies.

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Since its initial adoption, the compliance program continues to be expanded and developed to meet the industry's expectations and our needs. Specific written policies, procedures, training and educational materials and programs, as well as auditing and monitoring activities have been prepared and implemented to address the functional and operational aspects of our business. Specific areas identified through regulatory interpretation and enforcement activities have also been addressed in our program. Claims preparation and submission, including coding, billing, and cost reports, comprise the bulk of these areas. Financial arrangements with physicians and other referral sources, including compliance with anti-kickback and Stark laws and emergency department treatment and transfer requirements are also the focus of policy and training, standardized documentation requirements, and review and audit.

Medical Staff and Employees

Our facilities had approximately 68,700 employees on December 31, 2014, of whom approximately 48,700 were employed full-time. Our hospitals are staffed by licensed physicians who have been admitted to the medical staff of individual hospitals. In a number of our markets, physicians may have admitting privileges at other hospitals in addition to ours. Within our acute care division, approximately 160 physicians are employed by physician practice management subsidiaries of ours either directly or through contracts with affiliated group practices structured as 501A corporations. Members of the medical staffs of our hospitals also serve on the medical staffs of hospitals not owned by us and may terminate their affiliation with our hospitals at any time. In addition, within our behavioral health division, approximately 400 psychiatrists are employed by subsidiaries of ours either directly or through contracts with affiliated group practices structured as 501A corporations. Each of our hospitals is managed on a day-to-day basis by a managing director employed by a subsidiary of ours. In addition, a Board of Governors, including members of the hospital's medical staff, governs the medical, professional and ethical practices at each hospital. We believe that our relations with our employees are satisfactory.

Approximately 1,750 of our employees at seven of our hospitals are unionized. At Valley Hospital Medical Center, unionized employees belong to the Culinary Workers and Bartenders Union, the International Union of Operating Engineers and the Service Employees International Union ("SEIU"). Nurses and technicians at Desert Springs Hospital are represented by the SEIU and International Union of Operating Engineers. At The George Washington University Hospital, unionized employees are represented by the SEIU or the Hospital Police Association. At the Psychiatric Institute of Washington, clinical, clerical, support and maintenance employees are represented by the Communication Workers of America (AFL-CIO). Nurses at Corona Regional Medical Center are represented by the United Nurses Associations of California/Union of Health Care Professionals (UNAC/ UHCP). Registered Nurses, Licensed Practical Nurses, certain technicians and therapists, pharmacy assistants, and some clerical employees at HRI Hospital in Boston are represented by the SEIU. At Brooke Glen Behavioral Hospital, unionized employees are represented by the Teamsters and the Northwestern Nurses Association/ Pennsylvania Association of Staff Nurses and Allied Professionals. A union representation election was held at Rock River Academy and Residential Center ("RRARC") in August, 2014 for the Mental Health Technicians, LPNs, Drivers and Teachers' Assistants. The results of the election were not determinative, however, and in light of the decision to terminate RRARC's contract with Illinois Department of Children and Family Services and close the facility, we are in the process of resolving all outstanding NLRB litigation and fulfilling its statutory obligations to displaced workers under state and federal labor laws.

Competition

The health care industry is highly competitive. In recent years, competition among healthcare providers for patients has intensified in the United States due to, among other things, regulatory and technological changes, increasing use of managed care payment systems, cost containment pressures and a shift toward outpatient treatment. In all of the geographical areas in which we operate, there are other hospitals that provide services comparable to those offered by our hospitals. In addition, some of our competitors include hospitals that are owned by tax-supported governmental agencies or by nonprofit corporations and may be supported by endowments and charitable contributions and exempt from property, sale and income taxes. Such exemptions and support are not available to us.

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In some markets, certain of our competitors may have greater financial resources, be better equipped and offer a broader range of services than us. Certain hospitals that are located in the areas served by our facilities are specialty or large hospitals that provide medical, surgical and behavioral health services, facilities and equipment that are not available at our hospitals. The increase in outpatient treatment and diagnostic facilities, outpatient surgical centers and freestanding ambulatory surgical also increases competition for us.

The number and quality of the physicians on a hospital's staff are important factors in determining a hospital's success and competitive advantage. Typically, physicians are responsible for making hospital admissions decisions and for directing the course of patient treatment. We believe that physicians refer patients to a hospital primarily on the basis of the patient's needs, the quality of other physicians on the medical staff, the location of the hospital and the breadth and scope of services offered at the hospital's facilities. We strive to retain and attract qualified doctors by maintaining high ethical and professional standards and providing adequate support personnel, technologically advanced equipment and facilities that meet the needs of those physicians.

In addition, we depend on the efforts, abilities, and experience of our medical support personnel, including our nurses, pharmacists and lab technicians and other health care professionals. We compete with other health care providers in recruiting and retaining qualified hospital management, nurses and other medical personnel. Our acute care and behavioral health care facilities are experiencing the effects of a shortage of skilled nursing staff nationwide, which has caused and may continue to cause an increase in salaries, wages and benefits expense in excess of the inflation rate. In addition, in some markets like California, there are requirements to maintain specified nurse-staffing levels. To the extent we cannot meet those levels, we may by required to limit the healthcare services provided in these markets which would have a corresponding adverse effect on our net operating revenues.

Many states in which we operate hospitals have CON laws. The application process for approval of additional covered services, new facilities, changes in operations and capital expenditures is, therefore, highly competitive in these states. In those states that do not have CON laws or which set relatively high levels of expenditures before they become reviewable by state authorities, competition in the form of new services, facilities and capital spending is more prevalent. See "Regulation and Other Factors."

Our ability to negotiate favorable service contracts with purchasers of group health care services also affects our competitive position and significantly affects the revenues and operating results of our hospitals. Managed care plans attempt to direct and control the use of hospital services and to demand that we accept lower rates of payment. In addition, employers and traditional health insurers are increasingly interested in containing costs through negotiations with hospitals for managed care programs and discounts from established charges. In return, hospitals secure commitments for a larger number of potential patients. Generally, hospitals compete for service contracts with group health care service purchasers on the basis of price, market reputation, geographic location, quality and range of services, quality of the medical staff and convenience. The importance of obtaining contracts with managed care organizations varies from market to market depending on the market strength of such organizations.

A key element of our growth strategy is expansion through the acquisition of additional hospitals in select markets. The competition to acquire hospitals is significant. We face competition for acquisition candidates primarily from other for-profit health care companies, as well as from not-for-profit entities. Some of our competitors have greater resources than we do. We intend to selectively seek opportunities to expand our base of operations by adhering to our disciplined program of rational growth, but may not be successful in accomplishing acquisitions on favorable terms.

Relationship with Universal Health Realty Income Trust:

At December 31, 2014, we held approximately 5.9% of the outstanding shares of Universal Health Realty Income Trust (the "Trust"). We serve as Advisor to the Trust under an annually renewable advisory agreement pursuant to the terms of which we conduct the Trust's day-to-day affairs, provide administrative services and

present investment opportunities. In addition, certain of our officers and directors are also officers and/or directors of the Trust. Management believes that it has the ability to exercise significant influence over the Trust, therefore we account for our investment in the Trust using the equity method of accounting. We earned an advisory fee from the Trust, which is included in net revenues in the accompanying consolidated statements of income, of approximately $2.5 million during 2014, $2.4 million during 2013 and $2.1 million during 2012.

Our pre-tax share of income from the Trust was $3.2 million during 2014, $842,000 during 2013 and $1.2 million during 2012, and is included in net revenues in the accompanying consolidated statements of income for each year. Included in our share of the Trust's income for 2014 and 2012 was approximately $2.3 million in 2014 and $500,000 in 2012 related to our share of the net favorable impact realized by the Trust in connection with: (i) gains on the sale of medical office buildings (in 2012); (ii) gain on sale of a behavioral health hospital facility (in 2014), and; (iii) gain on fair value recognition resulting from the Trust's purchase of minority ownership interests in majority owned limited liability companies (in 2014).

The carrying value of our investment in the Trust was $9.3 million and $8.1 million at December 31, 2014 and 2013, respectively, and is included in other assets in the accompanying consolidated balance sheets. The market value of our investment in the Trust was $37.9 million at December 31, 2014 and $31.5 million at December 31, 2013, based on the closing price of the Trust's stock on the respective dates.

Total rent expense under the operating leases on the four hospital facilities with the Trust (as discussed below) was $16.8 million during 2014, $16.4 million during 2013 and $16.3 million during 2012. In addition, certain of our subsidiaries are tenants in several medical office buildings owned by the Trust or by limited liability companies in which the Trust holds 100% of the ownership interest.

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

During the third quarter of 2014, we provided notification to the Trust that, upon the December, 2014 expiration of the The Bridgeway's lease term, we intended to exercise our option to purchase the real property of the facility. On December 31, 2014, we purchased The Bridgeway's real property (a 103-bed behavioral health facility located in North Little Rock, Arkansas) from the Trust. Pursuant to the terms of the lease, we and the Trust were both required to obtain appraisals of the property to determine its fair market value. Based upon the property appraisals obtained by each party, the purchase price of The Bridgeway's real property was approximately $17.3 million.

In addition, we recently constructed two free-standing emergency departments ("FEDs") located in Weslaco and Mission, Texas which were completed and opened during the first quarter of 2015. The Trust purchased one of these FEDs from us in January, 2015 and the other in February, 2015. In conjunction with these sales, wholly-owned subsidiaries of ours, which will operate the FEDs, executed agreements with the Trust to lease the properties for initial terms of 10-years with six, 5-year renewal options. The aggregate construction cost/sales proceeds of these facilities was approximately $12.8 million and the aggregate rent expense paid to the Trust at the commencement of the leases will approximate $900,000 annually.

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The table below details the renewal options and terms for each of our three hospital facilities leased from the Trust as of December 31, 2014:

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

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

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

Executive Officers of the Registrant

The executive officers, whose terms will expire at such time as their successors are elected, are as follows:

Name and Age	Present Position with the Company
Alan B. Miller (77)	Chairman of the Board and Chief Executive Officer
Marc D. Miller (44)	President and Director
Steve G. Filton (57)	Senior Vice President, Chief Financial Officer and Secretary
Debra K. Osteen (59)	Senior Vice President, President of Behavioral Health Care Division
Marvin G. Pember (61)	Senior Vice President, President of Acute Care Division

Mr. Alan B. Miller has been Chairman of the Board and Chief Executive Officer since inception and also served as President from inception until May, 2009. Prior thereto, he was President, Chairman of the Board and Chief Executive Officer of American Medicorp, Inc. He currently serves as Chairman of the Board, Chief Executive Officer and President of Universal Health Realty Income Trust. He is the father of Marc D. Miller, our President and Director.

Mr. Marc D. Miller was elected President in May, 2009 and prior thereto served as Senior Vice President and co-head of our Acute Care Hospitals since 2007. He was elected a Director in May, 2006 and Vice President in 2005. He has served in various capacities related to our acute care division since 2000. He was elected to the Board of Trustees of Universal Health Realty Income Trust in December, 2008. He is the son of Alan B. Miller, our Chairman of the Board and Chief Executive Officer.

Mr. Filton was elected Senior Vice President and Chief Financial Officer in 2003 and he was elected Secretary in 1999. He had served as Vice President and Controller since 1991 and Director of Corporate Accounting since 1985.

Ms. Osteen was elected Senior Vice President in 2005 and serves as President of our Behavioral Health Care Division. She was elected Vice President in 2000 and has served in various capacities related to our Behavioral Health Care facilities since 1984.

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Mr. Pember commenced employment with us in August, 2011 and serves as President of our Acute Care Division. He was formerly employed for 12 years at Indiana University Health, Inc. (formerly known as Clarian Health Partners, Inc.), a nonprofit hospital system that operates multiple facilities in Indiana, where he served as Executive Vice President and Chief Financial Officer.

ITEM 1A. ***Risk Factors***

We are subject to numerous known and unknown risks, many of which are described below and elsewhere in this Annual Report. Any of the events described below could have a material adverse effect on our business, financial condition and results of operations. Additional risks and uncertainties that we are not aware of, or that we currently deem to be immaterial, could also impact our business and results of operations.

A significant portion of our revenue is produced by facilities located in Texas, Nevada and California.

Texas: We own 7 acute care hospitals and 22 behavioral healthcare facilities as listed in *Item 2. Properties.* On a combined basis, these facilities contributed 18% of our consolidated net revenues during each of 2014, 2013 and 2012. On a combined basis, after deducting an allocation for corporate overhead expense, these facilities generated 17% in 2014, 15% in 2013, and 12% in 2012 of our income from operations after net income attributable to noncontrolling interest.

Nevada: We own 6 acute care hospitals and 4 behavioral healthcare facilities as listed in *Item 2. Properties.* On a combined basis, these facilities contributed 16% of our consolidated net revenues during each of 2014, 2013 and 2012. On a combined basis, after deducting an allocation for corporate overhead expense, these facilities generated 11% in 2014, 6% in 2013, and 8% in 2012 of our income from operations after net income attributable to noncontrolling interest.

California: We own 5 acute care hospitals and 6 behavioral healthcare facilities as listed in *Item 2. Properties*. On a combined basis, these facilities contributed 10% in 2014, 9% in 2013, and 10% in 2012 of our consolidated net revenues. On a combined basis, after deducting an allocation for corporate overhead expense, these facilities generated 8% in 2014, 4% in 2013, and 6% in 2012 of our income from operations after net income attributable to noncontrolling interest.

The significant portion of our revenues and earnings derived from these facilities makes us particularly sensitive to legislative, regulatory, economic, environmental and competition changes in Texas Nevada and California. Any material change in the current payment programs or regulatory, economic, environmental or competitive conditions in these states could have a disproportionate effect on our overall business results.

Our revenues and results of operations are significantly affected by payments received from the government and other third party payors.

We derive a significant portion of our revenue from third-party payors, including the Medicare and Medicaid programs. Changes in these government programs in recent years have resulted in limitations on reimbursement and, in some cases, reduced levels of reimbursement for healthcare services. Payments from federal and state government programs are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations, requirements for utilization review, and federal and state funding restrictions, all of which could materially increase or decrease program payments, as well as affect the cost of providing service to patients and the timing of payments to facilities. We are unable to predict the effect of recent and future policy changes on our operations. In addition, the uncertainty and fiscal pressures placed upon federal and state governments as a result of, among other things, the substantial deterioration in general economic conditions and the funding requirements from the federal healthcare reform legislation, may affect the availability of taxpayer funds for Medicare and Medicaid programs. In addition, the vast majority of the net revenues generated at our behavioral health facilities located in the United Kingdom are derived from governmental payors. If the rates paid or the scope of services covered by governmental payors in the United States or United Kingdom are reduced, there could be a material adverse effect on our business, financial position and results of operations.

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We receive Medicaid revenues in excess of $90 million annually from each of Texas, Washington, D.C., Pennsylvania, California, Illinois, Nevada, Virginia and Florida, making us particularly sensitive to reductions in Medicaid and other state based revenue programs as well as regulatory, economic, environmental and competitive changes in those states. Based upon the state budgets for those states for the 2015 fiscal year (which generally began at various times during the second half of 2014), we estimate that, on a blended basis, our aggregate Medicaid rates were relatively unchanged from the 2014 fiscal year rates.

In addition to changes in government reimbursement programs, our ability to negotiate favorable contracts with private payors, including managed care providers, significantly affects the revenues and operating results of our hospitals. Private payors, including managed care providers, increasingly are demanding that we accept lower rates of payment.

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

Reductions or changes in Medicare funding could have a material adverse effect on our future results of operations.

On January 3, 2013, President Obama signed into law the American Taxpayer Relief Act of 2012 (the "2012 Act"). The 2012 Act postponed for two months sequestration cuts mandated under the Budget Control Act of 2011. The postponed sequestration cuts include a 2% annual reduction over ten years in Medicare spending to providers. Medicaid is exempt from sequestration. In order to offset the costs of the legislation, the 2012 Act reduces payments to other providers totaling almost $26 billion over ten years. Approximately half of those funds will come from reductions in Medicare reimbursement to hospitals. Although the Bipartisan Budget Act of 2013 has reduced certain sequestration-related budgetary cuts, spending reductions related to the Medicare program remain in place. On December 26, 2013, President Obama signed into law H.J. Res. 59, the Bipartisan Budget Act of 2013, which includes the Pathway for SGR Reform Act of 2013 ("the Act"). In addition, on February 15, 2014, Public Law 113-082 was enacted. The Act and subsequent federal legislation achieves new savings by extending sequestration for mandatory programs—including Medicare—for another three years, through 2024. Please see *Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations, Sources of Revenue-Medicare*, for additional disclosure.

The 2012 Act includes a document and coding ("DCI") adjustment and a reduction in Medicaid disproportionate share hospital ("DSH") payments. Expected to save $10.5 billion over 10 years, the DCI adjustment decreases projected Medicare hospital payments for inpatient and overnight care through a downward adjustment in annual base payment increases. These reductions are meant to recoup what Medicare authorities consider to be "overpayments" to hospitals that occurred as a result of the transition to Medicare Severity Diagnosis Related Groups. The reduction in Medicaid DSH payments is expected to save $4.2 billion over 10 years. This provision extends the changes regarding DSH payments established by the Legislation and determines future allotments off of the rebased level.

We are subject to uncertainties regarding health care reform.

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (the "PPACA"). The Healthcare and Education Reconciliation Act of 2010 (the "Reconciliation Act"), which contains a number of amendments to the PPACA, was signed into law on March 30, 2010. Two primary goals of the PPACA, combined with the Reconciliation Act (collectively referred to as the "Legislation"), are to provide for increased access to coverage for healthcare and to reduce healthcare-related expenses.

Although it is expected that as a result of the Legislation there may be a reduction in uninsured patients, which should reduce our expense from uncollectible accounts receivable, the Legislation makes a number of

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other changes to Medicare and Medicaid which we believe may have an adverse impact on us. It has been projected that the Legislation will result in a net reduction in Medicare and Medicaid payments to hospitals totaling $155 billion over 10 years. The Legislation revises reimbursement under the Medicare and Medicaid programs to emphasize the efficient delivery of high quality care and contains a number of incentives and penalties under these programs to achieve these goals. The Legislation provides for decreases in the annual market basket update for federal fiscal years 2010 through 2019, a productivity offset to the market basket update beginning October 1, 2011 for Medicare Part B reimbursable items and services and beginning October 1, 2012 for Medicare inpatient hospital services. The Legislation and subsequent revisions provide for reductions to both Medicare DSH and Medicaid DSH payments. The Medicare DSH reductions began in October, 2013 with no material adverse impact to the reimbursements we receive expected until 2015 while Medicaid DSH reimbursements would not be adversely impacted until 2016. The Legislation implements a value-based purchasing program, which will reward the delivery of efficient care. Conversely, certain facilities will receive reduced reimbursement for failing to meet quality parameters; such hospitals will include those with excessive readmission or hospital-acquired condition rates.

A 2012 U.S. Supreme Court ruling limited the federal government's ability to expand health insurance coverage by holding unconstitutional sections of the Legislation that sought to withdraw federal funding for state noncompliance with certain Medicaid coverage requirements. Pursuant to that decision, the federal government may not penalize states that choose not to participate in the Medicaid expansion program by reducing their existing Medicaid funding. Therefore, states can choose to accept or not to participate without risking the loss of federal Medicaid funding. As a result, many states, including Texas, have not expanded their Medicaid programs without the threat of loss of federal funding.

There have been several attempts in Congress to repeal or modify various provisions of the PPACA. We cannot predict whether or not any of these proposed changes to the PPACA will become law and therefore can provide no assurance that changes to the PPACA, as currently implemented, will not have a material adverse effect on our future results of operations.

In addition, a case currently pending before The Supreme Court of the United States, *King vs. Burwell*, challenges the federal government's ability to subsidize premiums paid by certain eligible individuals that obtain health insurance policies through federally facilitated exchanges. A number of our hospitals operate in states that utilize federally facilitated exchanges. The Supreme Court of the United States' decision in this case could result in an increased number of uninsured patients treated at our hospitals located in these states which would have an adverse effect on our future results of operations.

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

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

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requirement remain pending. The Legislation also expands the Recovery Audit Contractor program to Medicaid. These amendments also make it easier for severe fines and penalties to be imposed on healthcare providers that violate applicable laws and regulations.

We have partnered with local physicians in the ownership of certain of our facilities. These investments have been permitted under an exception to the physician self-referral law. The Legislation permits existing physician investments in a hospital to continue under a "grandfather" clause if the arrangement satisfies certain requirements and restrictions, but physicians are prohibited from increasing the aggregate percentage of their ownership in the hospital. The Legislation also imposes certain compliance and disclosure requirements upon existing physician-owned hospitals and restricts the ability of physician-owned hospitals to expand the capacity of their facilities.

The impact of the Legislation on each of our hospitals may vary. Because Legislation provisions are effective at various times over the next several years, we anticipate that many of the provisions in the Legislation may be subject to further revision. We cannot predict the impact the Legislation may have on our business, results of operations, cash flow, capital resources and liquidity, or whether we will be able to successfully adapt to the changes required by the Legislation.

We are required to treat patients with emergency medical conditions regardless of ability to pay.

In accordance with our internal policies and procedures, as well as the Emergency Medical Treatment and Active Labor Act, or EMTALA, we provide a medical screening examination to any individual who comes to one of our hospitals while in active labor and/or seeking medical treatment (whether or not such individual is eligible for insurance benefits and regardless of ability to pay) to determine if such individual has an emergency medical condition. If it is determined that such person has an emergency medical condition, we provide such further medical examination and treatment as is required to stabilize the patient's medical condition, within the facility's capability, or arrange for transfer of such individual to another medical facility in accordance with applicable law and the treating hospital's written procedures. Our obligations under EMTALA may increase substantially going forward; CMS has sought stakeholder comments concerning the potential applicability of EMTALA to hospital inpatients and the responsibilities of hospitals with specialized capabilities, respectively, but has yet to issue further guidance in response to that request. If the number of indigent and charity care patients with emergency medical conditions we treat increases significantly, or if regulations expanding our obligations to inpatients under EMTALA is proposed and adopted, our results of operations will be harmed.

If we are not able to provide high quality medical care at a reasonable price, patients may choose to receive their health care from our competitors.

In recent years, the number of quality measures that hospitals are required to report publicly has increased. CMS publishes performance data related to quality measures and data on patient satisfaction surveys that hospitals submit in connection with the Medicare program. Federal law provides for the future expansion of the number of quality measures that must be reported. Additionally, the Legislation requires all hospitals to annually establish, update and make public a list of their standard charges for products and services. If any of our hospitals achieve poor results on the quality measures or patient satisfaction surveys (or results that are lower than our competitors) or if our standard charges are higher than our competitors, our patient volume could decline because patients may elect to use competing hospitals or other health care providers that have better metrics and pricing. This circumstance could harm our business and results of operations.

An increase in uninsured and underinsured patients in our acute care facilities or the deterioration in the collectability of the accounts of such patients could harm our results of operations.

Collection of receivables from third-party payors and patients is our primary source of cash and is critical to our operating performance. Our primary collection risks relate to uninsured patients and the portion of the bill that is the patient's responsibility, which primarily includes co-payments and deductibles. However, we also have substantial receivables due to us as of December 31, 2014 (a significant portion of which is past due) from

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certain state-based funding programs, most particularly Illinois and Texas as discussed herein. We estimate our provisions for doubtful accounts based on general factors such as payor mix, the agings of the receivables, historical collection experience and assessment of probability of future collections. We routinely review accounts receivable balances in conjunction with these factors and other economic conditions that might ultimately affect the collectability of the patient accounts and make adjustments to our allowances as warranted. Significant changes in business office operations, payor mix, economic conditions or trends in federal and state governmental health coverage could affect our collection of accounts receivable, cash flow and results of operations. If we experience unexpected increases in the growth of uninsured and underinsured patients or in bad debt expenses, our results of operations will be harmed.

Our hospitals face competition for patients from other hospitals and health care providers.

The healthcare industry is highly competitive, and competition among hospitals, and other healthcare providers for patients and physicians has intensified in recent years. In all of the geographical areas in which we operate, there are other hospitals that provide services comparable to those offered by our hospitals. Some of our competitors include hospitals that are owned by tax-supported governmental agencies or by nonprofit corporations and may be supported by endowments and charitable contributions and exempt from property, sales and income taxes. Such exemptions and support are not available to us.

In some markets, certain of our competitors may have greater financial resources, be better equipped and offer a broader range of services than we. The number of inpatient facilities, as well as outpatient surgical and diagnostic centers, many of which are fully or partially owned by physicians, in the geographic areas in which we operate has increased significantly. As a result, most of our hospitals operate in an increasingly competitive environment.

If our competitors are better able to attract patients, recruit physicians and other healthcare professionals, expand services or obtain favorable managed care contracts at their facilities, we may experience a decline in patient volume and our business may be harmed.

Our performance depends on our ability to recruit and retain quality physicians.

Typically, physicians are responsible for making hospital admissions decisions and for directing the course of patient treatment. As a result, the success and competitive advantage of our hospitals depends, in part, on the number and quality of the physicians on the medical staffs of our hospitals, the admitting practices of those physicians and our maintenance of good relations with those physicians. Physicians generally are not employees of our hospitals, and, in a number of our markets, physicians have admitting privileges at other hospitals in addition to our hospitals. They may terminate their affiliation with us at any time. If we are unable to provide high ethical and professional standards, adequate support personnel and technologically advanced equipment and facilities that meet the needs of those physicians, they may be discouraged from referring patients to our facilities and our results of operations may decline.

It may become difficult for us to attract and retain an adequate number of physicians to practice in certain of the non-urban communities in which our hospitals are located. Our failure to recruit physicians to these communities or the loss of physicians in these communities could make it more difficult to attract patients to our hospitals and thereby may have a material adverse effect on our business, financial condition and results of operations.

Generally, the top ten attending physicians within each of our facilities represent a large share of our inpatient revenues and admissions. The loss of one or more of these physicians, even if temporary, could cause a material reduction in our revenues, which could take significant time to replace given the difficulty and cost associated with recruiting and retaining physicians.

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If we do not continually enhance our hospitals with the most recent technological advances in diagnostic and surgical equipment, our ability to maintain and expand our markets will be adversely affected.

The technology used in medical equipment and related devices is constantly evolving and, as a result, manufacturers and distributors continue to offer new and upgraded products to health care providers. To compete effectively, we must continually assess our equipment needs and upgrade when significant technological advances occur. If our facilities do not stay current with technological advances in the health care industry, patients may seek treatment from other providers and/or physicians may refer their patients to alternate sources, which could adversely affect our results of operations and harm our business.

If we fail to continue to meet the meaningful use criteria related to electronic health record systems ("EHR"), our operations could be harmed.

Pursuant to HITECH regulations, hospitals that do not qualify as a meaningful user of EHR by 2015 are subject to a reduced market basket update to the inpatient prospective payment system ("IPPS") standardized amount in 2015 and each subsequent fiscal year. We believe that all of our acute care hospitals have met the applicable meaningful use criteria and therefore are not subject to a reduced market basked update to the IPPS standardized amount in federal fiscal year 2015. However, under the HITECH Act, hospitals must continue to meet the applicable meaningful use criteria in each fiscal year or they will be subject to a market basket update reduction in a subsequent fiscal year. Failure of our acute care hospitals to continue to meet the applicable meaningful use criteria would have an adverse effect on our future net revenues and results of operations.

Our performance depends on our ability to attract and retain qualified nurses and medical support staff and we face competition for staffing that may increase our labor costs and harm our results of operations.

We depend on the efforts, abilities, and experience of our medical support personnel, including our nurses, pharmacists and lab technicians and other healthcare professionals. We compete with other healthcare providers in recruiting and retaining qualified hospital management, nurses and other medical personnel.

The nationwide shortage of nurses and other medical support personnel has been a significant operating issue facing us and other healthcare providers. This shortage may require us to enhance wages and benefits to recruit and retain nurses and other medical support personnel or require us to hire expensive temporary personnel. In addition, in some markets like California, there are requirements to maintain specified nurse-staffing levels. To the extent we cannot meet those levels, we may be required to limit the healthcare services provided in these markets, which would have a corresponding adverse effect on our net operating revenues.

We cannot predict the degree to which we will be affected by the future availability or cost of attracting and retaining talented medical support staff. If our general labor and related expenses increase, we may not be able to raise our rates correspondingly. Our failure to either recruit and retain qualified hospital management, nurses and other medical support personnel or control our labor costs could harm our results of operations.

Increased labor union activity is another factor that could adversely affect our labor costs. Union organizing activities and certain potential changes in federal labor laws and regulations could increase the likelihood of employee unionization in the future, to the extent a greater portion of our employee base unionized, it is possible our labor costs could increase materially.

If we fail to comply with extensive laws and government regulations, we could suffer civil or criminal penalties or be required to make significant changes to our operations that could reduce our revenue and profitability.

The healthcare industry is required to comply with extensive and complex laws and regulations at the federal, state and local government levels relating to, among other things: hospital billing practices and prices for services; relationships with physicians and other referral sources; adequacy of medical care and quality of medical equipment and services; ownership of facilities; qualifications of medical and support personnel;

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confidentiality, maintenance, privacy and security issues associated with health-related information and patient medical records; the screening, stabilization and transfer of patients who have emergency medical conditions; certification, licensure and accreditation of our facilities; operating policies and procedures, and; construction or expansion of facilities and services.

Among these laws are the federal False Claims Act, the Health Insurance Portability and Accountability Act of 1996, ("HIPAA"), the federal anti-kickback statute and the provision of the Social Security Act commonly known as the "Stark Law." These laws, and particularly the anti-kickback statute and the Stark Law, impact the relationships that we may have with physicians and other referral sources. We have a variety of financial relationships with physicians who refer patients to our facilities, including employment contracts, leases and professional service agreements. We also provide financial incentives, including minimum revenue guarantees, to recruit physicians into communities served by our hospitals. The Office of the Inspector General of the Department of Health and Human Services, or OIG, has enacted safe harbor regulations that outline practices that are deemed protected from prosecution under the anti-kickback statute. A number of our current arrangements, including financial relationships with physicians and other referral sources, may not qualify for safe harbor protection under the anti-kickback statute. Failure to meet a safe harbor does not mean that the arrangement necessarily violates the anti-kickback statute, but may subject the arrangement to greater scrutiny. We cannot assure that practices that are outside of a safe harbor will not be found to violate the anti-kickback statute. CMS published a Medicare self-referral disclosure protocol, which is intended to allow providers to self-disclose actual or potential violations of the Stark law. Because there are only a few judicial decisions interpreting the Stark law, there can be no assurance that our hospitals will not be found in violation of the Stark Law or that self-disclosure of a potential violation would result in reduced penalties.

Federal regulations issued under HIPAA contain provisions that require us to implement and, in the future, may require us to implement additional costly electronic media security systems and to adopt new business practices designed to protect the privacy and security of each of our patient's health and related financial information. Such privacy and security regulations impose extensive administrative, physical and technical requirements on us, restrict our use and disclosure of certain patient health and financial information, provide patients with rights with respect to their health information and require us to enter into contracts extending many of the privacy and security regulatory requirements to third parties that perform duties on our behalf. Additionally, recent changes to HIPAA regulations may result in greater compliance requirements, including obligations to report breaches of unsecured patient data, as well as create new liabilities for the actions of parties acting as business associates on our behalf.

These laws and regulations are extremely complex, and, in many cases, we do not have the benefit of regulatory or judicial interpretation. In the future, it is possible that different interpretations or enforcement of these laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. A determination that we have violated one or more of these laws (see *Item 3—Legal Proceedings*), or the public announcement that we are being investigated for possible violations of one or more of these laws, could have a material adverse effect on our business, financial condition or results of operations and our business reputation could suffer significantly. In addition, we cannot predict whether other legislation or regulations at the federal or state level will be adopted, what form such legislation or regulations may take or what their impact on us may be. See *Item 1 Business—Self-Referral and Anti-Kickback Legislation.*

If we are deemed to have failed to comply with the anti-kickback statute, the Stark Law or other applicable laws and regulations, we could be subjected to liabilities, including criminal penalties, civil penalties (including the loss of our licenses to operate one or more facilities), and exclusion of one or more facilities from participation in the Medicare, Medicaid and other federal and state healthcare programs. The imposition of such penalties could have a material adverse effect on our business, financial condition or results of operations.

We also operate health care facilities in the United Kingdom and have operations and commercial relationships with companies in other foreign jurisdictions and, as a result, are subject to certain U.S. and foreign

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laws applicable to businesses generally, including anti-corruption laws. The Foreign Corrupt Practices Act regulates U.S. companies in their dealings with foreign officials, prohibiting bribes and similar practices, and requires that they maintain records that fairly and accurately reflect transactions and appropriate internal accounting controls. In addition, the United Kingdom Bribery Act has wide jurisdiction over certain activities that affect the United Kingdom.

We are subject to occupational health, safety and other similar regulations and failure to comply with such regulations could harm our business and results of operations.

We are subject to a wide variety of federal, state and local occupational health and safety laws and regulations. Regulatory requirements affecting us include, but are not limited to, those covering: (i) air and water quality control; (ii) occupational health and safety (e.g., standards regarding blood-borne pathogens and ergonomics, etc.); (iii) waste management; (iv) the handling of asbestos, polychlorinated biphenyls and radioactive substances; and (v) other hazardous materials. If we fail to comply with those standards, we may be subject to sanctions and penalties that could harm our business and results of operations.

We may be subject to liabilities from claims brought against our facilities.

We are subject to medical malpractice lawsuits, product liability lawsuits, class action lawsuits and other legal actions in the ordinary course of business. Some of these actions may involve large claims, as well as significant defense costs. We cannot predict the outcome of these lawsuits or the effect that findings in such lawsuits may have on us. In an effort to resolve one or more of these matters, we may choose to negotiate a settlement. Amounts we pay to settle any of these matters may be material. All professional and general liability insurance we purchase is subject to policy limitations. We believe that, based on our past experience and actuarial estimates, our insurance coverage is adequate considering the claims arising from the operations of our hospitals. While we continuously monitor our coverage, our ultimate liability for professional and general liability claims could change materially from our current estimates. If such policy limitations should be partially or fully exhausted in the future, or payments of claims exceed our estimates or are not covered by our insurance, it could have a material adverse effect on our operations.

We may be subject to governmental investigations, regulatory actions and whistleblower lawsuits.

The federal False Claims Act permits private parties to bring qui tam, or whistleblower, lawsuits against companies. Whistleblower provisions allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. These private parties are entitled to share in any amounts recovered by the government, and, as a result, the number of whistleblower lawsuits that have been filed against providers has increased significantly in recent years. Because qui tam lawsuits are filed under seal, we could be named in one or more such lawsuits of which we are not aware. Please see *Item 3. Legal Proceedings* for disclosure of current related matters.

The failure of certain employers, or the closure of certain facilities, could have a disproportionate impact on our hospitals.

The economies in the non-urban communities in which our hospitals operate are often dependent on a small number of large employers. Those employers often provide income and health insurance for a disproportionately large number of community residents who may depend on our hospitals and other health care facilities for their care. The failure of one or more large employer or the closure or substantial reduction in the number of individuals employed at facilities located in or near the communities where our hospitals operate, could cause affected employees to move elsewhere to seek employment or lose insurance coverage that was otherwise available to them. The occurrence of these events could adversely affect our revenue and results of operations, thereby harming our business.

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If any of our existing health care facilities lose their accreditation or any of our new facilities fail to receive accreditation, such facilities could become ineligible to receive reimbursement under Medicare or Medicaid.

The construction and operation of healthcare facilities are subject to extensive federal, state and local regulation relating to, among other things, the adequacy of medical care, equipment, personnel, operating policies and procedures, fire prevention, rate-setting and compliance with building codes and environmental protection. Additionally, such facilities are subject to periodic inspection by government authorities to assure their continued compliance with these various standards.

All of our hospitals are deemed certified, meaning that they are accredited, properly licensed under the relevant state laws and regulations and certified under the Medicare program. The effect of maintaining certified facilities is to allow such facilities to participate in the Medicare and Medicaid programs. We believe that all of our healthcare facilities are in material compliance with applicable federal, state, local and other relevant regulations and standards. However, should any of our healthcare facilities lose their deemed certified status and thereby lose certification under the Medicare or Medicaid programs, such facilities would be unable to receive reimbursement from either of those programs and our business could be materially adversely effected.

Our growth strategy depends, in part, on acquisitions, and we may not be able to continue to acquire hospitals that meet our target criteria. We may also have difficulties acquiring hospitals from not-for-profit entities due to regulatory scrutiny.

Acquisitions of hospitals in select markets are a key element of our growth strategy. We face competition for acquisition candidates primarily from other for-profit healthcare companies, as well as from not-for-profit entities. Some of our competitors have greater resources than we do. Also, suitable acquisitions may not be accomplished due to unfavorable terms.

In addition, many states have enacted, or are considering enacting, laws that affect the conversion or sale of not-for-profit hospitals to for-profit entities. These laws generally require prior approval from the state attorney general, advance notification and community involvement. In addition, attorneys general in states without specific conversion legislation may exercise discretionary authority over such transactions. Although the level of government involvement varies from state to state, the trend is to provide for increased governmental review and, in some cases, approval of a transaction in which a not-for-profit entity sells a healthcare facility to a for-profit entity. The adoption of new or expanded conversion legislation, increased review of not-for-profit hospital conversions or our inability to effectively compete against other potential purchasers could make it more difficult for us to acquire additional hospitals, increase our acquisition costs or make it difficult for us to acquire hospitals that meet our target acquisition criteria, any of which could adversely affect our growth strategy and results of operations.

Further, the cost of an acquisition could result in a dilutive effect on our results of operations, depending on various factors, including the amount paid for the acquisition, the acquired hospital's results of operations, allocation of the purchase price, effects of subsequent legislation and limits on rate increases.

We may fail to improve or integrate the operations of the hospitals we acquire, which could harm our results of operations and adversely affect our growth strategy.

We may be unable to timely and effectively integrate the hospitals that we acquire with our ongoing operations. We may experience delays in implementing operating procedures and systems in newly acquired hospitals. Integrating a new hospital could be expensive and time consuming and could disrupt our ongoing business, negatively affect cash flow and distract management and other key personnel. In addition, acquisition activity requires transitions from, and the integration of, operations and, usually, information systems that are used by acquired hospitals. In addition, some of the hospitals we acquire had significantly lower operating margins than the hospitals we operate prior to the time of our acquisition. If we fail to improve the operating margins of the hospitals we acquire, operate such hospitals profitably or effectively integrate the operations of acquired hospitals, our results of operations could be harmed.

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If we acquire hospitals with unknown or contingent liabilities, we could become liable for material obligations.

Hospitals that we acquire may have unknown or contingent liabilities, including, but not limited to, liabilities for failure to comply with applicable laws and regulations. Although we typically attempt to exclude significant liabilities from our acquisition transactions and seek indemnification from the sellers of such hospitals for these matters, we could experience difficulty enforcing those obligations or we could incur material liabilities for the past activities of hospitals we acquire. Such liabilities and related legal or other costs and/or resulting damage to a facility's reputation could harm our business.

Our subsidiaries, PSI, and its subsidiaries, are subject to pending legal actions, governmental investigations and regulatory actions.

Our subsidiaries, PSI, and its subsidiaries, are subject to pending legal actions, governmental investigations and regulatory actions (see *Item 3-Legal Proceedings*). In addition, we are and may become subject to other loss contingencies, both known and unknown, which may relate to past, present and future facts, events, circumstances and occurrences. Should an unfavorable outcome occur in some or all of our legal proceedings or other loss contingencies, or if successful claims and other actions are brought against us in the future, there could be a material adverse impact on our financial position, results of operations and liquidity following the merger and our ability to achieve expected benefits of the merger.

In particular, government investigations, as well as qui tam lawsuits, may lead to material fines, penalties, damages payments or other sanctions, including exclusion from government healthcare programs. Settlements of lawsuits involving Medicare and Medicaid issues routinely require both monetary payments and corporate integrity agreements, each of which could have a material adverse effect on our business, financial condition, results of operations and/or cash flows.

State efforts to regulate the construction or expansion of health care facilities could impair our ability to expand.

Many of the states in which we operate hospitals have enacted Certificates of Need, or CON, laws as a condition prior to hospital capital expenditures, construction, expansion, modernization or initiation of major new services. Our failure to obtain necessary state approval could result in our inability to complete a particular hospital acquisition, expansion or replacement, make a facility ineligible to receive reimbursement under the Medicare or Medicaid programs, result in the revocation of a facility's license or impose civil or criminal penalties on us, any of which could harm our business.

In addition, significant CON reforms have been proposed in a number of states that would increase the capital spending thresholds and provide exemptions of various services from review requirements. In the past, we have not experienced any material adverse effects from those requirements, but we cannot predict the impact of these changes upon our operations.

Controls designed to reduce inpatient services may reduce our revenues.

Controls imposed by third-party payors designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Utilization review entails the review of the admission and course of treatment of a patient by managed care plans. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payor-required preadmission authorization and utilization review and by payor pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Efforts to impose more stringent cost controls are expected to continue. Although we cannot predict the effect these changes will have on our operations, significant limits on the scope of services reimbursed and on reimbursement rates and fees could have a material adverse effect on our business, financial position and results of operations.

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Our revenues and volume trends may be adversely affected by certain factors over which we have no control.

Our revenues and volume trends are dependent on many factors, including physicians' clinical decisions and availability, payor programs shifting to a more outpatient-based environment, whether or not certain services are offered, seasonal and severe weather conditions, including the effects of extreme low temperatures, hurricanes and tornados, earthquakes, current local economic and demographic changes. In addition, technological developments and pharmaceutical improvements may reduce the demand for healthcare services or the profitability of the services we offer.

A worsening of the economic and employment conditions in the United States could materially affect our business and future results of operations.

Our patient volumes, revenues and financial results depend significantly on the universe of patients with health insurance, which to a large extent is dependent on the employment status of individuals in our markets. Worsening of economic conditions may result in a higher unemployment rate which may increase the number of individuals without health insurance. As a result, our facilities may experience a decrease in patient volumes, particularly in less intense, more elective service lines, or an increase in services provided to uninsured patients. These factors could have a material unfavorable impact on our future patient volumes, revenues and operating results.

In addition, as of December 31, 2014, we had approximately $3.29 billion of goodwill recorded on our consolidated balance sheet. Should the revenues and financial results of our acute care and/or behavioral health care facilities be materially, unfavorably impacted due to, among other things, a worsening of the economic and employment conditions in the United States that could negatively impact our patient volumes and reimbursement rates, a continued rise in the unemployment rate and continued increases in the number of uninsured patients treated at our facilities, we may incur future charges to recognize impairment in the carrying value of our goodwill and other intangible assets, which could have a material adverse effect on our financial results.

Fluctuations in our operating results, quarter to quarter earnings and other factors may result in decreases in the price of our common stock.

The stock markets have experienced volatility that has often been unrelated to operating performance. These broad market fluctuations may adversely affect the trading price of our common stock and, as a result, there may be significant volatility in the market price of our common stock. If we are unable to operate our hospitals as profitably as we have in the past or as our stockholders expect us to in the future, the market price of our common stock will likely decline as stockholders could sell shares of our common stock when it becomes apparent that the market expectations may not be realized.

In addition to our operating results, many economic and seasonal factors outside of our control could have an adverse effect on the price of our common stock and increase fluctuations in our quarterly earnings. These factors include certain of the risks discussed herein, demographic changes, operating results of other hospital companies, changes in our financial estimates or recommendations of securities analysts, speculation in the press or investment community, the possible effects of war, terrorist and other hostilities, adverse weather conditions, the level of seasonal illnesses, managed care contract negotiations and terminations, changes in general conditions in the economy or the financial markets, or other developments affecting the health care industry.

Our financial results may be adversely affected by fluctuations in foreign currency exchange rates.

We are exposed to currency exchange risk with respect to the U.S. Dollar in relation to the Pound sterling, because a portion of our revenue and expenses are denominated in Pounds. We monitor changes in our exposure to exchange rate risk. While we may elect to enter into hedging arrangements to protect our business against certain currency fluctuations, these hedging arrangements do not provide comprehensive protection, and our results of operations could be adversely affected by foreign exchange fluctuations.

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We are subject to significant corporate regulation as a public company and failure to comply with all applicable regulations could subject us to liability or negatively affect our stock price.

As a publicly traded company, we are subject to a significant body of regulation, including the Sarbanes-Oxley Act of 2002. While we have developed and instituted a corporate compliance program based on what we believe are the current best practices in corporate governance and continue to update this program in response to newly implemented or changing regulatory requirements, we cannot provide assurance that we are or will be in compliance with all potentially applicable corporate regulations. For example, we cannot provide assurance that, in the future, our management will not find a material weakness in connection with its annual review of our internal control over financial reporting pursuant to Section 404 of the Sarbanes-Oxley Act. We also cannot provide assurance that we could correct any such weakness to allow our management to assess the effectiveness of our internal control over financial reporting as of the end of our fiscal year in time to enable our independent registered public accounting firm to state that such assessment will have been fairly stated in our Annual Report on Form 10-K or state that we have maintained effective internal control over financial reporting as of the end of our fiscal year. If we fail to comply with any of these regulations, we could be subject to a range of regulatory actions, fines or other sanctions or litigation. If we must disclose any material weakness in our internal control over financial reporting, our stock price could decline.

A cyber security incident could cause a violation of HIPAA, breach of member privacy, or other negative impacts.

We rely extensively on our information technology ("IT") systems to manage clinical and financial data, communicate with our patients, payors, vendors and other third parties and summarize and analyze operating results. In addition, we have made significant investments in technology to adopt and utilize electronic health records and to become meaningful users of health information technology pursuant to the American Recovery and Reinvestment Act of 2009. A cyber-attack that bypasses our IT security systems causing an IT security breach, loss of protected health information or other data subject to privacy laws, loss of proprietary business information, or a material disruption of our IT business systems, could have a material adverse impact on our business and result of operations. In addition, our future results of operations, as well as our reputation, could be adversely impacted by theft, destruction, loss, or misappropriation of public health information, other confidential data or proprietary business information.

Different interpretations of accounting principles could have a material adverse effect on our results of operations or financial condition.

Generally accepted accounting principles are complex, continually evolving and may be subject to varied interpretation by us, our independent registered public accounting firm and the SEC. Such varied interpretations could result from differing views related to specific facts and circumstances. Differences in interpretation of generally accepted accounting principles could have a material adverse effect on our financial position or results of operations.

We continue to see rising costs in construction materials and labor. Such increased costs could have an adverse effect on the cash flow return on investment relating to our capital projects.

The cost of construction materials and labor has significantly increased. As we continue to invest in modern technologies, emergency rooms and operating room expansions, the construction of medical office buildings for physician expansion and reconfiguring the flow of patient care, we spend large amounts of money generated from our operating cash flow or borrowed funds. Although we evaluate the financial feasibility of such projects by determining whether the projected cash flow return on investment exceeds our cost of capital, such returns may not be achieved if the cost of construction continues to rise significantly or the expected patient volumes are not attained.

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The deterioration of credit and capital markets may adversely affect our access to sources of funding and we cannot be certain of the availability and terms of capital to fund the growth of our business when needed.

We require substantial capital resources to fund our acquisition growth strategy and our ongoing capital expenditure programs for renovation, expansion, construction and addition of medical equipment and technology. We believe that our capital expenditure program is adequate to expand, improve and equip our existing hospitals. We cannot predict, however, whether financing for our growth plans and capital expenditure programs will be available to us on satisfactory terms when needed, which could harm our business.

To fund all or a portion of our future financing needs, we rely on borrowings from various sources including fixed rate, long-term debt as well as borrowings pursuant to our revolving credit facility and accounts receivable securitization program. If any of the lenders were unable to fulfill their future commitments, our liquidity could be impacted, which could have a material unfavorable impact our results of operations and financial condition.

In addition, global capital markets have experienced volatility that has tightened access to capital markets and other sources of funding. In the event we need to access the capital markets or other sources of financing, there can be no assurance that we will be able to obtain financing on acceptable terms or within an acceptable time. Our inability to obtain financing on terms acceptable to us could have a material unfavorable impact on our results of operations, financial condition and liquidity.

We depend heavily on key management personnel and the departure of one or more of our key executives or a significant portion of our local hospital management personnel could harm our business.

The expertise and efforts of our senior executives and key members of our local hospital management personnel are critical to the success of our business. The loss of the services of one or more of our senior executives or of a significant portion of our local hospital management personnel could significantly undermine our management expertise and our ability to provide efficient, quality healthcare services at our facilities, which could harm our business.

The number of outstanding shares of our Class B Common Stock is subject to potential increases or decreases.

At December 31, 2014, 23.3 million shares of Class B Common Stock were reserved for issuance upon conversion of shares of Class A, C and D Common Stock outstanding, for issuance upon exercise of options to purchase Class B Common Stock and for issuance of stock under other incentive plans. Class A, C and D Common Stock are convertible on a share for share basis into Class B Common Stock. To the extent that these shares were converted into or exercised for shares of Class B Common Stock, the number of shares of Class B Common Stock available for trading in the public market place would increase substantially and the current holders of Class B Common Stock would own a smaller percentage of that class.

In addition, from time-to-time our Board of Directors approve stock repurchase programs authorizing us to purchase shares of our Class B Common Stock on the open market at prevailing market prices or in negotiated transactions off the market. Such repurchases decrease the number of outstanding shares of our Class B Common Stock. Conversely, as a potential means of generating additional funds to operate and expand our business, we may from time-to-time issue equity through the sale of stock which would increase the number of outstanding shares of our Class B Common Stock. Based upon factors such as, but not limited to, the market price of our stock, interest rate on borrowings and uses or potential uses for cash, repurchase or issuance of our stock could have a dilutive effect on our future basic and diluted earnings per share.

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The right to elect the majority of our Board of Directors and the majority of the general shareholder voting power resides with the holders of Class A and C Common Stock, the majority of which is owned by Alan B. Miller, our Chief Executive Officer and Chairman of our Board of Directors.

Our Restated Certificate of Incorporation provides that, with respect to the election of directors, holders of Class A Common Stock vote as a class with the holders of Class C Common Stock, and holders of Class B Common Stock vote as a class with holders of Class D Common Stock, with holders of all classes of our Common Stock entitled to one vote per share.

As of March 24, 2014, the shares of Class A and Class C Common Stock constituted 7.4% of the aggregate outstanding shares of our Common Stock, had the right to elect five members of the Board of Directors and constituted 86.7% of our general voting power. As of March 24, 2014, the shares of Class B and Class D Common Stock (excluding shares issuable upon exercise of options) constituted 92.6% of the outstanding shares of our Common Stock, had the right to elect two members of the Board of Directors and constituted 13.3% of our general voting power.

As to matters other than the election of directors, our Restated Certificate of Incorporation provides that holders of Class A, Class B, Class C and Class D Common Stock all vote together as a single class, except as otherwise provided by law.

Each share of Class A Common Stock entitles the holder thereof to one vote; each share of Class B Common Stock entitles the holder thereof to one-tenth of a vote; each share of Class C Common Stock entitles the holder thereof to 100 votes (provided the holder of Class C Common Stock holds a number of shares of Class A Common Stock equal to ten times the number of shares of Class C Common Stock that holder holds); and each share of Class D Common Stock entitles the holder thereof to ten votes (provided the holder of Class D Common Stock holds a number of shares of Class B Common Stock equal to ten times the number of shares of Class D Common Stock that holder holds).

In the event a holder of Class C or Class D Common Stock holds a number of shares of Class A or Class B Common Stock, respectively, less than ten times the number of shares of Class C or Class D Common Stock that holder holds, then that holder will be entitled to only one vote for every share of Class C Common Stock, or one-tenth of a vote for every share of Class D Common Stock, which that holder holds in excess of one-tenth the number of shares of Class A or Class B Common Stock, respectively, held by that holder. The Board of Directors, in its discretion, may require beneficial owners to provide satisfactory evidence that such owner holds ten times as many shares of Class A or Class B Common Stock as Class C or Class D Common Stock, respectively, if such facts are not apparent from our stock records.

Since a substantial majority of the Class A shares and Class C shares are controlled by Mr. Alan B. Miller and members of his family who are also directors and officers of our company, and they can elect a majority of our company's directors and effect or reject most actions requiring approval by stockholders without the vote of any other stockholders, there are potential conflicts of interest in overseeing the management of our company.

In addition, because this concentrated control could discourage others from initiating any potential merger, takeover or other change of control transaction that may otherwise be beneficial to our businesses, our business and prospects and the trading price of our securities could be adversely affected.

ITEM 1B. ***Unresolved Staff Comments***

None.

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ITEM 2. *Properties*

Executive and Administrative Offices and Commercial Health Insurer

We own office buildings in King of Prussia and Wayne, Pennsylvania, Brentwood, Tennessee and Denton, Texas. We also own the operations and real property of Prominence Health Plan, a commercial insurer headquartered in Reno, Nevada, acquired by us during 2014.

Facilities

The following tables set forth the name, location, type of facility and, for acute care hospitals and behavioral health care facilities, the number of licensed beds:

Acute Care Hospitals

Name of Facility	Location	Number of Beds	Real Property Ownership Interest
Aiken Regional Medical Centers	Aiken, South Carolina	183	Owned
Aurora Pavilion	Aiken, South Carolina	62	Owned
Centennial Hills Hospital Medical Center (1)	Las Vegas, Nevada	177	Owned
Corona Regional Medical Center	Corona, California	238	Owned
Desert Springs Hospital (1)	Las Vegas, Nevada	293	Owned
Doctors' Hospital of Laredo (9)	Laredo, Texas	183	Owned
Fort Duncan Regional Medical Center	Eagle Pass, Texas	101	Owned
The George Washington University Hospital (2)	Washington, D.C.	371	Owned
Lakewood Ranch Medical Center	Bradenton, Florida	120	Owned
Manatee Memorial Hospital	Bradenton, Florida	319	Owned
Northern Nevada Medical Center	Sparks, Nevada	108	Owned
Northwest Texas Healthcare System	Amarillo, Texas	385	Owned
The Pavilion at Northwest Texas Healthcare System	Amarillo, Texas	90	Owned
Palmdale Regional Medical Center	Palmdale, California	157	Owned
South Texas Health System (4)			
Edinburg Regional Medical Center/Children's Hospital	Edinburg, Texas	213	Owned
McAllen Medical Center (3)	McAllen, Texas	441	Leased
McAllen Heart Hospital	McAllen, Texas	60	Owned
South Texas Behavioral Health Center	McAllen, Texas	134	Owned
Southwest Healthcare System			
Inland Valley Campus (3)	Wildomar, California	132	Leased
Rancho Springs Campus	Murrieta, California	120	Owned
Spring Valley Hospital Medical Center (1)	Las Vegas, Nevada	237	Owned
St. Mary's Regional Medical Center	Enid, Oklahoma	229	Owned
Summerlin Hospital Medical Center (1)	Las Vegas, Nevada	454	Owned
Temecula Valley Hospital	Temecula, California	140	Owned
Texoma Medical Center	Denison, Texas	288	Owned
TMC Behavioral Health Center	Denison, Texas	60	Owned
Valley Hospital Medical Center (1)	Las Vegas, Nevada	301	Owned
Wellington Regional Medical Center (3)	West Palm Beach, Florida	233	Leased

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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS

	December 31, 2014	December 31, 2013
	(Dollar amounts in thousands)	
Assets		
Current assets:		
Cash and cash equivalents	$ 32,069	$ 17,238
Accounts receivable, net	1,282,735	1,116,961
Supplies	108,115	101,781
Deferred income taxes	114,565	119,903
Other current assets	77,654	76,446
Total current assets	1,615,138	1,432,329
Property and Equipment		
Land	435,632	388,190
Buildings and improvements	3,948,501	3,593,055
Equipment	1,648,718	1,496,707
Property under capital lease	40,782	27,636
	6,073,633	5,505,588
Accumulated depreciation	(2,532,341)	(2,249,733)
	3,541,292	3,255,855
Construction-in-progress	138,397	186,314
	3,679,689	3,442,169
Other assets:		
Goodwill	3,291,213	3,049,016
Deferred charges	40,319	57,881
Other	348,084	330,328
	3,679,616	3,437,225
	$ 8,974,443	$ 8,311,723
Liabilities and Stockholders' Equity		
Current liabilities:		
Current maturities of long-term debt	$ 68,319	$ 99,312
Accounts payable	336,447	276,911
Accrued liabilities		
Compensation and related benefits	323,425	278,206
Interest	13,977	9,577
Taxes other than income	112,119	59,473
Other	327,094	329,282
Current federal and state income taxes	1,446	7,127
Total current liabilities	1,182,827	1,059,888
Other noncurrent liabilities	268,555	284,589
Long-term debt	3,210,215	3,209,762
Deferred income taxes	282,214	239,148
Commitments and contingencies (Note 8)		
Redeemable noncontrolling interest	239,552	218,107
Equity:		
Class A Common Stock, voting, $.01 par value; authorized 12,000,000 shares: issued and outstanding 6,595,708 shares in 2014 and 6,595,708 shares in 2013	66	66
Class B Common Stock, limited voting, $.01 par value; authorized 150,000,000 shares: issued and outstanding 91,427,258 shares in 2014 and 91,021,377 shares in 2013	914	910
Class C Common Stock, voting, $.01 par value; authorized 1,200,000 shares: issued and outstanding 664,000 shares in 2014 and 664,000 shares in 2013	7	7
Class D Common Stock, limited voting, $.01 par value; authorized 5,000,000 shares: issued and outstanding 29,121 shares in 2014 and 29,999 shares in 2013	0	0
Cumulative dividends	(255,196)	(225,531)
Retained earnings	4,015,387	3,499,337
Accumulated other comprehensive loss	(25,232)	(24,810)
Universal Health Services, Inc. common stockholders' equity	3,735,946	3,249,979
Noncontrolling interest	55,134	50,250
Total Equity	3,791,080	3,300,229
	$ 8,974,443	$ 8,311,723

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY
For the Years Ended December 31, 2014, 2013 and 2012
(in thousands)

	Redeemable Noncontrolling Interest	Class A Common	Class B Common	Class C Common	Class D Common	Cumulative Dividends	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	UHS Common Stockholders' Equity	Noncontrolling Interest	Total
Balance, January 1, 2012	$218,266	$ 66	$893	$ 7	$ 0	($147,515)	$2,494,076	($51,175)	$2,296,352	$ 50,766	$2,347,118
Common Stock											
Issued/(converted) including tax benefits from exercise of stock options	—	—	14	—	—	—	21,670	—	21,684	—	21,684
Repurchased	—	—	(4)	—	—	—	(19,150)	—	(19,154)	—	(19,154)
Restricted share-based compensation expense	—	—	—	—	—	—	2,308	—	2,308	—	2,308
Dividends paid	—	—	—	—	—	(58,395)	—	—	(58,395)	—	(58,395)
Stock option expense	—	—	—	—	—	—	20,083	—	20,083	—	20,083
Distributions to noncontrolling interests	(18,961)	—	—	—	—	—	—	—	—	(7,933)	(7,933)
Sale of minority ownership interests in majority owned businesses	—	—	—	—	—	—	—	—	—	(832)	(832)
Comprehensive income:											
Net income	34,998	—	—	—	—	—	443,446	—	443,446	10,603	454,049
Amortization of terminated hedge (net of income tax effect of $120)	—	—	—	—	—	—	—	(216)	(216)	—	(216)
Unrealized derivative gains on cash flow hedges (net of income tax effect of $2,528)	—	—	—	—	—	—	—	4,149	4,149	—	4,149
Minimum pension liability (net of income tax effect of $1,898)	—	—	—	—	—	—	—	3,088	3,088	—	3,088
Subtotal—comprehensive income	34,998	—	—	—	—	—	443,446	7,021	450,467	10,603	461,070
Balance, December 31, 2012	$234,303	$ 66	$903	$ 7	$ 0	($205,910)	$2,962,433	($44,154)	$2,713,345	$ 52,604	$2,765,949

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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY—(Continued)
For the Years Ended December 31, 2014, 2013 and 2012
(in thousands)

	Redeemable Noncontrolling Interest	Class A Common	Class B Common	Class C Common	Class D Common	Cumulative Dividends	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	UHS Common Stockholders' Equity	Noncontrolling Interest	Total
Common Stock											
Issued/(converted) including tax benefits from exercise of stock options	—	—	11	—	—	—	26,869	—	26,880	—	26,880
Repurchased	—	—	(4)	—	—	—	(27,197)	—	(27,201)	—	(27,201)
Restricted share-based compensation expense	—	—	—	—	—	—	664	—	664	—	664
Dividends paid	—	—	—	—	—	(19,621)	—	—	(19,621)	—	(19,621)
Stock option expense	—	—	—	—	—	—	25,835	—	25,835	—	25,835
Distributions to noncontrolling interests	(48,290)	—	—	—	—	—	—	—	—	(13,039)	(13,039)
Other	—	—	—	—	—	—	—	—	—	(511)	(511)
Comprehensive income:											
Net income	32,094	—	—	—	—	—	510,733	—	510,733	11,196	521,929
Amortization of terminated hedge (net of income tax effect of $120)	—	—	—	—	—	—	—	(216)	(216)	—	(216)
Unrealized derivative gains on cash flow hedges (net of income tax effect of $6,390)	—	—	—	—	—	—	—	10,573	10,573	—	10,573
Minimum pension liability (net of income tax effect of $5,670)	—	—	—	—	—	—	—	8,987	8,987	—	8,987
Subtotal—comprehensive income	32,094	—	—	—	—	—	510,733	19,344	530,077	11,196	541,273
Balance, December 31, 2013	$218,107	$ 66	$910	$ 7	$ 0	($225,531)	$3,499,337	($24,810)	$3,249,979	$ 50,250	$3,300,229

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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY—(Continued)
For the Years Ended December 31, 2014, 2013 and 2012
(in thousands)

	Redeemable Noncontrolling Interest	Class A Common	Class B Common	Class C Common	Class D Common	Cumulative Dividends	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	UHS Common Stockholders' Equity	Noncontrolling Interest	Total
Common Stock											
Issued/(converted) including tax benefits from exercise of stock options	—	—	14	—	—	—	41,787	—	41,801	—	41,801
Repurchased	—	—	(10)	—	—	—	(100,739)	—	(100,749)	—	(100,749)
Restricted share-based compensation expense	—	—	—	—	—	—	491	—	491	—	491
Dividends paid	—	—	—	—	—	(29,665)	—	—	(29,665)	—	(29,665)
Stock option expense	—	—	—	—	—	—	29,168	—	29,168	—	29,168
Distributions to noncontrolling interests	(26,016)	—	—	—	—	—	—	—	—	(7,666)	(7,666)
Other	—	—	—	—	—	—	—	—	—	358	358
Comprehensive income:											
Net income	47,461	—	—	—	—	—	545,343	—	545,343	12,192	557,535
Foreign currency translation adjustments	—	—	—	—	—	—	—	(2,431)	(2,431)	—	(2,431)
Amortization of terminated hedge (net of income tax effect of $120)	—	—	—	—	—	—	—	(216)	(216)	—	(216)
Unrealized derivative gains on cash flow hedges (net of income tax effect of $6,529)	—	—	—	—	—	—	—	11,139	11,139	—	11,139
Minimum pension liability (net of income tax effect of $5,356)	—	—	—	—	—	—	—	(8,914)	(8,914)	—	(8,914)
Subtotal—comprehensive income	47,461	—	—	—	—	—	545,343	(422)	544,921	12,192	557,113
Balance, December 31, 2014	$239,552	$ 66	$914	$ 7	$ 0	($255,196)	$4,015,387	($25,232)	$3,735,946	$ 55,134	$3,791,080

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

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UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2014	2013	2012
	(Amounts in thousands)		
Cash Flows from Operating Activities:			
Net income	$ 604,996	$ 554,023	$ 489,047
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation & amortization	375,624	337,356	308,690
Gains on sales of assets and businesses, net of losses	(7,837)	(3,114)	(27,085)
Stock-based compensation expense	31,092	27,783	22,518
Costs related to extinguishment of debt	19,730	0	29,170
Changes in assets & liabilities, net of effects from acquisitions and dispositions:			
Accounts receivable	(105,708)	(49,708)	(71,068)
Accrued interest	4,400	(1,197)	152
Accrued and deferred income taxes	33,920	34,861	(5,666)
Other working capital accounts	73,912	26,234	28,554
Other assets and deferred charges	13,667	8,984	30,976
Other	2,449	23,485	6,367
Accrued insurance expense, net of commercial premiums paid	59,276	(3,821)	62,660
Payments made in settlement of self-insurance claims	(69,645)	(70,645)	(75,084)
Net cash provided by operating activities	1,035,876	884,241	799,231
Cash Flows from Investing Activities:			
Property and equipment additions, net of disposals	(391,150)	(358,493)	(363,192)
Acquisition of property and businesses	(431,386)	(12,636)	(527,847)
Proceeds received from sales of assets and businesses	15,178	37,482	149,311
Costs incurred for purchase and implementation of electronic health records application	(13,488)	(49,811)	(54,362)
Increase in insurance subsidiary investments	(12,000)	0	0
Return of deposit on terminated purchase agreement	0	0	6,500
Net cash used in investing activities	(832,846)	(383,458)	(789,590)
Cash Flows from Financing Activities:			
Reduction of long-term debt	(879,129)	(440,224)	(849,647)
Additional borrowings	830,000	15,761	913,500
Financing costs	(14,976)	(231)	(8,283)
Repurchase of common shares	(100,749)	(27,201)	(19,154)
Dividends paid	(29,665)	(19,621)	(58,395)
Issuance of common stock	6,863	5,708	5,435
Excess income tax benefits related to stock based compensation	33,912	20,121	16,040
Profit distributions to noncontrolling interests	(33,680)	(61,329)	(26,895)
Net cash used in financing activities	(187,424)	(507,016)	(27,399)
Effect of exchange rate changes on cash and cash equivalents	(775)	0	0
Increase (decrease) in cash and cash equivalents	14,831	(6,233)	(17,758)
Cash and cash equivalents, beginning of period	17,238	23,471	41,229
Cash and cash equivalents, end of period	$ 32,069	$ 17,238	$ 23,471
Supplemental Disclosures of Cash Flow Information:			
Interest paid, including early redemption premium and original issue discount write-off in 2014	$ 130,279	$ 131,259	$ 157,415
Income taxes paid, net of refunds	$ 258,612	$ 259,896	$ 264,824
Noncash purchases of property and equipment	$ 35,469	$ 36,212	$ 34,896
Supplemental Disclosures of Noncash Investing and Financing Activities: See Notes 2, 4 and 7			

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

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1) BUSINESS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

The more significant accounting policies follow:

A) Principles of Consolidation: The consolidated financial statements include the accounts of our majority-owned subsidiaries and partnerships controlled by us or our subsidiaries as the managing general partner. All significant intercompany accounts and transactions have been eliminated.

B) Revenue Recognition: We record revenues and related receivables for health care services at the time the services are provided. Medicare and Medicaid revenues represented 36% of our net patient revenues during 2014, 38% during 2013 and 39% during 2012. Revenues from managed care entities, including health maintenance organizations and managed Medicare and Medicaid programs accounted for 50% of our net patient revenues during 2014 and 49% during each of 2013 and 2012.

We report net patient service revenue at the estimated net realizable amounts from patients and third-party payors and others for services rendered. We have agreements with third-party payors that provide for payments to us at amounts different from our established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments. Estimates of contractual allowances under managed care plans are based upon the payment terms specified in the related contractual agreements. We closely monitor our historical collection rates, as well as changes in applicable laws, rules and regulations and contract terms, to assure that provisions are made using the most accurate information available. However, due to the complexities involved in these estimations, actual payments from payors may be different from the amounts we estimate and record.

We estimate our Medicare and Medicaid revenues using the latest available financial information, patient utilization data, government provided data and in accordance with applicable Medicare and Medicaid payment rules and regulations. The laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation and as a result, there is at least a reasonable possibility that recorded estimates will change by material amounts in the near term. Certain types of payments by the Medicare program and state Medicaid programs (e.g. Medicare Disproportionate Share Hospital, Medicare Allowable Bad Debts and Inpatient Psychiatric Services) are subject to retroactive adjustment in future periods as a result of administrative review and audit and our estimates may vary from the final settlements. Such amounts are included in accounts receivable, net, on our Consolidated Balance Sheets. The vast majority of the net revenues generated at our behavioral health facilities located in the United Kingdom are derived from government based payors. The funding of both federal Medicare and state Medicaid programs, and the government based payor programs in the United Kingdom, are subject to legislative and regulatory changes. As such, we cannot provide any assurance that future legislation and regulations, if enacted, will not have a material impact on our future government based reimbursements. Adjustments related to the final settlement of these retrospectively determined amounts did not materially impact our results in 2014, 2013 and 2012. We provide care to patients who meet certain financial or economic criteria without charge or at amounts substantially less than our established rates. Because we do not pursue collection of amounts determined to qualify as charity care, they are not reported in net revenues or in accounts receivable, net. See additional disclosure below in *Charity Care, Uninsured Discounts and Provision for Doubtful Accounts* for our estimated uncompensated care provided and estimated cost of providing uncompensated care.

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

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

A portion of the accounts receivable at our acute care facilities are comprised of Medicaid accounts that are pending approval from third-party payers but we also have smaller amounts due from other miscellaneous payers such as county indigent programs in certain states. Our patient registration process includes an interview of the patient or the patient's responsible party at the time of registration. At that time, an insurance eligibility determination is made and an insurance plan code is assigned. There are various pre-established insurance profiles in our patient accounting system which determine the expected insurance reimbursement for each patient based on the insurance plan code assigned and the services rendered. Certain patients may be classified as Medicaid pending at registration based upon a screening evaluation if we are unable to definitively determine if they are currently Medicaid eligible. When a patient is registered as Medicaid eligible or Medicaid pending, our patient accounting system records net revenues for services provided to that patient based upon the established Medicaid reimbursement rates, subject to the ultimate disposition of the patient's Medicaid eligibility. When the patient's ultimate eligibility is determined, reclassifications may occur which impacts the reported amounts in future periods for the provision for doubtful accounts and other accounts such as Medicaid pending. Although the patient's ultimate eligibility determination may result in amounts being reclassified among these accounts from period to period, these reclassifications did not have a material impact on our results of operations in 2014, 2013 or 2012 since our facilities make estimates at each financial reporting period to reserve for amounts that are deemed to be uncollectible.

We also provide discounts to uninsured patients (included in "uninsured discounts" amounts below) who do not qualify for Medicaid or charity care. Because we do not pursue collection of amounts classified as uninsured discounts, they are not reported in our net revenues or in our net accounts receivable. In implementing the discount policy, we first attempt to qualify uninsured patients for governmental programs, charity care or any other discount program. If an uninsured patient does not qualify for these programs, the uninsured discount is applied. Effective January 1, 2014, in response to market conditions and other considerations, we modified our uninsured discount policy and increased the discount to 60% of gross charges from 30% previously. The increase in the uninsured discount in 2014 had no material impact on our net revenues, net income attributable to UHS or

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net accounts receivable, as compared to prior year periods. However, since we expect to collect only a small portion of amounts due from our uninsured patients, this change resulted in an increase in uninsured discounts and a decrease in the provision for doubtful accounts.

On a consolidated basis, we monitor our total self-pay receivables to ensure that the total allowance for doubtful accounts provides adequate coverage based on historical collection experience. Our accounts receivable are recorded net of allowance for doubtful accounts of $325 million and $395 million at December 31, 2014 and 2013, respectively.

Uncompensated care (charity care and uninsured discounts):

The following table shows the amounts recorded at our acute care hospitals for charity care and uninsured discounts, based on charges at established rates, for the years ended December 31, 2014, 2013 and 2012:

	(dollar amounts in thousands)					
	2014		2013		2012	
	Amount	%	Amount	%	Amount	%
Charity care	$ 515,435	45%	$593,474	59%	$ 778,268	74%
Uninsured discounts	620,587	55%	405,296	41%	267,304	26%
Total uncompensated care	$1,136,022	100%	$998,770	100%	$1,045,572	100%

The provision for doubtful accounts at our acute care hospitals decreased to approximately $590 million during 2014 as compared to $1.02 billion during 2013. The decrease in the provision for doubtful accounts during 2014, as compared to 2013, was primarily due to the increase in the uninsured discount effective January 1, 2014, and reclassifications among provision for doubtful accounts and other accounts such as Medicaid pending based upon our patients' ultimate eligibility determination, as discussed above.

The estimated cost of providing uncompensated care:

The estimated cost of providing uncompensated care, as reflected below, were based on a calculation which multiplied the percentage of operating expenses for our acute care hospitals to gross charges for those hospitals by the above-mentioned total uncompensated care amounts. The percentage of cost to gross charges is calculated based on the total operating expenses for our acute care facilities divided by gross patient service revenue for those facilities. An increase in the level of uninsured patients to our facilities and the resulting adverse trends in the provision for doubtful accounts and uncompensated care provided could have a material unfavorable impact on our future operating results.

	(amounts in thousands)		
	2014	2013	2012
Estimated cost of providing charity care	$ 78,475	$ 95,675	$131,890
Estimated cost of providing uninsured discounts related care	94,484	65,338	45,299
Estimated cost of providing uncompensated care	$172,959	$161,013	$177,189

Our accounts receivable as of December 31, 2014 and 2013 include amounts due from Illinois of approximately $44 million and $49 million, respectively. Collection of the outstanding receivables continues to be delayed due to state budgetary and funding pressures. Approximately $23 million as of December 31, 2014 and $28 million as of December 31, 2013, of the receivables due from Illinois were outstanding in excess of 60 days, as of each respective date. In addition, our accounts receivable as of December 31, 2014 and 2013 includes approximately $102 million and $62 million due from Texas in connection with Medicaid supplemental payment programs. The $102 million due from Texas as of December 31, 2014 consists of $45 million related to uncompensated care program revenues, $33 million related to disproportionate share hospital program revenues

and $24 million related to Delivery Service Reform Incentive Payment program ("DSRIP") revenues. Approximately $24 million of cash was received in January, 2015 from Texas related to the above-mentioned DSRIP receivables outstanding as of December 31, 2014. Although the accounts receivable due from Illinois and Texas could remain outstanding for the foreseeable future, since we expect to eventually collect all amounts due to us, no related reserves have been established in our consolidated financial statements. However, we can provide no assurance that we will eventually collect all amounts due to us from Illinois and/or Texas. Failure to ultimately collect all outstanding amounts due from these states would have an adverse impact on our future consolidated results of operations and cash flows.

D) Concentration of Revenues: Our five majority owned acute care hospitals in the Las Vegas, Nevada market contributed, on a combined basis, 14% of our consolidated net revenues during each year of 2014, 2013 and 2012.

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

Medicare EHR incentive payments: Federal regulations require that Medicare EHR incentive payments be computed based on the Medicare cost report that begins in the federal fiscal period in which a hospital meets the applicable "meaningful use" requirements. Since the annual Medicare cost report periods for each of our acute care hospitals ends on December 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 met the "meaningful use" criteria. Therefore, the majority of the Medicaid EHR incentive income recognition occurred in the period in which the applicable hospitals were deemed to have met initial "meaningful use" criteria. Upon meeting subsequent fiscal year "meaningful use" criteria, our hospitals may become entitled to additional Medicaid EHR incentive payments which will be recognized as incentive income in future periods. Medicaid EHR incentive payments received prior to our hospitals meeting the "meaningful use" criteria were included in other current liabilities (as deferred EHR incentive income) in our consolidated balance sheet.

F) Cash and Cash Equivalents: We consider all highly liquid investments purchased with maturities of three months or less to be cash equivalents.

G) Property and Equipment: Property and Equipment: Property and equipment are stated at cost. Expenditures for renewals and improvements are charged to the property accounts. Replacements, maintenance and repairs which do not improve or extend the life of the respective asset are expensed as incurred. We remove the cost and the related accumulated depreciation from the accounts for assets sold or retired and the resulting gains or losses are included in the results of operations. Construction-in-progress includes both construction projects and equipment not yet placed into service.

We capitalize interest expense on major construction projects while in progress. There was no capitalized interest recorded during 2014. We capitalized interest on major construction projects and the development and implementation of electronic health records applications amounting to $4.9 million during 2013 and $5.7 million during 2012.

Depreciation is provided on the straight-line method over the estimated useful lives of buildings and improvements (twenty to forty years) and equipment (three to fifteen years). Depreciation expense (excluding discontinued operations) was $314.5 million during 2014, $285.6 million during 2013 and $270.5 million during 2012.

H) Long-Lived Assets: We review our long-lived assets, including intangible assets, for impairment whenever events or circumstances indicate that the carrying value of these assets may not be recoverable. The assessment of possible impairment is based on our ability to recover the carrying value of our asset based on our estimate of its undiscounted future cash flow. If the analysis indicates that the carrying value is not recoverable from future cash flows, the asset is written down to its estimated fair value and an impairment loss is recognized. Fair values are determined based on estimated future cash flows using appropriate discount rates.

I) Goodwill and Intangible Assets: Goodwill and indefinite-lived intangible assets are reviewed for impairment at the reporting unit level on an annual basis or sooner if the indicators of impairment arise. Our judgments regarding the existence of impairment indicators are based on market conditions and operational performance of each reporting unit. We have designated September 1st as our annual impairment assessment date and performed an impairment assessment as of September 1, 2014 which indicated no impairment of goodwill or indefinite-lived intangible assets. There were also no impairments during 2013 or 2012. Future changes in the estimates used to conduct the impairment review, including profitability and market value projections, could indicate impairment in future periods potentially resulting in a write-off of a portion or all of our goodwill or indefinite-lived intangible assets.

Changes in the carrying amount of goodwill for the two years ended December 31, 2014 were as follows (in thousands):

	Acute Care Services	Behavioral Health Services	Total Consolidated
Balance, January 1, 2013	$382,696	$2,654,069	$3,036,765
Adjustments to goodwill (a)	315	11,936	12,251
Balance, December 31, 2013	383,011	2,666,005	3,049,016
Goodwill acquired during the period	4,088	246,124	250,212
Adjustments to goodwill (b)	0	(8,015)	(8,015)
Balance, December 31, 2014	$387,099	$2,904,114	$3,291,213

(a) The increase in the Behavioral Health Services' goodwill consists primarily of an amount that was reclassified from other assets.

(b) The decrease in the Behavioral Health Services' goodwill consists primarily of foreign currency translation adjustments.

J) Other Assets: Other assets consist primarily of amounts related to: (i) intangible assets acquired in connection with our acquisition of Psychiatric Solutions, Inc. ("PSI") in November, 2010 and Ascend Health Corporation in October, 2012, consisting of Medicare licenses, certificates of need and contracts to manage the operations of behavioral health services owned by third-parties (PSI only); (ii) prepaid fees for various software and other applications used by our hospitals; (iii) costs incurred in connection with the purchase and implementation of an electronic health records application for each of our acute care facilities; (iv) required capital reserves related to our commercial insurer; (v) deposits; (vi) investments in various businesses, including Universal Health Realty Income Trust; (vii) the invested assets related to a deferred compensation plan that is held by an independent trustee in a rabbi-trust and that has a related payable included in other noncurrent liabilities; (viii) the estimated future payments related to physician-related contractual commitments, as discussed below, and; (ix) other miscellaneous assets. As of December 31, 2014 and 2013, other intangible assets, net of accumulated amortization, were approximately $98 million and $97 million, respectively.

K) Physician Guarantees and Commitments: As of December 31, 2014 and 2013, our accrued liabilities-other, and our other assets included $2 million and $3 million, respectively, of estimated future payments related to physician-related contractual commitments. The $2 million of potential future financial obligations outstanding as of December 31, 2014 are potential 2015 obligations.

L) Self-Insured/Other Insurance Risks: We provide for self-insured risks, primarily general and professional liability claims and workers' compensation claims. Our estimated liability for self-insured professional and general liability claims is based on a number of factors including, among other things, the number of asserted claims and reported incidents, estimates of losses for these claims based on recent and historical settlement amounts, estimate of incurred but not reported claims based on historical experience, and estimates of amounts recoverable under our commercial insurance policies. All relevant information, including our own historical experience is used in estimating the expected amount of claims. While we continuously monitor these factors, our ultimate liability for professional and general liability claims could change materially from our current estimates due to inherent uncertainties involved in making this estimate. Our estimated self-insured reserves are reviewed and changed, if necessary, at each reporting date and changes are recognized currently as additional expense or as a reduction of expense. See Note 8 for discussion of adjustments to our prior year reserves for claims related to our self-insured general and professional liability and workers' compensation liability.

In addition, we also: (i) own a commercial health insurer headquartered in Reno, Nevada, and; (ii) maintain self-insured employee benefits programs for employee healthcare and dental claims. The ultimate costs related to these programs/operations include expenses for claims incurred and paid in addition to an accrual for the estimated expenses incurred in connection with claims incurred but not yet reported. Given our significant insurance-related exposure, there can be no assurance that a sharp increase in the number and/or severity of claims asserted against us will not have a material adverse effect on our future results of operations.

M) Income Taxes: Deferred tax assets and liabilities are recognized for the amount of taxes payable or deductible in future years as a result of differences between the tax bases of assets and liabilities and their reported amounts in the financial statements. We believe that future income will enable us to realize our deferred tax assets net of recorded valuation allowances relating to state net operating loss carry-forwards.

We operate in multiple jurisdictions with varying tax laws. We are subject to audits by any of these taxing authorities. Our tax returns have been examined by the Internal Revenue Service ("IRS") through the year ended December 31, 2006. We believe that adequate accruals have been provided for federal, foreign and state taxes. See Note 6—*Income Taxes,* for additional disclosure.

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

O) Redeemable Noncontrolling Interests and Noncontrolling Interest: Outside owners hold noncontrolling, minority ownership interests of: (i) approximately 28% in our five acute care facilities (and one additional facility currently under construction) located in Las Vegas, Nevada; (ii) 20% in an acute care facility located in Washington, D.C.; (iii) approximately 11% in an acute care facility located in Laredo, Texas, and; (iv) 20% in a behavioral health care facility located in Philadelphia, Pennsylvania. The redeemable noncontrolling interest balances of $240 million as of December 31, 2014 and $218 million as of December 31, 2013, and the noncontrolling interest balances of $55 million as of December 31, 2014 and $50 million as of December 31, 2013, consist primarily of the third-party ownership interests in these hospitals.

In connection with five acute care facilities (and an additional facility currently under construction) located in Las Vegas, Nevada, the minority ownership interests of which are reflected as redeemable noncontrolling

interests on our Consolidated Balance Sheet, the outside owners have certain "put rights" that, if exercisable, and if exercised, require us to purchase the minority member's interests at fair market value. The put rights are exercisable upon the occurrence of: (i) certain specified financial conditions falling below established thresholds; (ii) breach of the management contract by the managing member (a subsidiary of ours), or; (iii) if the minority member's ownership percentage is reduced to less than certain thresholds. In connection with a behavioral health care facility located in Philadelphia, Pennsylvania and acquired by us as part of the PSI acquisition, the minority ownership interest of which is also reflected as redeemable noncontrolling interests on our Consolidated Balance Sheet, the outside owner has a "put option" to put its entire ownership interest to us at any time. If exercised, the put option requires us to purchase the minority member's interest at fair market value.

P) Accumulated Other Comprehensive Income: The accumulated other comprehensive income ("AOCI") component of stockholders' equity includes: net unrealized gains and losses on effective cash flow hedges, foreign currency translation adjustments and the net minimum pension liability of a non-contributory defined benefit pension plan which covers employees at one of our subsidiaries. See Note 10, "Pension Plan" for additional disclosure regarding the defined benefit pension plan.

The amounts recognized in AOCI for the two years ended December 31, 2014 were as follows (in thousands):

	Net Unrealized Gains (Losses) on Effective Cash Flow Hedges	Foreign Currency Translation Adjustment	Minimum Pension Liability	Total AOCI
Balance, January 1, 2013, net of income tax	$(24,527)	$ 0	$(19,627)	$(44,154)
2013 activity:				
Pretax amount	16,627	0	14,657	31,284
Income tax effect	(6,270)	0	(5,670)	(11,940)
Change, net of income tax	10,357	0	8,987	19,344
Balance, January 1, 2014, net of income tax	(14,170)	0	(10,640)	(24,810)
2014 activity:				
Pretax amount	17,332	(2,431)	(14,270)	631
Income tax effect	(6,409)	0	5,356	(1,053)
Change, net of income tax	10,923	(2,431)	(8,914)	(422)
Balance, December 31, 2014, net of income tax	$ (3,247)	$(2,431)	$(19,554)	$(25,232)

Q) Accounting for Derivative Financial Investments and Hedging Activities: We manage our ratio of fixed to floating rate debt with the objective of achieving a mix that management believes is appropriate. To manage this risk in a cost-effective manner, we, from time to time, enter into interest rate swap agreements in which we agree to exchange various combinations of fixed and/or variable interest rates based on agreed upon notional amounts.

We account for our derivative and hedging activities using the Financial Accounting Standard Board's ("FASB") guidance which requires all derivative instruments, including certain derivative instruments embedded in other contracts, to be carried at fair value on the balance sheet. For derivative transactions designated as hedges, we formally document all relationships between the hedging instrument and the related hedged item, as well as its risk-management objective and strategy for undertaking each hedge transaction.

Derivative instruments designated in a hedge relationship to mitigate exposure to variability in expected future cash flows, or other types of forecasted transactions, are considered cash flow hedges. Cash flow hedges are accounted for by recording the fair value of the derivative instrument on the balance sheet as either an asset or liability, with a corresponding amount recorded in accumulated other comprehensive income ("AOCI") within stockholders' equity. Amounts are reclassified from AOCI to the income statement in the period or periods the hedged transaction affects earnings.

We use interest rate derivatives in our cash flow hedge transactions. Such derivatives are designed to be highly effective in offsetting changes in the cash flows related to the hedged liability. For derivative instruments designated as cash flow hedges, the ineffective portion of the change in expected cash flows of the hedged item are recognized currently in the income statement.

Derivative instruments designated in a hedge relationship to mitigate exposure to changes in the fair value of an asset, liability, or firm commitment attributable to a particular risk, such as interest rate risk, are considered fair value hedges. Fair value hedges are accounted for by recording the changes in the fair value of both the derivative instrument and the hedged item in the income statement.

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

R) Stock-Based Compensation: At December 31, 2014, we have a number of stock-based employee compensation plans. Pursuant to the FASB's guidance, we expense the grant-date fair value of stock options and other equity-based compensation pursuant to the straight-line method over the stated vesting period of the award using the Black-Scholes option-pricing model.

The expense associated with share-based compensation arrangements is a non-cash charge. In the Consolidated Statements of Cash Flows, share-based compensation expense is an adjustment to reconcile net income to cash provided by operating activities. The applicable FASB guidance requires that cash flows resulting from tax deductions in excess of compensation cost recognized be classified as financing cash flows.

S) Earnings per Share: Basic earnings per share are based on the weighted average number of common shares outstanding during the year. Diluted earnings per share are based on the weighted average number of common shares outstanding during the year adjusted to give effect to common stock equivalents.

The following table sets forth the computation of basic and diluted earnings per share, for the periods indicated:

	Twelve Months Ended December 31,		
	2014	2013	2012
Basic and diluted:			
Net Income	$604,996	$554,023	$489,047
Less: Net income attributable to noncontrolling interest	(59,653)	(43,290)	(45,601)
Less: Net income attributable to unvested restricted share grants	(236)	(294)	(497)
Net income attributable to UHS—basic and diluted	$545,107	$510,439	$442,949
Basic earnings per share attributable to UHS:			
Weighted average number of common shares—basic	98,826	98,033	96,821
Total basic earnings per share	$ 5.52	$ 5.21	$ 4.57
Diluted earnings per share attributable to UHS:			
Weighted average number of common shares	98,826	98,033	96,821
Net effect of dilutive stock options and grants based on the treasury stock method	1,718	1,328	890
Weighted average number of common shares and equivalents—diluted	100,544	99,361	97,711
Total diluted earnings per share	$ 5.42	$ 5.14	$ 4.53

The "Net effect of dilutive stock options and grants based on the treasury stock method", for all years presented above, excludes certain outstanding stock options applicable to each year since the effect would have been anti-dilutive. The excluded weighted-average stock options totaled 2,250 during 2014, 4,000 during 2013, and 2.0 million during 2012.

T) Fair Value of Financial Instruments: The fair values of our registered debt and investments are based on quoted market prices. The fair values of other long-term debt, including capital lease obligations, are estimated by discounting cash flows using period-end interest rates and market conditions for instruments with similar maturities and credit quality. The carrying amounts reported in the balance sheet for cash, accounts receivable, accounts payable, and short-term borrowings approximates their fair values due to the short-term nature of these instruments. Accordingly, these items have been excluded from the fair value disclosures included elsewhere in these notes to consolidated financial statements.

U) Use of Estimates: The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires us to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

V) Mergers and Acquisitions: The acquisition method of accounting for business combinations requires that the assets acquired and liabilities assumed be recorded at the date of acquisition at their respective fair values with limited exceptions. Fair value is defined as the exchange price that would be received for an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. Any excess of the purchase price (consideration transferred) over the estimated fair values of net assets acquired is recorded as goodwill. Transaction costs and costs to restructure the acquired company are expensed as incurred. The fair value of intangible assets, including Medicare Licenses, Certificates of Need, and certain contracts, is based on significant judgments made by our management, and accordingly, for significant items we typically obtain assistance from third party valuation specialists.

W) GPO Agreement/Minority Ownership Interest: During 2013, we entered into a new group purchasing organization agreement ("GPO") and acquired a minority interest in the GPO for a nominal amount. In connection with the completion of an initial public offering of the stock of the GPO, during the fourth quarter of 2013, we received cash proceeds for the sale of a portion of our ownership interest, which were recorded as deferred income and included in liabilities on our consolidated balance sheet as of December 31, 2014 and 2013. The deferred income is being recognized, on a pro rata basis, as a reduction to our supplies expense over the expected life of the GPO agreement. Also in connection with this GPO agreement and related minority interest ownership, we received shares of restricted stock in the GPO which vest ratably over a seven-year period, contingent upon our continued participation and minority ownership interest in the GPO. We are recognizing the fair value of this restricted stock, as a reduction to our supplies expense, in our consolidated statements of income on a pro rata basis over the vesting period.

X) Provider Taxes: We incur health-care related taxes ("Provider Taxes") imposed by states in the form of a licensing fee, assessment or other mandatory payment which are related to: (i) healthcare items or services; (ii) the provision of, or the authority to provide, the health care items or services, or; (iii) the payment for the health care items or services. Such Provider Taxes are subject to various federal regulations that limit the scope and amount of the taxes that can be levied by states in order to secure federal matching funds as part of their respective state Medicaid programs. We derive a related Medicaid reimbursement benefit from assessed Provider Taxes in the form of Medicaid claims based payment increases and/or lump sum Medicaid supplemental payments. Under these programs, including the impact of Uncompensated Care and Upper Payment Limit programs, and the Texas Delivery System Reform Incentive program, we earned revenues of approximately $293 million during 2014, $213 million during 2013, and $176 million during 2012. These revenues were offset by

assessments of $137 million during 2014, $84 million during 2013, and $93 million during 2012, resulting in a net aggregate benefit of $156 million, $130 million, and $83 million, respectively. The aggregate net benefit is earned from multiple states and therefore no particular state's portion is individually material to our consolidated financial statements. In addition, under various disproportionate share hospital payment programs and the Nevada state plan amendment program, we earned revenues of $59 million in 2014, $54 million in 2013, and $47 million in 2012.

Y) Recent Accounting Standards:

In April 2014, the Financial Accounting Standards Board ("FASB") updated the accounting guidance related to the definition of a discontinued operation and the related disclosures. The updated accounting guidance defines a discontinued operation as a disposal of a component or a group of components that is to be disposed of or is classified as held for sale and represents a strategic shift that has or will have a major effect on an entity's operations and financial results. The updated guidance is applicable to us effective January 1, 2015 with early adoption permitted. We do not expect the adoption of this update to have a material impact on our consolidated financial statements.

In May 2014, the FASB issued Accounting Standards Update ("ASU") 2014-09, "Revenue from Contracts with Customers", which provides guidance for revenue recognition. The standard's core principle is that a company will recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods or services. This ASU also requires additional disclosures. ASU 2014-09 is effective for annual reporting periods beginning after December 15, 2016. We are currently in the process of evaluating the impact of adoption of this ASU on our consolidated financial statements.

In August 2014, FASB issued ASU No. 2014-15, "Preparation of Financial Statements—Going Concern (Subtopic 205-40), Disclosure of Uncertainties about an Entity's Ability to Continue as a Going Concern" (ASU 2014-15). Continuation of a reporting entity as a going concern is presumed as the basis for preparing financial statements unless and until the entity's liquidation becomes imminent. Preparation of financial statements under this presumption is commonly referred to as the going concern basis of accounting. If and when an entity's liquidation becomes imminent, financial statements should be prepared under the liquidation basis of accounting in accordance with Subtopic 205-30, "Presentation of Financial Statements—Liquidation Basis of Accounting". Even when an entity's liquidation is not imminent, there may be conditions or events that raise substantial doubt about the entity's ability to continue as a going concern. In those situations, financial statements should continue to be prepared under the going concern basis of accounting, but the new criteria in ASU 2014-15 should be followed to determine whether to disclose information about the relevant conditions and events. The amendments in ASU 2014-15 are effective for the annual period ending after December 15, 2016, and for annual periods and interim periods thereafter. Early application is permitted. We will evaluate the going concern considerations in this ASU.

2) ACQUISITIONS AND DIVESTITURES

2015 Acquisition:

In February, 2015, we acquired the Orchard Portman House Hospital (now called Cygnet Hospital-Taunton), a 46-bed behavioral health care facility located near Taunton, United Kingdom.

Year ended December 31, 2014:

2014 Acquisitions of Assets and Businesses:

During 2014 we spent $431 million to:

- acquire the stock of Cygnet Health Care Limited ("Cygnet") which consists of 17 facilities located throughout the United Kingdom including 15 inpatient behavioral health hospitals and 2 nursing homes with a total of 723 beds (during the third quarter);

- acquire and fund the required capital reserves related to Prominence Health Plan, a commercial health insurer headquartered in Reno, Nevada (during the second quarter);
- acquire the Psychiatric Institute of Washington, a 124-bed behavioral health care facility and outpatient treatment center located in Washington, D.C. (during the second quarter);
- acquire the operations of Palo Verde Behavioral Health, a 48-bed behavioral health facility in Tucson, Arizona (during the first quarter);
- acquire the real property of The Bridgeway, a 103-bed behavioral health care facility located in North Little Rock, Arkansas, that was previously leased from Universal Health Realty Income Trust (during the fourth quarter);
- acquire the previously leased real property of Cygnet Hospital-Harrow, a 44-bed behavioral health care facility located in the United Kingdom, the operations of which were acquired as part of our acquisition of Cygnet (during the fourth quarter), and;
- acquire physician practices.

The aggregate net purchase price of the facilities was allocated to assets and liabilities based on their preliminary estimated fair values as follows:

	Amount (000s)
Working capital, net	$ (41,000)
Property & equipment	174,000
Goodwill	250,000
Other assets	59,000
Income tax assets, net of deferred tax liabilities	4,000
Debt	(16,000)
Other	1,000
Cash paid in 2014 for acquisitions	$431,000

Goodwill of the facilities acquired is computed, pursuant to the residual method, by deducting the fair value of the acquired assets and liabilities from the total purchase price. The factors that contribute to the recognition of goodwill, which may also influence the purchase price, include the following for each of the acquired facilities: (i) the historical cash flows and income levels; (ii) the reputations in their respective markets; (iii) the nature of the respective operations, and; (iv) the future cash flows and income growth projections. The vast majority of the goodwill resulting from these transactions is not deductible for federal income tax purposes (see Note 6. Income Taxes).

Included in our consolidated net revenues for the year ended December 31, 2014 was an aggregate of approximately $175 million representing the net revenues generated at the Cygnet facilities, the commercial health insurer located in Reno, Nevada and the 124-bed behavioral health care facility and outpatient treatment center located in Washington, D.C., from their respective dates of acquisition through December 31, 2014. The aggregate effect of the earnings generated by these facilities since the dates of acquisition, less the cost on the borrowings utilized to finance the acquisition, was not material to our 2014 net income attributable to UHS and net income attributable to UHS per diluted share.

Assuming the acquisitions occurred on January 1, 2014, our 2014 pro forma net revenues would have been approximately $8.28 billion and our pro forma net income attributable to UHS would have been approximately $558 million, or $5.55 per diluted share. Assuming the above-mentioned acquisitions occurred on January 1, 2013, our 2013 unaudited pro forma net revenues would have been approximately $7.62 billion and our

unaudited pro forma net income attributable to UHS would have been approximately $522 million and $5.25 per diluted share.

2014 Divestiture of Assets and Businesses:

During 2014 we received $15 million in connection with the divestiture of a non-operating investment (during the first quarter) and the real property of a closed behavioral health facility (during the second quarter).

Year ended December 31, 2013:

2013 Acquisitions of Assets and Businesses:

During 2013, we spent an aggregate of $13 million for the purchase of real property located in Pennsylvania, Nevada and Arizona. The aggregate net purchase price of these properties was allocated to property and equipment on our consolidated balance sheet.

2013 Divestiture of Assets and Businesses:

During 2013, we received an aggregate of $37 million in connection with the divestiture of Peak Behavioral Health Services (sold during the second quarter of 2013) and certain other assets and real property including three previously closed behavioral health care facilities. As discussed below in *Discontinued Operations*, we agreed to sell Peak Behavioral Health Services as part of our agreement with the Federal Trade Commission in connection with our acquisition of Ascend Health Corporation ("Ascend") in October of 2012. The aggregate pre-tax gain on these divestitures was approximately $3 million and in included in our 2013 consolidated results of operations.

Year ended December 31, 2012:

2012 Acquisitions of Assets and Businesses:

During 2012, we spent $528 million to acquire the following assets and businesses:

- spent $503 million to acquire nine behavioral health care facilities from Ascend in October, 2012, and;
- spent $25 million in connection with the acquisition of physician practices and various real property.

The aggregate net purchase price of the facilities was allocated to assets and liabilities based on their estimated fair values as follows:

	Amount (000s)
Working capital, net	$ 21,000
Property & equipment	60,000
Goodwill	446,000
Other assets	9,000
Income tax assets, net of deferred tax liabilities	(1,000)
Other liabilities	(7,000)
Cash paid in 2012 for acquisitions	$528,000

Goodwill of the facilities acquired is computed, pursuant to the residual method, by deducting the fair value of the acquired assets and liabilities from the total purchase price. The factors that contribute to the recognition of goodwill, which may also influence the purchase price, include the following for each of the acquired facilities:

(i) the historical cash flows and income levels; (ii) the reputations in their respective markets; (iii) the nature of the respective operations, and; (iv) the future cash flows and income growth projections.

During the period of October 10, 2012 through December 31, 2012, the facilities acquired from Ascend generated $42 million of net revenues which are included in our consolidated net revenues for the year ended December 31, 2012. The aggregate effect of the earnings generated by these facilities since the date of acquisition, less the cost on the borrowings utilized to finance the acquisition, and less the above-mentioned transaction costs, was not material to our 2012 net income attributable to UHS and net income attributable to UHS per diluted share. Assuming the acquisition of Ascend occurred on January 1, 2012, our 2012 unaudited pro forma net revenues would have been approximately $7.11 billion and our unaudited pro forma net income attributable to UHS and unaudited pro forma net income attributable to UHS per diluted share would have been $464 million and $4.74 per diluted share, respectively.

2012 Divestiture of Assets and Businesses:

During 2012, we received $149 million from the divestiture of assets and businesses, including the following:

- received $93 million for the sale of Auburn Regional Medical Center ("Auburn"), a 159-bed acute care hospital located in Auburn, Washington (sold in October of 2012);
- received $50 million for the sale of the Hospital San Juan Capestrano, a 108-bed acute care hospital located in Rio Piedras, Puerto Rico (sold in January of 2012 pursuant to our below-mentioned agreement with the FTC in connection with our acquisition of PSI in November, 2010), and;
- received an aggregate of $6 million for the sale of the real property of two non-operating behavioral health facilities and our majority ownership interest in an outpatient surgery center located in Puerto Rico.

Included in our 2012 consolidated results of operations was a $26 million pre-tax gain on the divestiture of Auburn. The divestiture of San Juan Capestrano (in January, 2012) did not have a material impact on our consolidated results of operations.

Discontinued Operations

There were no material divestitures during 2014.

In connection with the receipt of antitrust clearance from the Federal Trade Commission ("FTC") in connection with our acquisition of Ascend Health Corporation in October of 2012, we agreed to certain conditions, including the divestiture of Peak Behavioral Health Services ("Peak"), a 104-bed behavioral health care facility located in Santa Teresa, New Mexico. The divestiture of Peak was completed during the second quarter of 2013 for total cash proceeds of approximately $24 million resulting in a pre-tax gain of approximately $3 million which is included in our 2013 consolidated financial statements.

In October of 2012, we completed the divestiture of Auburn Regional Medical Center ("Auburn"), a 159-bed acute care hospital located in Auburn, Washington, for total cash proceeds of approximately $93 million. This divestiture resulted in a pre-tax gain of $26 million which was included in our 2012 consolidated financial statements.

In connection with the receipt of antitrust clearance from the FTC in connection with our acquisition of PSI in November, 2010, we agreed to divest three former PSI facilities (which were divested during 2011) as well as one of our legacy behavioral health facilities in Puerto Rico, which we divested in 2012.

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

	2013	2012
Net revenues	$ 7,813	$95,226
Income (loss) from discontinued operations, before income taxes	932	(3,472)
Gain on divestiture	3,080	26,419
Income from discontinued operations, before income tax expense	4,012	22,947
Income tax expense	(1,506)	(8,688)
Income from discontinued operations, net of income taxes	$ 2,506	$14,259

3) FINANCIAL INSTRUMENTS

Fair Value Hedges:

During 2014, 2013 and 2012, we had no fair value hedges outstanding.

Cash Flow Hedges:

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

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

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

The fair value of interest rate swap agreements approximates the amount at which they could be settled, based on estimates obtained from the counterparties. We assess the effectiveness of our hedge instruments on a quarterly basis. We performed periodic assessments of the cash flow hedge instruments during 2014 and 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 December 31, 2014 and 2013, each swap agreement entered into by us was in a liability position which would require us to make the 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 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 also entered into six forward starting interest rate swaps in 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 $75 million, $25 million and $100 million became effective in December, 2011 and had corresponding fixed rates of 1.32%, 1.96% and 2.50%. The $75 million, $25 million and $100 million interest rate swaps matured in December, 2012, December, 2013 and December, 2014, respectively.

During 2011, we entered into a forward starting interest rate cap, which is now expired, 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. The three-month LIBOR never reached 7.00% during the term of the cap, which expired in December, 2013, and therefore no payment was made to us.

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 a liability of $6 million at December 31, 2014, all of which is included in other current liabilities. At December 31, 2013, the fair value of our interest rate swaps was a liability of $24 million, of which $19 million was included in other current liabilities and $5 million was included in other noncurrent liabilities on the accompanying balance sheet.

4) LONG-TERM DEBT

A summary of long-term debt follows:

	December 31, 2014	December 31, 2013
	(amounts in thousands)	
Long-term debt:		
Notes payable and Mortgages payable (including obligations under capitalized leases of $21,600 in 2014 and $6,633 in 2013) and term loans with varying maturities through 2037; weighted average interest rates of 6.4% in 2014 and 5.9% in 2013 and 2012 (see Note 7 regarding capitalized leases)	$ 41,257	$ 37,553
Revolving credit and on-demand credit facility	140,500	25,500
Term Loan A, net of unamortized discount of $2,035 in 2014 and $3,340 in 2013	1,761,872	935,308
Term Loan B, net of unamortized discount of $6,473 in 2013	0	543,527
Term Loan A2	0	871,875
Revenue bonds, interest at floating rates of 0.05% at December 31, 2014 and 0.10% at December 31, 2013, with varying maturities through 2015	5,300	5,300
Accounts receivable securitization program	330,000	240,000
3.75% Senior Secured Notes due 2019, net of unamortized discount of $198 in 2014	299,802	0
4.75% Senior Secured Notes due 2022, net of unamortized discount of $204 in 2014	299,796	0
7.125% Senior Secured Notes due 2016, including unamortized net premium of $7 in 2014 and $11 in 2013	400,007	400,011
7.00% Senior Unsecured Notes due 2018	0	250,000
	3,278,534	3,309,074
Less-Amounts due within one year	(68,319)	(99,312)
	$3,210,215	$3,209,762

During the third quarter of 2014, we completed the following financing transactions:

- On August 7, 2014, we entered into a Fourth Amendment (the "Fourth Amendment") to our credit agreement dated as of November 15, 2010, as amended on March 15, 2011, September 21, 2012 and May 16, 2013, among UHS, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders ("Credit Agreement"). The Credit Agreement, as amended, which is scheduled to mature in August, 2019, consists of: (i) an $800 million revolving credit facility ($140 million of borrowings outstanding as of December 31, 2014), and; (ii) a $1.775 billion term loan A facility ($1.764 billion of borrowings outstanding as of December 31, 2014) which combined our previously outstanding term loan A and term loan A2 facilities which were scheduled to mature in 2016;
- Repaid $550 million of outstanding borrowings pursuant to our previously outstanding term loan B facility which was scheduled to mature in 2016;
- Increased the borrowing capacity on our existing accounts receivable securitization program ("Securitization") to $360 million from $275 million, effective August 1, 2014. The Securitization, the terms of which remain the same as the previous agreement, as discussed below, is scheduled to mature in October, 2016;
- Issued $300 million aggregate principal amount of 3.750% senior secured notes due in 2019 (see below for additional disclosure);
- Issued $300 million aggregate principal amount of 4.750% senior secured notes due in 2022 (see below for additional disclosure);

- Redeemed our previously outstanding $250 million, 7.00% senior unsecured notes due in 2018 on July 31, 2014 for an aggregate price equal to 104.56% of the principal amount.

In connection with these transactions, our 2014 results of operations included a $36 million pre-tax charge incurred for the costs related to the extinguishment of debt. This charge consisted of the write-off of deferred charges ($20 million) and original issue discount on the extinguished debt ($5 million) as well as the make-whole premium paid ($11 million) on the early redemption of the $250 million, 7.00% senior unsecured notes.

Borrowings under the Credit Agreement bear interest at either (1) the ABR rate which is defined as the rate per annum equal to, at our election: the greatest of (a) the lender's prime rate, (b) the weighted average of the federal funds rate, plus 0.5% and (c) one month LIBOR rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.50% to 1.25% for revolving credit and term loan-A borrowings, or (2) the one, two, three or six month LIBOR rate (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.50% to 2.25% for revolving credit and term loan-A borrowings. As of December 31, 2014, the applicable margins were 0.50% for ABR-based loans, 1.50% for LIBOR-based loans under the revolving credit and term loan-A facilities.

As of December 31, 2014, we had $140 million of outstanding borrowings pursuant to the terms of our $800 million revolving credit facility and we had $640 million of available borrowing capacity, net of $500,000 of outstanding borrowings pursuant to a short-term, on-demand credit facility and $20 million of outstanding letters of credit. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Credit Agreement is secured by certain assets of the Company and our material subsidiaries and guaranteed by our material subsidiaries.

Pursuant to the terms of the Fourth Amendment to our Credit Agreement, term loan-A quarterly installment payments of approximately: (i) $11 million commenced during the fourth quarter of 2014 and are scheduled to continue through September, 2016, and; (ii) $22 million are scheduled from the fourth quarter of 2016 through June, 2019. Prior to commencement of the Fourth Amendment, we made scheduled principal payments of $36 million on the term loan-A and term loan A2 facilities during 2014 and $72 million during 2013.

As discussed above, on August 1, 2014, our accounts receivable securitization program ("Securitization"), with a group of conduit lenders and liquidity banks which is scheduled to mature in October, 2016, was amended to increase the borrowing capacity to $360 million from $275 million. Substantially all of the patient-related accounts receivable of our acute care hospitals ("Receivables") serve as collateral for the outstanding borrowings. We have accounted for this Securitization as borrowings. We maintain effective control over the Receivables since, pursuant to the terms of the Securitization, the Receivables are sold from certain of our subsidiaries to special purpose entities that are wholly-owned by us. The Receivables, however, are owned by the special purpose entities, can be used only to satisfy the debts of the wholly-owned special purpose entities, and thus are not available to us except through our ownership interest in the special purpose entities. The wholly-owned special purpose entities use the Receivables to collateralize the loans obtained from the group of third-party conduit lenders and liquidity banks. The group of third-party conduit lenders and liquidity banks do not have recourse to us beyond the assets of the wholly-owned special purpose entities that securitize the loans. At December 31, 2014, we had $330 million of outstanding borrowings and $30 million of additional capacity pursuant to the terms of our accounts receivable securitization program.

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

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

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

On July 31, 2014, we redeemed the $250 million, 7.00% senior unsecured notes (the "Unsecured Notes"), which were scheduled to mature on October 1, 2018, at a redemption price equal to 104.56% of the principal amount of the Unsecured Notes resulting in a make-whole premium payment of approximately $11 million. The Unsecured Notes were issued on September 29, 2010 and registered in April, 2011. Interest on the Unsecured Note was payable semiannually in arrears on April 1st and October 1st of each year.

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

The average amounts outstanding during each of years 2014, 2013 and 2012 under the current and prior Credit Agreements, demand notes and accounts receivable securitization programs was $2.4 billion, $2.9 billion and $2.9 billion, respectively, with corresponding interest rates of 1.8%, 2.2% and 2.9%, respectively, including commitment and facility fees. The maximum amounts outstanding at any month-end were $2.65 billion in 2014, $3.00 billion in 2013 and $3.06 billion in 2012. The effective interest rate on our current and prior Credit Agreements, accounts receivable securitization programs, and demand notes, which includes the respective interest expense, commitment and facility fees, designated interest rate swaps expense and amortization of deferred financing costs and original issue discounts, was 3.2% in 2014, 3.6% in 2013 and 4.5% in 2012.

Our Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens and indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage and minimum interest coverage ratios. We are in compliance with all required covenants as of December 31, 2014.

The carrying value of our debt at December 31, 2014 and 2013 was $3.3 billion. The fair values of our debt at December 31, 2014 and 2013 were $3.3 billion and $3.4 billion, respectively. The fair value of our debt was computed based upon quotes received from financial institutions. We consider these to be "level 2" in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with debt instruments.

Aggregate maturities follow:

	(000s)
2015	$ 68,319
2016	787,437
2017	90,675
2018	90,882
2019	1,925,923
Later	315,298
Total	$3,278,534

5) COMMON STOCK

Dividends

Cash dividends of $0.30 per share ($29.7 million in the aggregate) were declared and paid during 2014, $.20 per share ($19.6 million in the aggregate) were declared and paid during 2013 and $.60 per share ($58.4 million in the aggregate), including a $.40 per share special cash dividend ($38.9 million) were declared and paid during 2012. All classes of our common stock have similar economic rights.

Stock Repurchase Programs

In various prior years, our Board of Directors 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. In conjunction with the new stock repurchase program discussed below, remaining shares available for repurchase pursuant to prior authorizations were cancelled.

In July, 2014, our Board of Directors authorized a new stock repurchase program whereby, from time to time as conditions allow, we may spend up to $400 million to purchase shares of our Class B Common Stock on the open market or in negotiated private transactions. There is no expiration date for our stock repurchase program. Upon approval of the new stock purchase program, our previously announced stock repurchase program was cancelled. The following schedule provides information related to our stock repurchase program for each of the three years ended December 31, 2014. All of the shares repurchased during 2013 and 2012 related to income tax withholding obligations resulting from the exercise of stock options and the vesting of restricted stock grants. No shares were repurchased during 2013 or 2012 pursuant to our publicly announced stock repurchase program. During 2014, 548,192 shares ($58.0 million in the aggregate) were repurchased pursuant to the terms of our recently authorized stock repurchase program and 480,972 shares ($42.7 million in the aggregate) were repurchased in connection with income tax withholding obligations resulting from the exercise of stock options and the vesting of restricted stock grants.

	Additional dollars authorized for repurchase (in thousands)	Total number of shares purchased	Total number of shares cancelled	Average price paid per share for forfeited restricted shares	Total number of shares purchased as part of publicly announced programs	Average price pad per share for shares purchased as part of publicly announced program	Aggregate purchase price paid (in thousands)	Aggregate purchase price paid for shares purchased as part of publicly announced program	Maximum number of shares that may yet be purchased under the program	Maximum number of dollars that may yet be purchased under the program (in thousands)
Balance as of January 1, 2012									767,704	N/A
2012	—	433,312	—	N/A	—	N/A	$ 19,154	N/A	767,704	N/A
2013	—	427,170	—	N/A	—	N/A	$ 27,201	N/A	767,704	N/A
2014	$400,000	1,029,164	767,704	N/A	548,192	$105.71	$100,749	$57,950	N/A	$342,050
Total for three year period ended December 31, 2014	$400,000	1,889,646	767,704	N/A	548,192	$105.71	$147,104	$57,950		

Stock-based Compensation Plans

At December 31, 2014, we have a number of stock-based employee compensation plans. Pursuant to the FASB's guidance, we expense the grant-date fair value of stock options and other equity-based compensation pursuant to the straight-line method over the stated vesting period of the award using the Black-Scholes option-pricing model.

Pre-tax compensation costs of $29.2 million during 2014, $25.8 million during 2013, and $20.1 million during 2012 were recognized related to outstanding stock options. In addition, pre-tax compensation costs of $1.9 million during 2014, $2.0 million during 2013 and $2.4 million during 2012 were recognized related to amortization of restricted stock and discounts provided in connection with shares purchased pursuant to our 2005 Employee Stock Purchase Plan.

The expense associated with stock-based compensation arrangements is a non-cash charge. In the Consolidated Statements of Cash Flows, stock-based compensation expense is an adjustment to reconcile net income to cash provided by operating activities and aggregated to $31.1 million in 2014, $27.8 million in 2013 and $22.5 million in 2012. In accordance with ASC 718, excess income tax benefits related to stock-based compensation are classified as cash inflows from financing activities on the Consolidated Statement of Cash Flows. During 2014, 2013 and 2012 we generated $33.9 million, $20.1 million and $16.0 million, respectively, of excess income tax benefits related to stock based compensation which are reflected as cash inflows from financing activities in our Consolidated Statements of Cash Flows, as included herein.

We adopted the 2005 Stock Incentive Plan, as amended in 2008 and 2010, (the "Stock Incentive Plan") which replaced our Amended and Restated 1992 Stock Option Plan which expired in July of 2005. An aggregate of 23 million shares of Class B Common Stock has been reserved under the Stock Incentive Plan. During 2014, 2013 and 2012, stock options, net of cancellations, of approximately 2.8 million, 2.6 million and 2.6 million, respectively, were granted. The per option weighted-average grant-date fair value of options granted during 2014, 2013 and 2012 was $17.23, $13.33 and $10.73, respectively. Stock options to purchase Class B Common Stock have been granted to our officers, key employees and members of our Board of Directors. All stock options were granted with an exercise price equal to the fair market value on the date of the grant. Options are exercisable ratably over a four-year period beginning one year after the date of the grant. All outstanding options expire five years after the date of the grant. As of December 31, 2014, approximately 3.1 million shares of Class B Common Stock remain available for issuance pursuant to the Stock Incentive Plan.

The fair value of each option grant was estimated on the date of grant using the Black-Scholes option-pricing model. The following weighted average assumptions were derived from averaging the number of options granted during the most recent five-year period. The weighted-average assumptions reflected below were based upon twenty-one options grants for the five-year period ending December 31, 2014 and eighteen option grants for each of the five-year periods ended December 31, 2013 and 2012.

Year Ended December 31,	2014	2013	2012
Volatility	35%	36%	33%
Interest rate	1%	1%	1%
Expected life (years)	3.4	3.6	3.5
Forfeiture rate	10%	11%	10%
Dividend yield	0.4%	0.5%	0.6%

The risk-free rate is based on the U.S. Treasury zero coupon four year yield in effect at the time of grant. The expected life of the stock options granted was estimated using the historical behavior of employees. Expected volatility was based on historical volatility for a period equal to the stock option's expected life. Expected dividend yield is based on our dividend yield at the time of grant.

The table below summarizes our stock option activity during each of the last three years:

Outstanding Options	Number of Shares	Average Option Price	Range (High-Low)
Balance, January 1, 2012	7,558,945	$31.63	$ 54.79-$16.22
Granted	2,966,850	$37.01	$ 44.83-$36.95
Exercised	(2,608,007)	$23.22	$ 46.97-$16.22
Cancelled	(481,550)	$38.00	$ 46.97-$16.22
Balance, January 1, 2013	7,436,238	$36.31	$ 54.79-$16.22
Granted	2,889,750	$53.51	$ 79.79-$53.38
Exercised	(2,288,666)	$32.27	$ 54.79-$16.22
Cancelled	(416,364)	$43.93	$ 53.38-$16.22
Balance, January 1, 2014	7,620,958	$43.63	$ 79.79-$30.32
Granted	2,845,500	$78.65	$102.21-$78.17
Exercised	(2,277,469)	$38.50	$ 73.65-$30.32
Cancelled	(291,538)	$55.63	$ 78.17-$36.95
Balance, December 31, 2014	7,897,451	$57.29	$102.21-$36.95
Outstanding options vested and exercisable as of December 31, 2014	1,412,422	$43.59	$ 79.79-$36.97

The following table provides information about unvested options for the year December 31, 2014:

	Shares	Weighted Average Grant Date Fair Value
Unvested options as of January 1, 2014	5,864,830	$12.12
Granted	2,845,500	$17.23
Vested	(1,937,013)	$11.90
Cancelled	(288,288)	$13.64
Unvested options as of December 31, 2014	6,485,029	$14.36

The following table provides information regarding all options outstanding at December 31, 2014:

	Options Outstanding	Options Exercisable
Number of options outstanding	7,897,451	1,412,422
Weighted average exercise price	$ 57.29	$ 43.59
Aggregate intrinsic value as of December 31, 2014	$426,248,728	$95,577,868
Weighted average remaining contractual life	2.9	1.8

The total in-the-money value of all stock options exercised during the years ended December 31, 2014, 2013 and 2012 were $112.5 million, $70.9 million and $54.4 million, respectively.

The weighted average remaining contractual life for options outstanding and weighted average exercise price per share for exercisable options at December 31, 2014 were as follows:

Exercise Price	Options Outstanding Shares	Weighted Average Exercise Price Per Share	Weighted Average Remaining Contractual Life (in Years)	Exercisable Options Shares	Weighted Average Exercise Price Per Share	Expected to Vest Options (a) Shares	Weighted Average Exercise Price Per Share
$36.95 – $43.46	1,690,463	$37.00	2.0	465,688	$37.02	1,100,460	$36.99
$43.67 – $46.97	1,201,213	43.68	1.0	647,025	43.67	497,938	43.68
$53.38 – $73.65	2,241,625	53.52	3.0	299,209	53.58	1,745,261	53.51
$78.17 – $102.21	2,764,150	78.66	4.2	500	79.79	2,483,140	78.66
Total	7,897,451	$57.29	2.9	1,412,422	$43.59	5,826,799	$60.27

(a) Assumes a weighted average forfeiture rate of 10.2%.

In addition to the Stock Incentive Plan, we have the following stock incentive and purchase plans: (i) the 2010 Employees' Restricted Stock Purchase Plan ("2010 Plan") which allows eligible participants to purchase shares of Class B Common Stock at par value, subject to certain restrictions, and; (ii) a 2005 Employee Stock Purchase Plan which allows eligible employees to purchase shares of Class B Common Stock at a ten percent discount. There were 26,189, 10,000 and 54,127 shares of restricted stock granted pursuant to the 2010 Plan during 2014, 2013 and 2012, respectively, with various ratable vesting periods ranging up to four years from the date of grant. There were 75,303, 90,587 and 117,901 shares issued pursuant to the Employee Stock Purchase Plan during 2014, 2013 and 2012, respectively.

We have reserved 6.0 million shares of Class B Common Stock for issuance under these various plans (excluding terminated plans) and have issued approximately 1.1 million shares, net of cancellations, pursuant to the terms of these plans (excluding terminated plans) as of December 31, 2014. As of December 31, 2014, approximately 4.9 million shares of Class B Common Stock remain available for issuance pursuant to these various plans.

At December 31, 2014, 23,297,420 shares of Class B Common Stock were reserved for issuance upon conversion of shares of Class A, C and D Common Stock outstanding, for issuance upon exercise of options to purchase Class B Common Stock and for issuance of stock under other incentive plans. Class A, C and D Common Stock are convertible on a share for share basis into Class B Common Stock.

6) INCOME TAXES

Components of income tax expense/(benefit) are as follows (amounts in thousands):

	Year Ended December 31,		
	2014	2013	2012
Current			
Federal	$248,172	$256,545	$254,021
Foreign	4,167	1,655	9,084
State	23,224	28,490	39,076
	275,563	286,690	302,181
Deferred			
Federal and foreign	41,583	25,341	(21,408)
State	7,525	3,278	(6,157)
	49,108	28,619	(27,565)
Total	$324,671	$315,309	$274,616

Deferred taxes are required to be classified based on the financial statement classification of the related assets and liabilities which give rise to temporary differences. Deferred taxes result from temporary differences between the financial statement carrying amounts and the tax bases of assets and liabilities. The components of deferred taxes are as follows (amounts in thousands):

	Year Ended December 31,	
	2014	2013
Deferred income tax assets:		
Self-insurance reserves	$ 84,915	$ 87,483
Compensation accruals	55,788	49,302
State and foreign net operating loss carryforwards and other state and foreign deferred tax assets	60,521	57,204
Other currently non-deductible accrued liabilities	16,739	24,587
Net pension liability—OCI only	11,746	6,390
Doubtful accounts and other reserves	18,428	33,905
Other combined items—OCI only	2,615	9,018
	250,752	267,889
Less: Valuation Allowance	(52,764)	(46,841)
Net deferred income tax assets:	197,988	221,048
Deferred income tax liabilities:		
Depreciable and amortizable assets	(362,674)	(337,669)
Other deferred tax liabilities	(2,963)	(2,624)
Net deferred income tax liabilities	$(167,649)	$(119,245)

There was no material impact of deferred taxes recorded in conjunction with the acquisition of Prominence Health Plan, the Psychiatric Institute of Washington and Cygnet Health Care.

The effective tax rates, as calculated by dividing the provision for income taxes by income before income taxes, were as follows for each of the years ended December 31, 2014, 2013 and 2012 (dollar amounts in thousands):

	2014	2013	2012
Provision for income taxes	$324,671	$315,309	$274,616
Income before income taxes	929,667	869,332	763,663
Effective tax rate	34.9%	36.3%	36.0%

Impacting the effective tax rates during 2014, 2013 and 2012 were favorable discrete tax items of approximately $1 million recorded during each year to adjust the estimated liabilities for uncertain tax positions.

The foreign provision for income taxes is based on foreign pre-tax earnings of $15 million, $6 million, and $38 million in 2014, 2013, and 2012, respectively. The Company's consolidated financial statements provide for any related tax liability on undistributed earnings that the Company does not intend to be indefinitely reinvested outside the U.S. Certain of the Company's undistributed international earnings intended to be indefinitely reinvested in operations outside the U.S. have a statutory rate of 21%. As of December 31, 2014, U.S. income taxes have not been provided on a cumulative total of $10 million of such earnings. The amount of unrecognizable deferred tax liability related to these temporary differences is estimated to be approximately $4 million.

A reconciliation between the federal statutory rate and the effective tax rate is as follows:

	Year Ended December 31,		
	2014	2013	2012
Federal statutory rate	35.0%	35.0%	35.0%
State taxes, net of federal income tax benefit	2.3	2.5	3.0
Nondeductible transaction costs	—	—	0.2
Divestiture gain	—	0.3	—
Other items	—	0.4	0.1
Impact of income attributable to noncontrolling interests	(2.4)	(1.9)	(2.3)
Effective tax rate	34.9%	36.3%	36.0%

Included in "Other current assets" on our Consolidated Balance Sheet are prepaid federal, foreign, and state income taxes amounting to approximately $17 million and $5 million as of December 31, 2014 and 2013, respectively.

The net deferred tax assets and liabilities are comprised as follows (amounts in thousands):

	Year Ended December 31,	
	2014	2013
Current deferred taxes		
Assets	$ 115,870	$ 121,097
Liabilities	(1,305)	(1,194)
Total deferred taxes-current	114,565	119,903
Noncurrent deferred taxes		
Assets	85,792	103,221
Liabilities	(368,006)	(342,369)
Total deferred taxes-noncurrent	(282,214)	(239,148)
Total deferred tax liabilities	$(167,649)	$(119,245)

The assets and liabilities classified as current relate primarily to the allowance for uncollectible patient accounts, compensation-related accruals and the current portion of the temporary differences related to self-insurance reserves. At December 31, 2014, state net operating loss carryforwards (expiring in years 2015 through 2034), and credit carryforwards available to offset future taxable income approximated $1.11 billion representing approximately $54 million in deferred state tax benefit (net of the federal benefit). At December 31, 2014, there were foreign net operating loss carryforwards of approximately $7 million expiring through 2022 representing approximately $3 million in deferred foreign tax benefit.

A valuation allowance is required when it is more likely than not that some portion of the deferred tax assets will not be realized. Based on available evidence, it is more likely than not that certain of our state tax benefits will not be realized. Therefore, valuation allowances of approximately $50 million and $44 million have been reflected as of December 31, 2014 and 2013, respectively. During 2014, the valuation allowance on these state tax benefits increased by approximately $6 million due to additional net operating losses incurred. In addition, valuation allowances of approximately $3 million have been reflected as of December 31, 2014 and 2013 related to foreign net operating losses. There were no significant increases in valuation allowances as a result of the acquisition of Prominence Health Plan, the Psychiatric Institute of Washington and Cygnet Health Care.

We adopted the provisions of Accounting for Uncertainty in Income Taxes effective January 1, 2007. During 2014 and 2013, the estimated liabilities for uncertain tax positions (including accrued interest and penalties) were increased less than $1 million due to tax positions taken in the current and prior years. During

2014, the estimated liabilities for uncertain tax positions (including accrued interest and penalties) were reduced due to the lapse of the statute of limitations resulting in a net income tax benefit of approximately $1 million. The balance at each of December 31, 2014 and 2013, if subsequently recognized, that would favorably affect the effective tax rate and the provision for income taxes is approximately $2 million for each date.

We recognize accrued interest and penalties associated with uncertain tax positions as part of the tax provision. As of December 31, 2014 and 2013, we have accrued interest and penalties of less than $1 million as of each date. The U.S. federal statute of limitations remains open for the 2011 and subsequent years. Foreign and U.S. state and local jurisdictions have statutes of limitations generally ranging for 3 to 4 years. The statute of limitations on certain jurisdictions could expire within the next twelve months. It is reasonably possible that the amount of unrecognized tax benefits will change during the next 12 months, however, it is anticipated that any such change, if it were to occur, would not have a material impact on our results of operations.

The tabular reconciliation of unrecognized tax benefits for the years ended December 31, 2014, 2013 and 2012 is as follows (amounts in thousands).

	As of December 31,		
	2014	2013	2012
Balance at January 1,	$ 3,369	$ 6,824	$ 7,403
Additions based on tax positions related to the current year	50	50	200
Additions for tax positions of prior years	195	283	386
Reductions for tax positions of prior years	(1,212)	(1,260)	(1,165)
Settlements	—	(2,528)	—
Balance at December 31,	$ 2,402	$ 3,369	$ 6,824

7) LEASE COMMITMENTS

Three of our hospital facilities are held under operating leases with Universal Health Realty Income Trust with terms expiring in 2016 (see Note 9 for additional disclosure). We also lease the real property of certain facilities (see Item 2. *Properties* for additional disclosure).

A summary of property under capital lease follows (amounts in thousands):

	As of December 31,	
	2014	2013
Land, buildings and equipment	$ 40,782	$ 27,636
Less: accumulated amortization	(27,556)	(27,382)
	$ 13,226	$ 254

Future minimum rental payments under lease commitments with a term of more than one year as of December 31, 2014, are as follows (amounts in thousands):

Year	Capital Leases	Operating Leases
	(000s)	
2015	$ 3,293	$ 58,904
2016	3,261	49,043
2017	3,308	31,619
2018	3,322	25,940
2019	3,370	22,229
Later years	22,356	147,288
Total minimum rental	$ 38,910	$335,023
Less: Amount representing interest	(17,310)	
Present value of minimum rental commitments	21,600	
Less: Current portion of capital lease obligations	(1,080)	
Long-term portion of capital lease obligations	$ 20,520	

During 2014, we assumed a capital lease obligation of approximately $16 million in connection with our acquisition of the Psychiatric Institute of Washington, a 124-bed behavioral health care facility located in Washington, D.C. We incurred no additional capital lease obligations during 2013 or 2012. In the ordinary course of business, our facilities routinely lease equipment pursuant to new lease arrangements that will likely result in future lease and rental expense in excess of amounts indicated above.

8) COMMITMENTS AND CONTINGENCIES

Professional and General Liability, Workers' Compensation Liability and Property Insurance

Professional and General Liability and Workers Compensation Liability:

Effective November, 2010, excluding certain subsidiaries acquired since 2010 as discussed below, the vast majority of our subsidiaries are self-insured for professional and general liability exposure up to $10 million and $3 million per occurrence, respectively. Our subsidiaries were provided with several excess policies through commercial insurance carriers which provide for coverage in excess of the applicable per occurrence self-insured retention (either $3 million or $10 million) up to $250 million per occurrence and in the aggregate for claims incurred in 2014 and up to $200 million per occurrence and in the aggregate for claims incurred from 2011 through 2013. We remain liable for 10% of the claims paid pursuant to the commercially insured coverage in excess of $10 million up to $60 million per occurrence and in the aggregate.

Since our acquisition of Psychiatric Solutions, Inc. ("PSI") in November, 2010, the former PSI subsidiaries are self-insured for professional and general liability exposure up to $3 million per occurrence. The nine behavioral health facilities acquired from Ascend Health Corporation ("Ascend") in October, 2012 have general and professional liability policies through commercial insurance carriers which provide for up to $12 million of aggregate coverage, subject to a $100,000 per occurrence deductible. The 18 facilities acquired from Cygnet Health Care Limited ("Cygnet"), consisting of 16 inpatient behavioral health hospitals and 2 nursing homes, have policies through a commercial insurance carrier located in the United Kingdom that provides for £10 million of professional liability coverage and £25 million of general liability coverage. The facilities acquired from PSI, Ascend and Cygnet, like our other facilities, are also provided excess coverage through commercial insurance carriers for coverage in excess of the underlying commercial policy limitations, as mentioned above.

Our estimated liability for self-insured professional and general liability claims is based on a number of factors including, among other things, the number of asserted claims and reported incidents, estimates of losses

for these claims based on recent and historical settlement amounts, estimates of incurred but not reported claims based on historical experience, and estimates of amounts recoverable under our commercial insurance policies. While we continuously monitor these factors, our ultimate liability for professional and general liability claims could change materially from our current estimates due to inherent uncertainties involved in making this estimate. Given our significant self-insured exposure for professional and general liability claims, there can be no assurance that a sharp increase in the number and/or severity of claims asserted against us will not have a material adverse effect on our future results of operations.

As of December 31, 2014, the total accrual for our professional and general liability claims was $193 million, of which $51 million is included in current liabilities. As of December 31, 2013, the total accrual for our professional and general liability claims was $206 million, of which $44 million is included in current liabilities.

We recorded reductions to our professional and general liability self-insurance reserves (relating to prior years) amounting to $20 million during 2014, $81 million during 2013 and $27 million during 2012. The favorable change recorded during 2014 and 2012 resulted from favorable changes in our estimated future claims payments pursuant to a reserve analysis. The favorable change in our estimated future claims payments recorded during 2013, relating to years prior to 2013, were due primarily to: (i) an increased weighting given to company-specific metrics (to 100% from 75%), and decreased general industry metrics (to 0% from 25%), related to projected incidents per exposure, historical claims experience and loss development factors; (ii) historical data which measured the realized favorable impact of medical malpractice tort reform experienced in several states in which we operate, and; (iii) a decrease in claims related to certain higher risk specialties (such as obstetrical) due to a continuation of the company-wide patient safety initiative undertaken during the last several years. As the number of our facilities and our patient volumes have increased, thereby providing for a statistically significant data group, and taking into consideration our long-history of company-specific risk management programs and claims experience, our reserve analyses have included a greater emphasis on our historical professional and general liability experience which has developed favorably as compared to general industry trends.

As of December 31, 2014, the total accrual for our workers' compensation liability claims was $67 million, of which $32 million is included in current liabilities. As of December 31, 2013, the total accrual for our workers' compensation liability claims was $64 million, of which $34 million is included in current liabilities. The adjustments recorded during the last three years to our prior year reserves for workers' compensation claims did not have a material impact on our consolidated results of operations for the years ended December 31, 2014, 2013 or 2012.

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 PSI 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, subject to a $25,000 deductible. Non-critical flood losses have either a $250,000 or $500,000 deductible, based upon the location of the facility. Since certain of our facilities have been designated by our insurer as flood prone, we have elected to purchase policies from The National Flood Insurance Program to cover a substantial portion of the applicable deductible. Property insurance for the facilities acquired from Cygnet are provided on an all risk basis up to a £180 million limit that includes coverage for real and personal property as well as business interruption losses.

Legal Proceedings

We are subject to claims and suits in the ordinary course of business, including those arising from care and treatment afforded by our hospitals and are party to 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 2010 at several of our acute care facilities. The DOJ alleges that ICDs were implanted and billed by our facilities in contravention of a National Coverage 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 February, 2013, the OIG served a subpoena requesting various documents from January, 2008 to the date of the subpoena directed at Universal Health Services, Inc. ("UHS") concerning it and UHS of Delaware, Inc., and several UHS owned behavioral health facilities including: Keys of Carolina, Old Vineyard Behavioral Health, The Meadows Psychiatric Center, Streamwood Behavioral Health, Hartgrove Hospital, Rock River Academy and Residential Treatment Center, Roxbury Treatment Center, Harbor Point Behavioral Health Center, f/k/a, The Pines Residential Treatment Center, including the Crawford, Brighton and Kempsville campuses, Wekiva Springs Center and River Point Behavioral Health. Prior to receiving this subpoena: (i) the Keys of Carolina and Old Vineyard received notification during the second half of 2012 from the United States Department of Justice of its intent to proceed with an investigation following requests for documents for the period of January, 2007 to the date of the subpoenas from the North Carolina state Attorney General's Office; (ii) Harbor Point Behavioral Health Center received a subpoena in December, 2012 from the Attorney General of the Commonwealth of Virginia requesting various documents from July, 2006 to the date of the subpoena, and; (iii) The Meadows Psychiatric Center received a subpoena from the OIG in February, 2013 requesting certain documents from 2008 to the date of the subpoena. Unrelated to these matters, the Keys of Carolina was closed and the real property was sold in January, 2013. We were advised that a qui tam action had been filed against Roxbury Treatment Center but the government declined to intervene and the case was dismissed.

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

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

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

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

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

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

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

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

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

Department of Justice Investigation of Friends Hospital:

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

Department of Justice Investigation of Riveredge Hospital:

In 2008, Riveredge Hospital in Chicago, Illinois received a subpoena from the DOJ requesting certain information from the facility. Additional requests for documents were also received from the DOJ in 2009 and 2010. The requested documents have been provided to the DOJ. All documents requested and produced pertained to the operations of the facility while under PSI's ownership prior to our acquisition. At present, we are uncertain as to the focus, scope or extent of the investigation, liability of the facility and/or potential financial exposure, if any, in connection with this matter.

General:

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 payment suspension, 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.

In addition to our long-term debt obligations as discussed in Note 4. *Long-Term Debt* and our operating lease obligations as discussed in Note 7. *Lease Commitments*, we have various other contractual commitments outstanding as of December 31, 2014 as follows: (i) other combined estimated future purchase obligations of $205 million related to a long-term contract with third-parties consisting primarily of certain revenue cycle data processing services for our acute care facilities ($87 million), expected future costs to be paid to a third-party vendor in connection with the purchase, implementation and on-going operation of an electronic health records application for each of our acute care facilities ($117 million) and estimated minimum liabilities for physician commitments expected to be paid in the future ($2 million); (ii) estimated construction commitment of $151 million made to a third-party for construction of a new acute care hospital located in Henderson, Nevada; (iii) combined estimated future payments of $251 million related to our non-contributory, defined benefit pension plan ($234 million consisting of estimated payments through 2089) and other retirement plan liabilities ($17 million), and; (iv) accrued and unpaid estimated claims expense incurred in connection with our commercial health insurer and self-insured employee benefit plans ($58 million).

9) RELATIONSHIP WITH UNIVERSAL HEALTH REALTY INCOME TRUST AND RELATED PARTY TRANSACTIONS

Relationship with Universal Health Realty Income Trust:

At December 31, 2014, we held approximately 5.9% of the outstanding shares of Universal Health Realty Income Trust (the "Trust"). We serve as Advisor to the Trust under an annually renewable advisory agreement pursuant to the terms of which we conduct the Trust's day-to-day affairs, provide administrative services and present investment opportunities. In addition, certain of our officers and directors are also officers and/or directors of the Trust. Management believes that it has the ability to exercise significant influence over the Trust, therefore we account for our investment in the Trust using the equity method of accounting. We earned an advisory fee from the Trust, which is included in net revenues in the accompanying consolidated statements of income, of approximately $2.5 million during 2014, $2.4 million during 2013 and $2.1 million during 2012.

Our pre-tax share of income from the Trust was $3.2 million during 2014, $842,000 during 2013 and $1.2 million during 2012, and is included in net revenues in the accompanying consolidated statements of income for each year. Included in our share of the Trust's income for 2014 and 2012 was approximately $2.3 million in 2014 and $500,000 in 2012 related to our share of the net favorable impact realized by the Trust in connection with: (i) gains on the sale of medical office buildings (in 2012); (ii) gain on sale of a behavioral health hospital facility (in 2014), and; (iii) gain on fair value recognition resulting from the Trust's purchase of minority ownership interests in majority owned limited liability companies (in 2014).

The carrying value of our investment in the Trust was $9.3 million and $8.1 million at December 31, 2014 and 2013, respectively, and is included in other assets in the accompanying consolidated balance sheets. The market value of our investment in the Trust was $37.9 million at December 31, 2014 and $31.5 million at December 31, 2013, based on the closing price of the Trust's stock on the respective dates.

Total rent expense under the operating leases on the four hospital facilities with the Trust (as discussed below) was $16.8 million during 2014, $16.4 million during 2013 and $16.3 million during 2012. In addition, certain of our subsidiaries are tenants in several medical office buildings owned by the Trust or by limited liability companies in which the Trust holds 100% of the ownership interest.

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

During the third quarter of 2014, we provided notification to the Trust that, upon the December, 2014 expiration of the The Bridgeway's lease term, we intended to exercise our option to purchase the real property of the facility. On December 31, 2014, we purchased The Bridgeway's real property (a 103-bed behavioral health facility located in North Little Rock, Arkansas) from the Trust. Pursuant to the terms of the lease, we and the Trust were both required to obtain appraisals of the property to determine its fair market value. Based upon the property appraisals obtained by each party, the purchase price of The Bridgeway's real property was approximately $17.3 million.

In addition, we recently constructed two free-standing emergency departments ("FEDs") located in Weslaco and Mission, Texas which were completed and opened during the first quarter of 2015. The Trust purchased one of these FEDs from us in January, 2015 and the other in February, 2015. In conjunction with these sales, wholly-owned subsidiaries of ours, which will operate the FEDs, executed agreements with the Trust to lease the properties for initial terms of 10-years with six, 5-year renewal options. The aggregate construction cost/sales proceeds of these facilities was approximately $12.8 million and the aggregate rent expense paid to the Trust at the commencement of the leases will approximate $900,000 annually.

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

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

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

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

Other Related Party Transactions:

In December, 2010, our Board of Directors approved the Company's entering into supplemental life insurance plans and agreements on the lives of our chief executive officer ("CEO") and his wife. As a result of these agreements, based on actuarial tables and other assumptions, during the life expectancies of the insureds, we would pay approximately $25 million in premiums, and certain trusts owned by our chief executive officer, would pay approximately $8 million in premiums. Based on the projected premiums mentioned above, and assuming the policies remain in effect until the death of the insureds, we will be entitled to receive death benefit proceeds of no less than $33 million representing the $25 million of aggregate premiums paid by us as well as the $8 million of aggregate premiums paid by the trusts. During each of 2014 and 2013 we paid approximately $1.3 million in premium payments and during 2012, we paid approximately $1.4 million in premium payments. These agreements did not have a material effect on our consolidated financial statements or results of operations during 2014, 2013 or 2012.

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

10) PENSION PLAN

We maintain contributory and non-contributory retirement plans for eligible employees. Our contributions to the contributory plan amounted to $35.7 million, $29.9 million and $27.3 million in 2014, 2013 and 2012, respectively. The non-contributory plan is a defined benefit pension plan which covers employees of one of our subsidiaries. The benefits are based on years of service and the employee's highest compensation for any five years of employment. Our funding policy is to contribute annually at least the minimum amount that should be funded in accordance with the provisions of ERISA.

The following table shows the reconciliation of the defined benefit pension plan as of December 31, 2014 and 2013:

	2014	2013
	(000s)	
Change in plan assets:		
Fair value of plan assets at beginning of year	$106,469	$104,074
Actual return (loss) on plan assets	16,470	8,037
Employer contributions	0	0
Benefits paid	(5,605)	(5,042)
Administrative expenses	(637)	(600)
Fair value of plan assets at end of year	$116,697	$106,469
Change in benefit obligation:		
Benefit obligation at beginning of year	$103,558	$114,529
Service cost	966	1,060
Interest cost	4,986	4,528
Benefits paid	(5,605)	(5,042)
Actuarial (gain) loss	23,437	(11,517)
Benefit obligation at end of year	$127,342	$103,558
Amounts recognized in the Consolidated Balance Sheet:		
Other non-current assets	$ 0	$ 2,911
Other non-current liabilities	10,645	0
Total amounts recognized at end of year	$ 10,645	$ 2,911

	2014	2013	2012
		(000s)	
Components of net periodic cost (benefit)			
Service cost	$ 966	$ 1,060	$ 1,144
Interest cost	4,985	4,528	4,659
Expected return on plan assets	(7,772)	(7,601)	(7,301)
Recognized actuarial loss	1,107	3,305	4,219
Net periodic cost	$ (714)	$ 1,292	$ 2,721

	2014	2013
Measurement Dates		
Benefit obligations	12/31/2014	12/31/2013
Fair value of plan assets	12/31/2014	12/31/2013

	2014	2013
Weighted average assumptions as of December 31		
Discount rate	3.95%	4.95%
Rate of compensation increase	4.00%	4.00%

	2014	2013	2012
Weighted-average assumptions for net periodic benefit cost calculations			
Discount rate	4.95%	4.05%	4.40%
Expected long-term rate of return on plan assets	7.50%	7.50%	8.00%
Rate of compensation increase	4.00%	4.00%	4.00%

The accumulated benefit obligation was $126.4 million and $102.3 million as of December 31, 2014 and 2013, respectively. As of December 31, 2014, the accumulated benefit obligation exceeded the fair value of plan assets by $9.7 million. As of December 31, 2013, the fair value of plan assets exceeded the accumulated benefit obligation by $4.1 million.

We estimate that there will be a $3.2 million net loss amortized from accumulated other comprehensive income during 2015.

The market values of our pension plan assets at December 31, 2014 and December 31, 2013 by asset category are as follows:

December 31, 2014	Total	Level 1	Level 2	Level 3
Equities:				
U.S. Large Cap	$ 9,212	$—	$ 9,212	$—
U.S. Mid Cap	2,852	—	2,852	—
U.S. Small Cap	2,626	—	2,626	—
International Developed	6,181	—	6,181	—
Emerging Markets	4,139	—	4,139	—
Fixed income:				
Core Fixed Income	27,062	—	27,062	—
Long Duration Fixed Income	61,718	—	61,718	—
Real Estate:				
REIT Fund	2,395	—	2,395	—
Cash/Currency:				
Cash Equivalents	512	—	512	—
Total market value	$116,697	$—	$116,697	$—

December 31, 2013	Total	Level 1	Level 2	Level 3
Equities:				
U.S. Large Cap	$ 8,600	$—	$ 8,600	$—
U.S. Mid Cap	2,740	—	2,740	—
U.S. Small Cap	2,725	—	2,725	—
International Developed	6,508	—	6,508	—
Emerging Markets	4,154	—	4,154	—
Fixed income:				
Core Fixed Income	23,222	—	23,222	—
Long Duration Fixed Income	55,933	—	55,933	—
Real Estate:				
REIT Fund	2,124	—	2,124	—
Cash/Currency:				
Cash Equivalents	463	—	463	—
Total market value	$106,469	$—	$106,469	$—

To develop the expected long-term rate of return on plan assets assumption, we considered the historical returns and the future expectations for returns for each asset class, as well as the target asset allocation of the pension portfolio.

The following table shows expected benefit payments for the years ended December 31, 2014 through 2024 for our defined pension plan. There will be benefit payments under this plan beyond 2024.

Estimated Future Benefit Payments (000s)	
2015	$ 5,967
2016	6,231
2017	6,449
2018	6,661
2019	6,858
2020-2024	35,959
Total	$68,125

	2014	2013
Plan Assets		
Asset Category		
Equity securities	21%	23%
Fixed income securities	76%	74%
Other	3%	3%
Total	100%	100%

Investment Policy, Guidelines and Objectives have been established for the defined benefit pension plan. The investment policy is in keeping with the fiduciary requirements under existing federal laws and managed in accordance with the Prudent Investor Rule. Total portfolio risk is regularly evaluated and compared to that of the plan's policy target allocation and judged on a relative basis over a market cycle. The following asset allocation policy and ranges have been established in accordance with the overall risk and return objectives of the portfolio:

	As of 12/31/14	Permitted Range
Total Equity	21%	10-30%
Total Fixed Income	76%	70-90%
Other	3%	0-10%

In accordance with the investment policy, the portfolio will invest in high quality, large and small capitalization companies traded on national exchanges, and investment grade securities. The investment managers will not write or buy options for speculative purposes; securities may not be margined or sold short. The manager may employ futures or options for the purpose of hedging exposure, and will not purchase unregistered sectors, private placements, partnerships or commodities.

11) SEGMENT REPORTING

Our reportable operating segments consist of acute care hospital services and behavioral health care services. The "Other" segment column below includes centralized services including information services, purchasing, reimbursement, accounting, taxation, legal, advertising, design and construction and patient accounting as well as the operating results for our other operating entities including outpatient surgery and radiation centers. The chief operating decision making group for our acute care hospital services and behavioral health care services is comprised of our Chief Executive Officer, the President and the Presidents of each operating segment. The Presidents for each operating segment also manage the profitability of each respective segment's various facilities. The operating segments are managed separately because each operating segment represents a business unit that offers different types of healthcare services or operates in different healthcare environments. The accounting policies of the operating segments are the same as those described in the summary of significant accounting policies included in this Annual Report on Form 10-K for the year ended December 31, 2014. 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.

2014	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Dollar amounts in thousands)			
Gross inpatient revenues	$14,943,102	$6,689,753	—	$21,632,855
Gross outpatient revenues	$ 8,147,031	$ 784,309	$ 34,238	$ 8,965,578
Total net revenues	$ 4,105,090	$3,945,467	$ 14,769	$ 8,065,326
Income (loss) before allocation of corporate overhead and income taxes	$ 465,328	$ 944,068	$(479,729)	$ 929,667
Allocation of corporate overhead	$ (178,781)	$ (98,811)	$ 277,592	$ 0
Income (loss) after allocation of corporate overhead and before income taxes	$ 286,547	$ 845,257	$(202,137)	$ 929,667
Total assets	$ 3,362,870	$5,286,960	$ 324,613	$ 8,974,443

2013	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Dollar amounts in thousands)			
Gross inpatient revenues	$13,469,269	$6,294,046	—	$19,763,315
Gross outpatient revenues	$ 6,828,307	$ 744,510	$ 40,460	$ 7,613,277
Total net revenues	$ 3,576,369	$3,667,967	$ 39,486	$ 7,283,822
Income (loss) before allocation of corporate overhead and income taxes	$ 342,191	$ 895,869	$(368,728)	$ 869,332
Allocation of corporate overhead	$ (184,444)	$ (89,447)	$ 273,891	$ 0
Income (loss) after allocation of corporate overhead and before income taxes	$ 157,747	$ 806,422	$ (94,837)	$ 869,332
Total assets	$ 3,125,626	$4,966,182	$ 219,915	$ 8,311,723

SUPPLEMENTAL- 1

2012	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Dollar amounts in thousands)			
Gross inpatient revenues	$12,406,567	$5,764,370	—	$18,170,937
Gross outpatient revenues	$ 6,134,615	$ 646,177	$ 48,183	$ 6,828,975
Total net revenues	$ 3,461,416	$3,460,141	$ 39,843	$ 6,961,400
Income (loss) before allocation of corporate overhead and income taxes	$ 337,385	$ 838,603	$(412,325)	$ 763,663
Allocation of corporate overhead	$ (162,056)	$ (84,597)	$ 246,653	$ 0
Income (loss) after allocation of corporate overhead and before income taxes	$ 175,329	$ 754,006	$(165,672)	$ 763,663
Total assets	$ 2,984,169	$4,979,965	$ 236,709	$ 8,200,843

12) QUARTERLY RESULTS (unaudited)

The following tables summarize the quarterly financial data for the two years ended December 31, 2014 and 2013:

2014	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Total
	(amounts in thousands, except per share amounts)				
Net revenues	$1,920,166	$2,019,821	$2,017,758	$2,107,581	$8,065,326
Net income	$ 151,852	$ 166,614	$ 96,038	$ 190,492	$ 604,996
Less: Net income attributable to noncontrolling interests	$ 13,774	$ 14,943	$ 13,241	$ 17,695	$ 59,653
Net income attributable to UHS	$ 138,078	$ 151,671	$ 82,797	$ 172,797	$ 545,343
Earnings per share attributable to UHS- Basic:					
Total basic earnings per share	$ 1.40	$ 1.53	$ 0.84	$ 1.75	$ 5.52
Earnings per share attributable to UHS- Diluted:					
Total diluted earnings per share	$ 1.38	$ 1.51	$ 0.82	$ 1.71	$ 5.42

The 2014 quarterly financial data presented above includes the following:

First Quarter:

- an unfavorable $8.9 million pre-tax impact ($4.9 million, or $.05 per diluted share, net of taxes) recorded in connection with the implementation of EHR applications;
- a favorable $10.1 million pre-tax impact ($6.3 million, or $0.07 per diluted share, net of taxes) resulting from the gain realized on the sale of a non-operating investment.

Second Quarter:

- an unfavorable $7.1 million pre-tax impact ($3.9 million, or $.04 per diluted share, net of taxes) recorded in connection with the implementation of EHR applications.

Third Quarter:

- an unfavorable $7.9 million pre-tax impact ($4.5 million, or $.04 per diluted share, net of taxes) recorded in connection with the implementation of EHR applications;

- an unfavorable $36.2 million pre-tax impact ($22.7 million, or $0.23 per diluted share, net of taxes) recorded in connection with the costs related to extinguishment of debt resulting primarily from the early redemption of our previously outstanding $250 million, 7.00% senior unsecured notes that were scheduled to mature in 2018 and the repayment of $550 million of borrowings pursuant to the terms of our previously outstanding Term Loan B facility which was scheduled to mature in 2016;
- an unfavorable $44.0 million pre-tax impact ($27.6 million, or $0.27 per diluted share, net of taxes) incurred in connection with the previously disclosed $65 million settlement of the Garden City matter. This matter was a shareholder class action lawsuit filed in 2009 against PSI and certain of its former officers alleging their violations of federal securities laws and we assumed the defense and liability of this matter as a result of our acquisition of PSI in 2010. This charge is net of approximately $17 million of commercial insurance recoveries that we were entitled to and a previously recorded estimated reserve.

Fourth Quarter:

- a favorable $13.8 million pre-tax impact ($8.6 million, or $.08 per diluted share, net of taxes) recorded in connection with the implementation of EHR applications;
- a favorable $19.7 million pre-tax impact reduction ($11.7 million, or $.12 per diluted share, net of taxes) to our professional and general liability self-insurance reserves relating to years prior to 2014, as discussed in *Self-Insured/Other Insurance Risks.*

2013	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Total
	(amounts in thousands, except per share amounts)				
Net revenues	$1,831,632	$1,834,975	$1,816,369	$1,800,846	$7,283,822
Net income	$ 129,935	$ 167,803	$ 123,099	$ 133,186	$ 554,023
Less: Net income attributable to noncontrolling interests	$ 10,151	$ 15,962	$ 8,512	$ 8,665	$ 43,290
Net income attributable to UHS	$ 119,784	$ 151,841	$ 114,587	$ 124,521	$ 510,733
Earnings per share attributable to UHS- Basic:					
Total basic earnings per share	$ 1.23	$ 1.55	$ 1.17	$ 1.27	$ 5.21
Earnings per share attributable to UHS- Diluted:					
Total diluted earnings per share	$ 1.21	$ 1.53	$ 1.15	$ 1.24	$ 5.14

The 2013 quarterly financial data presented above includes the following:

First Quarter:

- an unfavorable $1.1 million pre-tax impact ($327,000, or $.01 per diluted share, net of taxes) recorded in connection with the implementation of EHR applications.

Second Quarter:

- an unfavorable $8.9 million pre-tax impact ($4.9 million, or $.05 per diluted share, net of taxes) recorded in connection with the implementation of EHR applications;
- a favorable $65.0 million pre-tax impact reduction ($37.8 million, or $.38 per diluted share, net of taxes) to our professional and general liability self-insurance reserves relating to years prior to 2013, as discussed in *Self-Insured/Other Insurance Risks.*

Third Quarter:

- a favorable $8.4 million pre-tax impact ($5.1 million, or $.05 per diluted share, net of taxes) recorded in connection with the implementation of EHR applications.

Fourth Quarter:

- a favorable $19.4 million pre-tax impact ($11.8 million, or $.12 per diluted share, net of taxes) recorded in connection with the implementation of EHR applications;
- a favorable $15.6 million pre-tax impact reduction ($9.2 million, or $.09 per diluted share, net of taxes) to our professional and general liability self-insurance reserves relating to years prior to 2013, as discussed in *Self-Insured/Other Insurance Risks.*

13) SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION

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

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

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

SUPPLEMENTAL- 1

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF INCOME
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2014

(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net revenues before provision for doubtful accounts	$ 0	$6,100,777	$2,692,752	$ (29,220)	$8,764,309
Less: Provision for doubtful accounts	0	471,181	227,802	0	698,983
Net Revenues	0	5,629,596	2,464,950	(29,220)	8,065,326
Operating charges:					
Salaries, wages and benefits	0	2,757,738	1,087,723	0	3,845,461
Other operating expenses	0	1,217,525	592,556	(27,100)	1,782,981
Supplies expense	0	546,578	349,115	0	895,693
Depreciation and amortization	0	269,490	106,134	0	375,624
Lease and rental expense	0	58,619	37,494	(2,120)	93,993
EHR incentive income	0	(19,480)	(8,422)	0	(27,902)
Costs related to extinguishment of debt	36,171	0	0	0	36,171
	36,171	4,830,470	2,164,600	(29,220)	7,002,021
Income from operations	(36,171)	799,126	300,350	0	1,063,305
Interest expense	127,528	4,516	1,594	0	133,638
Interest (income) expense, affiliate	0	88,246	(88,246)	0	0
Equity in net income of consolidated affiliates	(646,386)	(184,385)	0	830,771	0
Income before income taxes	482,687	890,749	387,002	(830,771)	929,667
Provision for income taxes	(62,656)	305,320	82,007	0	324,671
Net income	545,343	585,429	304,995	(830,771)	604,996
Less: Income attributable to noncontrolling interests	0	0	59,653	0	59,653
Net income attributable to UHS	$ 545,343	$ 585,429	$ 245,342	$(830,771)	$ 545,343

SUPPLEMENTAL- 1

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF INCOME
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2013

(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net revenues before provision for doubtful accounts	$ 0	$5,658,699	$2,780,983	$ (28,644)	$8,411,038
Less: Provision for doubtful accounts	0	657,106	470,110	0	1,127,216
Net Revenues	0	5,001,593	2,310,873	(28,644)	7,283,822
Operating charges:					
Salaries, wages and benefits	0	2,573,205	1,031,415	0	3,604,620
Other operating expenses	0	972,170	523,382	(26,808)	1,468,744
Supplies expense	0	510,078	311,011	0	821,089
Depreciation and amortization	0	236,958	100,214	0	337,172
Lease and rental expense	0	62,518	37,076	(1,836)	97,758
EHR incentive income	0	(43,027)	(17,997)	0	(61,024)
	0	4,311,902	1,985,101	(28,644)	6,268,359
Income from operations	0	689,691	325,772	0	1,015,463
Interest expense	139,793	3,365	2,973	0	146,131
Interest (income) expense, affiliate	0	84,640	(84,640)	0	0
Equity in net income of consolidated affiliates	(597,020)	(141,004)	0	738,024	0
Income before income taxes	457,227	742,690	407,439	(738,024)	869,332
Provision for income taxes	(53,506)	262,346	106,469	0	315,309
Net income	510,733	480,344	300,970	(738,024)	554,023
Less: Income attributable to noncontrolling interests	0	0	43,290	0	43,290
Net income attributable to UHS	$ 510,733	$ 480,344	$ 257,680	$(738,024)	$ 510,733

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF INCOME
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2012

(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net revenues before provision for doubtful accounts	$ 0	$5,152,816	$2,562,781	$ (27,526)	$7,688,071
Less: Provision for doubtful accounts	0	411,538	315,133	0	726,671
Net Revenues	0	4,741,278	2,247,648	(27,526)	6,961,400
Operating charges:					
Salaries, wages and benefits	0	2,452,187	988,730	0	3,440,917
Other operating expenses	0	899,274	502,592	(25,744)	1,376,122
Supplies expense	0	496,848	302,773	0	799,621
Depreciation and amortization	0	210,867	91,559	0	302,426
Lease and rental expense	0	59,596	37,071	(1,782)	94,885
Transaction costs	0	5,716	0	0	5,716
EHR incentive income	0	(14,284)	(15,754)	0	(30,038)
Costs related to extinguishment of debt	29,170	0	0	0	29,170
	29,170	4,110,204	1,906,971	(27,526)	6,018,819
Income from operations	(29,170)	631,074	340,677	0	942,581
Interest expense	172,467	3,749	2,702	0	178,918
Interest (income) expense, affiliate	0	93,363	(93,363)	0	0
Equity in net income of consolidated affiliates	(567,906)	(141,983)	0	709,889	0
Income before income taxes	366,269	675,945	431,338	(709,889)	763,663
Provision for income taxes	(77,177)	237,072	114,721	0	274,616
Net income	443,446	438,873	316,617	(709,889)	489,047
Less: Income attributable to noncontrolling interests	0	0	45,601	0	45,601
Net income attributable to UHS	$ 443,446	$ 438,873	$ 271,016	$(709,889)	$ 443,446

SUPPLEMENTAL- 1

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2014
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net income	$545,343	$585,429	$304,995	$(830,771)	$604,996
Other comprehensive income (loss):					
Unrealized derivative gains on cash flow hedges	17,668	0	0	0	17,668
Amortization of terminated hedge	(336)	0	0	0	(336)
Minimum Pension Liability	(14,270)	(14,270)	0	14,270	(14,270)
Foreign currency translation adjustment	(2,431)	(2,431)	0	2,431	(2,431)
Other comprehensive income before tax	631	(16,701)	0	16,701	631
Income tax expense related to items of other comprehensive income	1,053	(5,356)	0	5,356	1,053
Total other comprehensive income, net of tax	(422)	(11,345)	0	11,345	(422)
Comprehensive income	544,921	574,084	304,995	(819,426)	604,574
Less: Comprehensive income attributable to noncontrolling interests	0	0	59,653	0	59,653
Comprehensive income attributable to UHS	$544,921	$574,084	$245,342	$(819,426)	$544,921

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2013
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net income	$510,733	$480,344	$300,970	$(738,024)	$554,023
Other comprehensive income (loss):					
Unrealized derivative gains on cash flow hedges	16,963	0	0	0	16,963
Amortization of terminated hedge	(336)	0	0	0	(336)
Minimum Pension Liability	14,657	14,657	0	(14,657)	14,657
Other comprehensive income before tax	31,284	14,657	0	(14,657)	31,284
Income tax expense related to items of other comprehensive income	11,940	5,670	0	(5,670)	11,940
Total other comprehensive income, net of tax	19,344	8,987	0	(8,987)	19,344
Comprehensive income	530,077	489,331	300,970	(747,011)	573,367
Less: Comprehensive income attributable to noncontrolling interests	0	0	43,290	0	43,290
Comprehensive income attributable to UHS	$530,077	$489,331	$257,680	$(747,011)	$530,077

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2012

(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net income	$443,446	$438,873	$316,617	$(709,889)	$489,047
Other comprehensive income (loss):					
Unrealized derivative gains on cash flow hedges	6,677	0	0	0	6,677
Amortization of terminated hedge	(336)	0	0	0	(336)
Minimum Pension Liability	4,986	4,986	0	(4,986)	4,986
Other comprehensive income before tax	11,327	4,986	0	(4,986)	11,327
Income tax expense related to items of other comprehensive income	4,306	1,898	0	(1,898)	4,306
Total other comprehensive income, net of tax	7,021	3,088	0	(3,088)	7,021
Comprehensive income	450,467	441,961	316,617	(712,977)	496,068
Less: Comprehensive income attributable to noncontrolling interests	0	0	45,601	0	45,601
Comprehensive income attributable to UHS	$450,467	$441,961	$271,016	$(712,977)	$450,467

SUPPLEMENTAL- 1

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING BALANCE SHEET
AS OF DECEMBER 31, 2014
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Assets					
Current assets:					
Cash and cash equivalents	$ 0	$ 21,784	$ 10,285	$ 0	$ 32,069
Accounts receivable, net	0	933,971	348,764	0	1,282,735
Supplies	0	67,847	40,268	0	108,115
Deferred income taxes	113,822	743	0	0	114,565
Other current assets	0	62,431	15,223	0	77,654
Total current assets	113,822	1,086,776	414,540	0	1,615,138
Investments in subsidiaries	7,013,540	1,661,296	0	(8,674,836)	0
Intercompany receivable	103,808	0	408,682	(512,490)	0
Intercompany note receivable	0	0	1,222,637	(1,222,637)	0
Property and equipment	0	4,494,567	1,717,463	0	6,212,030
Less: accumulated depreciation	0	(1,686,192)	(846,149)	0	(2,532,341)
	0	2,808,375	871,314	0	3,679,689
Other assets:					
Goodwill	0	2,764,555	526,658	0	3,291,213
Deferred charges	32,379	5,402	2,538	0	40,319
Other	9,601	283,302	55,181	0	348,084
	$7,273,150	$ 8,609,706	$3,501,550	$(10,409,963)	$ 8,974,443
Liabilities and Stockholders' Equity					
Current liabilities:					
Current maturities of long-term debt	$ 44,874	$ 1,260	$ 22,185	0	$ 68,319
Accounts payable and accrued liabilities	20,245	1,051,309	41,508	0	1,113,062
Federal and state taxes	1,446	0	0	0	1,446
Total current liabilities	66,565	1,052,569	63,693	0	1,182,827
Intercompany payable	0	512,490	0	(512,490)	0
Other noncurrent liabilities	1,322	189,456	77,777	0	268,555
Long-term debt	3,187,103	20,212	2,900	0	3,210,215
Intercompany note payable	0	1,222,637	0	(1,222,637)	0
Deferred income taxes	282,214	0	0	0	282,214
Redeemable noncontrolling interests	0	0	239,552	0	239,552
UHS common stockholders' equity	3,735,946	5,612,342	3,062,494	(8,674,836)	3,735,946
Noncontrolling interest	0	0	55,134	0	55,134
Total equity	3,735,946	5,612,342	3,117,628	(8,674,836)	3,791,080
	$7,273,150	$ 8,609,706	$3,501,550	$(10,409,963)	$ 8,974,443

SUPPLEMENTAL- 1

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING BALANCE SHEET
AS OF DECEMBER 31, 2013
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Assets					
Current assets:					
Cash and cash equivalents	$ 0	$ 7,990	$ 9,248	$ 0	$ 17,238
Accounts receivable, net	0	799,898	317,063	0	1,116,961
Supplies	0	63,562	38,219	0	101,781
Deferred income taxes	76,719	43,184	0	0	119,903
Other current assets	0	63,786	12,660	0	76,446
Total current assets	76,719	978,420	377,190	0	1,432,329
Investments in subsidiaries	6,378,499	1,476,911	0	(7,855,410)	0
Intercompany receivable	226,592	0	531,411	(758,003)	0
Intercompany note receivable	0	0	982,568	(982,568)	0
Property and equipment	0	4,093,914	1,597,988	0	5,691,902
Less: accumulated depreciation	0	(1,478,758)	(770,975)	0	(2,249,733)
	0	2,615,156	827,013	0	3,442,169
Other assets:					
Goodwill	0	2,552,190	496,826	0	3,049,016
Deferred charges	49,866	5,577	2,438	0	57,881
Other	8,411	251,365	70,552	0	330,328
	$6,740,087	$ 7,879,619	$3,287,998	$(9,595,981)	$ 8,311,723
Liabilities and Stockholders' Equity					
Current liabilities:					
Current maturities of long-term debt	$ 97,403	916	993	0	$ 99,312
Accounts payable and accrued liabilities	28,099	837,354	87,996	0	953,449
Federal and state taxes	4,963	2,164	0	0	7,127
Total current liabilities	130,465	840,434	88,989	0	1,059,888
Intercompany payable	0	758,003	0	(758,003)	0
Other noncurrent liabilities	7,591	199,104	77,894	0	284,589
Long-term debt	3,168,819	5,337	35,606	0	3,209,762
Intercompany note payable	0	982,568	0	(982,568)	0
Deferred income taxes	183,233	55,915	0	0	239,148
Redeemable noncontrolling interests	0	0	218,107	0	218,107
UHS common stockholders' equity	3,249,979	5,038,258	2,817,152	(7,855,410)	3,249,979
Noncontrolling interest	0	0	50,250	0	50,250
Total equity	3,249,979	5,038,258	2,867,402	(7,855,410)	3,300,229
	$6,740,087	$ 7,879,619	$3,287,998	$(9,595,981)	$ 8,311,723

SUPPLEMENTAL- 1

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2014
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net cash provided by operating activities	$ 18,579	$ 687,101	$ 330,196	$0	$1,035,876
Cash Flows from Investing Activities:					
Property and equipment additions, net of disposals	0	(230,102)	(161,048)	0	(391,150)
Acquisition of property and businesses	0	(422,081)	(9,305)	0	(431,386)
Proceeds received from sale of assets and businesses	0	11,450	3,728	0	15,178
Costs incurred for purchase and development of electronic health records application	0	(13,488)	0	0	(13,488)
Increase in insurance subsidiary investments	0	(12,000)	0	0	(12,000)
Net cash used in investing activities	0	(666,221)	(166,625)	0	(832,846)
Cash Flows from Financing Activities:					
Reduction of long-term debt	(866,748)	(867)	(11,514)	0	(879,129)
Additional borrowings	830,000	0	0	0	830,000
Financing costs	(14,976)	0	0	0	(14,976)
Repurchase of common shares	(100,749)	0	0	0	(100,749)
Dividends paid	(29,665)	0	0	0	(29,665)
Issuance of common stock	6,863	0	0	0	6,863
Excess income tax benefits related to stock based compensation	33,912	0	0	0	33,912
Profit distributions to noncontrolling interests	0	0	(33,680)	0	(33,680)
Changes in intercompany balances with affiliates, net	122,784	(5,444)	(117,340)	0	0
Net cash (used in) provided by financing activities	(18,579)	(6,311)	(162,534)	0	(187,424)
Effect of exchange rate changes on cash and cash equivalents	0	(775)	0	0	(775)
Increase in cash and cash equivalents	0	13,794	1,037	0	14,831
Cash and cash equivalents, beginning of period	0	7,990	9,248	0	17,238
Cash and cash equivalents, end of period	$ 0	$ 21,784	$ 10,285	$0	$ 32,069

SUPPLEMENTAL- 1

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2013

(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net cash provided by operating activities	$ 17,946	$ 587,083	$ 279,212	$0	$ 884,241
Cash Flows from Investing Activities:					
Property and equipment additions, net of disposals	0	(269,419)	(89,074)	0	(358,493)
Acquisition of property and businesses	0	(8,094)	(4,542)	0	(12,636)
Proceeds received from sale of assets and businesses	0	7,916	29,566	0	37,482
Costs incurred for purchase and development of electronic health records application	0	(49,811)	0	0	(49,811)
Net cash used in investing activities	0	(319,408)	(64,050)	0	(383,458)
Cash Flows from Financing Activities:					
Reduction of long-term debt	(429,996)	(109)	(10,119)	0	(440,224)
Additional borrowings	15,761	0	0	0	15,761
Financing costs	(231)	0	0	0	(231)
Repurchase of common shares	(27,201)	0	0	0	(27,201)
Dividends paid	(19,621)	0	0	0	(19,621)
Issuance of common stock	5,708	0	0	0	5,708
Excess income tax benefits related to stock based compensation	20,121	0	0	0	20,121
Profit distributions to noncontrolling interests	0	0	(61,329)	0	(61,329)
Changes in intercompany balances with affiliates, net	417,513	(271,525)	(145,988)	0	0
Net cash used in financing activities	(17,946)	(271,634)	(217,436)	0	(507,016)
Decrease in cash and cash equivalents	0	(3,959)	(2,274)	0	(6,233)
Cash and cash equivalents, beginning of period	0	11,949	11,522	0	23,471
Cash and cash equivalents, end of period	$ 0	$ 7,990	$ 9,248	$0	$ 17,238

SUPPLEMENTAL- 1

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2012

(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net cash (used in) provided by operating activities	$ (37,648)	$ 594,606	$ 242,273	$ 0	$ 799,231
Cash Flows from Investing Activities:					
Property and equipment additions, net of disposals	0	(312,190)	(51,002)	0	(363,192)
Acquisition of property and businesses	0	(513,596)	(14,251)	0	(527,847)
Proceeds received from sale of assets and businesses	0	142,667	6,644	0	149,311
Costs incurred for purchase and development of electronic health records application	0	(54,362)	0	0	(54,362)
Return of Deposit on terminated purchase agreement	6,500	0	0	0	6,500
Net cash provided by (used in) investing activities	6,500	(737,481)	(58,609)	0	(789,590)
Cash Flows from Financing Activities:					
Reduction of long-term debt	(843,002)	0	(8,258)	1,613	(849,647)
Additional borrowings	913,500	1,613	0	(1,613)	913,500
Financing costs	(8,283)	0	0	0	(8,283)
Repurchase of common shares	(19,154)	0	0	0	(19,154)
Dividends paid	(58,395)	0	0	0	(58,395)
Issuance of common stock	5,435	0	0	0	5,435
Excess income tax benefits related to stock based compensation	16,040	0	0	0	16,040
Profit distributions to noncontrolling interests	0	0	(26,895)	0	(26,895)
Changes in intercompany balances with affiliates, net	25,007	119,990	(144,997)	0	0
Net cash provided by (used in) financing activities	31,148	121,603	(180,150)	0	(27,399)
Increase (decrease) in cash and cash equivalents	0	(21,272)	3,514	0	(17,758)
Cash and cash equivalents, beginning of period	0	33,221	8,008	0	41,229
Cash and cash equivalents, end of period	$ 0	$ 11,949	$ 11,522	$ 0	$ 23,471

SUPPLEMENTAL- 1

SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
(amounts in thousands)

Allowance for Doubtful Accounts Receivable:	Balance at beginning of period	Charges to costs and expenses	Acquisitions of business	Write-off of uncollectible accounts	Balance at end of period
Year ended December 31, 2014	$395,035	$ 698,983	$ 506	$ (769,876)	$324,648
Year ended December 31, 2013	$311,387	$1,127,216	$ —	$(1,043,568)	$395,035
Year ended December 31, 2012	$253,405	$ 726,671	$5,632	$ (674,321)	$311,387

Valuation Allowance for Deferred Tax Assets:	Balance at beginning of period	Charges to costs and expenses	Acquisitions of business	Write-offs	Balance at end of period
Year ended December 31, 2014	$46,841	$5,923	$—	$—	$52,764
Year ended December 31, 2013	$44,511	$2,330	$—	$—	$46,841
Year ended December 31, 2012	$42,143	$2,368	$—	$—	$44,511

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CORPORATE INFORMATION

SUPPLEMENTAL- 1

EXECUTIVE OFFICES

Universal Corporate Center
367 South Gulph Road
P.O. Box 61558
King of Prussia, PA 19406
(610) 768-3300

REGIONAL OFFICES

Western Region
Summerlin Hospital Medical Office Building III
10105 Banburry Cross Drive
Suite 230
Las Vegas, NV 89144
(702) 360-9040

Behavioral Health Regional Office
110 Westwood Place
Suite 100
Brentwood, TN 37027
(615) 250-0000

ANNUAL MEETING

May 20, 2015, 10:00 a.m.
Universal Corporate Center
367 South Gulph Road
King of Prussia, PA 19406

COMPANY COUNSEL

Norton Rose Fulbright
New York, New York

AUDITORS

PricewaterhouseCoopers LLP
Philadelphia, Pennsylvania

TRANSFER AGENT AND REGISTRAR

Computershare
250 Royall Street
Canton, MA 02021
1-800-851-9677

Shareholder website:
www.computershare.com/investor

Shareholder online inquiries:
https://www-us.computershare.com/investor/Contact

TDD: Hearing Impaired # 1-800-231-5469

Please contact Computershare for prompt assistance on address changes, lost certificates, consolidation of duplicate accounts or related matters.

INTERNET ADDRESS

The Company can be accessed online at www.uhsinc.com.

LISTING

Class B Common Stock: New York Stock Exchange under the symbol UHS

PUBLICATIONS

For copies of the Company's annual report, Form 10-K, Form 10-Q, quarterly earnings releases, and proxy statements, please call 1-800-874-5819, or write

Investor Relations
Universal Health Services, Inc.
Universal Corporate Center
367 South Gulph Road
P.O. Box 61558
King of Prussia, PA 19406

FINANCIAL COMMUNITY INQUIRIES

The Company welcomes inquiries from members of the financial community seeking information on the Company. These should be directed to Steve Filton, Chief Financial Officer.

DISCLOSURE UNDER 303A.12(a)

In accordance with Section 303A.12(a) of The New York Stock Exchange Listed Company Manual, we submitted our CEO's Certification to the New York Stock Exchange in 2014. Additionally, contained in Exhibits 31.1 and 31.2 of our Annual Report on Form 10-K filed with the Securities and Exchange Commission on February 26, 2015, are our CEO's and CFO's Certifications regarding the quality of our public disclosure under Section 302 of the Sarbanes-Oxley Act of 2002.

OFFICERS AND SENIOR MANAGEMENT

CORPORATE OFFICERS

Alan B. Miller
Chief Executive Officer
and Chairman of the Board

Marc D. Miller
President

Steve G. Filton
Senior Vice President and
Chief Financial Officer

Debra K. Osteen
Senior Vice President

Marvin G. Pember
Senior Vice President

Charles F. Boyle
Vice President
and Controller

Geraldine Johnson Geckle
Vice President
Human Resources

Laurence L. Harrod
Vice President
Behavioral Finance

Matthew D. Klein
Vice President and
General Counsel

Thomas J. Marchozzi
Vice President
Acute Finance

Michael S. Nelson
Vice President
Information Services

Cheryl K. Ramagano
Vice President
and Treasurer

STAFF VICE PRESIDENTS

George Brunner
Vice President and
Deputy General Counsel

James Caponi
Vice President
Chief Compliance and
Privacy Officer

Mark D'Arcy
Vice President
Design and Construction

Robert Engelhard
Vice President
Insurance

Robert Halinski
Vice President
Reimbursement

Nancy Kurtzman
Vice President
Employee Benefits

Darryl Long
Vice President
Supply Chain Operations

Kenneth Lubben
Vice President
Information Services

Mary Ann Ninnis
Vice President
Advertising

Jeanne Schmid
Vice President
Labor Relations

Robert Zurad
Vice President
Tax

ACUTE CARE DIVISION

Marvin G. Pember
President

Frank Lopez
Regional Vice President

Douglas Matney
Regional Vice President

Karla Perez
Regional Vice President

Kevin DiLallo
Group Vice President

Michael Fencel
Group Vice President

David Kibbe
Divisional Vice President

Craig Conti
Vice President
Development

Charles DeBusk
Vice President
Performance and
Process Improvement

Michael Foye
Vice President
Revenue Cycle Services

John Johannessen
Vice President
Independence Physician
Management

Andrew Littauer
Vice President
Managed Care

Terry McGoldrick
Vice President
Chief Nursing Officer

Lynda Smirz, MD
Vice President
Chief Medical Officer

Thomas Summerill
Vice President
Health Plan Relations
and Contracting

Paul Tirjan
Vice President

BEHAVIORAL HEALTH DIVISION

Debra K. Osteen
President

Robert A. Deney
Senior Vice President

Gary M. Gilberti
Senior Vice President

Martin C. Schappell
Senior Vice President

David Cole
Chief Executive Officer
Cygnet Health Care

Geoff Botak
Divisional Vice
President

Joe C. Crabtree
Divisional Vice
President

John Hollinsworth
Divisional Vice
President

Roz Hudson
Divisional Vice
President

Shelley Nowak
Divisional Vice
President

Sharon Worsham
Divisional Vice
President

Matthew W. Crouch
Regional Vice President

John Willingham
Regional Vice President

Karen E. Johnson
Senior Vice President
Clinical Services and
Division Compliance
Officer

Darien Applegate
Senior Vice President
Business Development

Carothers H. Evans
Senior Vice President
Business Development

Isa Diaz
Vice President
Strategic Planning
and Public Affairs

Tasha Hoffmann
Vice President
Admission Services

Michael R. Lyons
Vice President
Specialty Education

Robert E. Minor
Vice President
Development

UHS of Delaware, Inc. is the management company for, and a wholly owned subsidiary of Universal Health Services, Inc. All of our "Corporate Officers" listed above are employees of UHS of Delaware, Inc. The Staff Vice Presidents and officers of the Acute and Behavioral Divisions listed above are solely officers and employees of UHS of Delaware, Inc.

BOARD OF DIRECTORS

SUPPLEMENTAL- 1

Seated left to right: Lawrence S. Gibbs, Eileen C. McDonnell and Anthony Pantaleoni. Standing left to right: Robert H. Hotz, Marc D. Miller, Alan B. Miller and John H. Herrell.

Alan B. Miller[3,4]
Chairman of the Board
Chief Executive Officer

Marc D. Miller[3,4]
President

Lawrence S. Gibbs[1,3,5]
Macro Portfolio Manager at Ramius LLC. Prior thereto, Portfolio Manager at Millennium Partners LLC. Portfolio Manager at JP Morgan Chase Bank N.A.

John H. Herrell[1*,2,5]
Former Chief Administrative Officer and Member, Board of Trustees, Mayo Foundation, Rochester, MN

Robert H. Hotz[1,2*,3,4,5*]
Senior Managing Director, Head of Investment Banking, Head of the Board of Directors Advisory Service, Member of the Board of Directors Houlihan Lokey Howard & Zukin, New York, NY; Former Senior Vice Chairman, Investment Banking for the Americas, UBS Warburg, LLC, New York, NY

Eileen C. McDonnell[1]
Chairman, President and Chief Executive Officer of The Penn Mutual Life Insurance Company. Served as president of New England Financial, a wholly owned subsidiary of MetLife, and senior vice president of the Guardian Life Insurance Company. Member of The Penn Mutual Board of Trustees.

Anthony Pantaleoni[3,4]
Of Counsel, Fulbright & Jaworski, L.L.P., New York, NY

Committees of the Board: [1]Audit Committee, [2]Compensation Committee, [3]Executive Committee, [4]Finance Committee, [5]Nominating/Corporate Governance Committee, *Committee Chairman

MIX
Paper from responsible sour

SUPPLEMENTAL- 1

UHS | 35

UNIVERSAL HEALTH SERVICES, INC.
Universal Corporate Center
P.O. Box 61558
367 South Gulph Road
King of Prussia, PA 19406
www.uhsinc.com

Supplemental – 1
CN1505-019

Section C (Orderly Development)
Item 7.d

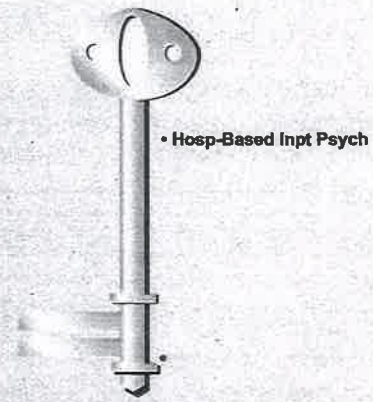
Joint Commission Accreditation Survey

THE JOINT COMMISSION

Recognizes

Lakeside Behavioral Health System, LLC
Memphis, TN

as a



Top Performer on Key Quality Measures®

2012

Mark R. Chassin, M.D., M.P.P., M.P.H.
President and Chief Executive Officer

Jerod M. Loeb, Ph.D.
Executive Vice President
Division of Healthcare Quality Evaluation

HCO# 1646

SUPPLEMENTAL- 1

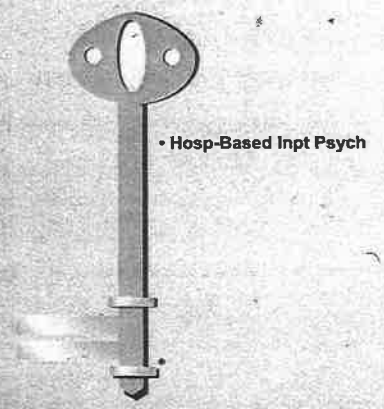
THE JOINT COMMISSION

Recognizes

Lakeside Behavioral Health System, LLC Memphis, TN

as a

Top Performer on Key Quality Measures®



2013

Mark R. Chassin, M.D., M.P.P., M.P.H.
President and Chief Executive Officer

Margaret VanAmringe
Executive Vice President, Public Policy
and Government Relations

HCO#1646

SUPPLEMENTAL 1

The Joint Commission

SUPPLEMENTAL

September 11, 2013

Anna J. Golden, RN
CEO
Lakeside Behavioral Health System, LLC
2911 Brunswick Road
Memphis, TN 38133

Joint Commission ID #: 1646
Program: Behavioral Health Care Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 09/11/2013.

Dear Ms. Golden:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Behavioral Health Care

This accreditation cycle is effective beginning June 04, 2013. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

The Joint Commission

SUPPLEMENTAL- 1

September 11, 2013

Anna J. Golden, RN
CEO
Lakeside Behavioral Health System, LLC
2911 Brunswick Road
Memphis, TN 38133

Joint Commission ID #: 1646
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 09/11/2013

Dear Ms. Golden:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning June 06, 2013. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

Supplemental – 1
CN1505-019

Section C (Orderly Development)
Item 7.d

Tennessee Department of Mental Health and Substance Abuse Services Survey and Plan of Correction

SUPPLEMENTAL- 1

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
West Tennessee Regional Office of Licensure
951 Court Avenue
MEMPHIS, TENNESSEE 38103

BILL HASLAM
GOVERNOR

E. DOUGLAS VARNEY
COMMISSIONER

COMPLIANCE EVENT STATUS REPORT

LICENSEE:	Licensee ID: 1012	FACILITY:	Site ID: 2248
UHS of Lakeside, LLC 2911 Brunswick Road Memphis, TN 38133		Lakeside Behavioral Health System 2911 Brunswick Road Memphis, TN 38133	

NOTICE TO LICENSEE: A review has been completed of your recently submitted plan of compliance. The approval status given your plan is indicated below. Read the approval status given below carefully. This approval status form and your plan of compliance should become part of your records.

DATE OF NOTICE / REPORT: 12/12/14
DATE OF ASSOCIATED NOTICE OF NON-COMPLIANCE: 11/12/14
COMPLIANCE EVENT & DATE: Annual Inspection 11/7/14
Site ID:2248 Event ID:2,968

I. REVIEW OF PLAN OF NON-COMPLIANCE COMPLETED BY:

Sandra Randle

Sandy Randle, West Tennessee Licensure

II. APPROVAL STATUS OF PLAN OF NON-COMPLIANCE:

POC Approved
Your plan of compliance has been accepted. You are expected to meet the terms of your plan. Re-inspection may be conducted to verify compliance. With re-inspection, you will incur a $50 re-inspection fee.

EVENT SUMMARY

09450-5-02 Licensure Administration and Procedures	0 deficiencies
09450-5-04-.02 Life Safety: HealthCare Occupancies	5 deficiencies
09450-5-04-.09 Life Safety: Mobile Non-ambulatory	0 deficiencies
09450-5-05-.02 Adequacy of Facility Environment and Ancillary Services (ALL FACILITIES)	5 deficiencies
09450-5-05-.03 Adequacy of Facility Environment & Ancillary Services (RESIDENTIAL)	3 deficiencies
09450-5-05-.04 Adequacy of Facility Environment & Ancillary Services (NON-RESIDENTIAL)	0 deficiencies
09450-5-05-.05 Adequacy of Facility Environment & Ancillary Services (FOOD SERVICE)	2 deficiencies
09450-5-05-.06 Adequacy of Facility Environment & Ancillary Services (TRANSPORTATION)	0 deficiencies
09450-5-05-.07 Adequacy of Facility Environment & Ancillary Services (CHILDREN)	0 deficiencies
09450-5-05-.09 Adequacy of Facility Environment & Ancillary Services (VISION LOSS)	0 deficiencies
09450-5-05-.10 Residential Facilities Serving Hearing Impaired (HEARING LOSS)	0 deficiencies
09450-5-05-.11 Non-Residential Facilities Serving Hearing Impaired (HEARING LOSS)	0 deficiencies
09450-5-06 Program Requirements for All Services and Facilities (DEEMED)	1 deficiency
09450-5-14 Mental Health Outpatient Facilities (DEEMED)	0 deficiencies
09450-5-15 Mental Health Adult Day Treatment Services (DEEMED)	0 deficiencies
09450-5-16 Mental Health Hospital Facilities (DEEMED)	1 deficiency

SUPPLEMENTAL-1

09450-5-17 Mental Health Adult Residential Treatment Services (DEEMED)	0 deficiencies
09450-5-18 Mental Health Crisis Stabilization Unit Facilities (DEEMED)	0 deficiencies
09450-5-30 Mental Health Intensive Day Treatment Program Children & Adolescents Faciltie	0 deficiencies
09450-5-33 Mental Health Partial Hospitalization Programs (DEEMED)	0 deficiencies
09450-5-37 Mental Health Residential Treatment Facility For Children and Youth (DEEMED)	0 deficiencies
09450-5-43 Alcohol and Drug Non-Residential Rehabilitation Treatment Facilities (DEEMED)	0 deficiencies
09450-5-44 Alcohol and Drug Residential Detoxification Treatment Facilities (DEEMED)	0 deficiencies
09450-5-45 Alcohol and Drug Residential Rehabilitation Treatment Facilities (DEEMED)	0 deficiencies
09450-5-46 Alcohol and Drug Residential Treatment Facilities for Children and Youth (DEEM	0 deficiencies

Supplemental – 1
CN1505-019

Project Completion Forecast Chart

PROJECT COMPLETION FORECAST CHART

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

Assuming the CON approval becomes the final agency action **on 08/26/15;** indicate the number of days from the above agency decision date to each phase of the completion forecast.

Phase	DAYS REQUIRED	Anticipated Date 8/26/2015 (MONTH/YEAR)
1. Architectural and engineering contract signed	5	August 2015
2. Construction documents approved by the Tennessee Department of Health	90	November 2015
3. Construction contract signed	1	August 2015
4. Building permit secured	45	October 2015
5. Site preparation completed	30	November 2015
6. Building construction commenced	1	November 2015
7. Construction 40% complete	70	January 2016
8. Construction 80% complete	70	March 2016
9. Construction 100% complete (approval for occupancy)	30	April 2016
10. *Issuance of license	10	May 2016
11. *Initiation of service	15	May 2016
12. Final Architectural Certification of Payment	30	June 2016
13. Final Project Report Form (HF0055)	30	July 2016

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

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

SUPPLEMENTAL #1

May 22, 2015
11:56 am

Behavioral Health Care Facilities

Name of Facility	Location	Number of Beds	Real Property Ownership Interest
Alabama Clinical Schools	Birmingham, Alabama	80	Owned
Alhambra Hospital	Rosemead, California	103	Owned
Alliance Health Center	Meridian, Mississippi	214	Owned
Anchor Hospital	Atlanta, Georgia	127	Owned
Arbour Counseling Services	Rockland, Massachusetts	—	Owned
The Arbour Hospital	Boston, Massachusetts	136	Owned
Arbour Senior Care	Rockland, Massachusetts	—	Owned
Arbour-Fuller Hospital	South Attleboro, Massachusetts	103	Owned
Arbour-HRI Hospital	Brookline, Massachusetts	68	Owned
Arrowhead Behavioral Health	Maumee, Ohio	48	Owned
Atlantic Shores Hospital	Fort Lauderdale, Florida	72	Owned
Austin Lakes Hospital	Austin, Texas	58	Leased
Austin Oaks Hospitals	Austin, Texas	80	Owned
Behavioral Educational Services	Riverdale, Florida	—	Leased
Behavioral Hospital of Bellaire	Houston, Texas	124	Leased
Belmont Pines Hospital	Youngstown, Ohio	102	Owned
Benchmark Behavioral Health System	Woods Cross, Utah	94	Owned
Bloomington Meadows Hospital	Bloomington, Indiana	78	Owned
Boulder Creek Academy	Bonners Ferry, Idaho	96	Owned
Brentwood Behavioral Health of Mississippi	Flowood, Mississippi	105	Owned
Brentwood Hospital	Shreveport, Louisiana	200	Owned
The Bridgeway	North Little Rock, Arkansas	103	Owned
Brook Hospital—Dupont	Louisville, Kentucky	88	Owned
Brook Hospital—KMI	Louisville, Kentucky	110	Owned
Brooke Glen Behavioral Hospital	Fort Washington, Pennsylvania	146	Owned
Brynn Marr Hospital	Jacksonville, North Carolina	100	Owned
Calvary Addiction Recovery Center	Phoenix, Arizona	58	Owned
Canyon Ridge Hospital	Chino, California	106	Owned
The Carolina Center for Behavioral Health	Greer, South Carolina	130	Owned
Cedar Grove Residential Treatment Center	Murfreesboro, Tennessee	36	Owned
Cedar Hills Hospital (10)	Beaverton, Oregon	89	Owned
Cedar Ridge	Oklahoma City, Oklahoma	60	Owned
Cedar Ridge Residential Treatment Center	Oklahoma City, Oklahoma	56	Owned
Cedar Springs Behavioral Health	Colorado Springs, Colorado	110	Owned
Centennial Peaks	Louisville, Colorado	72	Owned
Center for Change	Orem, Utah	58	Owned
Central Florida Behavioral Hospital	Orlando, Florida	126	Owned
Chicago Children's Center for Behavioral Health	Chicago, Illinois	40	Leased
Clarion Psychiatric Center	Clarion, Pennsylvania	74	Owned
Coastal Behavioral Health	Savannah, Georgia	50	Owned
Coastal Harbor Treatment Center	Savannah, Georgia	145	Owned
Columbus Behavioral Center for Children and Adolescents	Columbus, Indiana	56	Owned
Community Cornerstones	Rio Piedras, Puerto Rico	—	Leased
Compass Intervention Center	Memphis, Tennessee	108	Owned
Copper Hills Youth Center	West Jordan, Utah	197	Owned
Cottonwood Treatment Center	S. Salt Lake City, Utah	86	Leased

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Name of Facility	Location	Number of Beds	Real Property Ownership Interest
Crescent Pines	Stockbridge, Georgia	50	Owned
Cumberland Hall	Hopkinsville, Kentucky	97	Owned
Cumberland Hospital	New Kent, Virginia	118	Owned
Cypress Creek Hospital	Houston, Texas	96	Owned
Cygnet Hospital—Beckton	Beckton, UK	62	Owned
Cygnet Hospital—Bierley	Bierley, UK	63	Owned
Cygnet Wing—Blackheath	Blackheath, UK	32	Leased
Cygnet Lodge—Brighouse	Brighouse, UK	25	Owned
Cygnet Hospital—Derby	Derby, UK	47	Owned
Cygnet Hospital—Ealing	Ealing, UK	26	Leased
Cygnet Hospital—Godden Green	Godden Green, UK	39	Owned
Cygnet Hospital—Harrogate	Harrogate, UK	36	Owned
Cygnet Hospital—Harrow	Harrow, UK	44	Owned
Cygnet Hospital—Kewstoke	Kewstoke, UK	69	Owned
Cygnet Lodge—Lewisham	Lewisham, UK	20	Owned
Cygnet Hospital—Stevenage	Stevenage, UK	88	Owned
Cygnet Hospital—Taunton	Taunton, UK	46	Owned
Cygnet Lodge—Westlands	Westlands, UK	15	Owned
Cygnet Hospital—Wyke	Wyke, UK	47	Owned
Del Amo Hospital	Torrance, California	166	Owned
Diamond Grove Center	Louisville, Mississippi	55	Owned
Dover Behavioral Health	Dover, Delaware	73	Owned
El Paso Behavioral Health System	El Paso, Texas	163	Owned
Emerald Coast Behavioral Hospital	Panama City, Florida	86	Owned
Fairmount Behavioral Health System	Philadelphia, Pennsylvania	239	Owned
Fairfax Hospital	Kirkland, Washington	157	Owned
Fairfax Hospital—Everett	Everett, Washington	30	Leased
First Home Care (VA)	Portsmouth, Virginia	—	Leased
First Hospital Panamericano—Cidra	Cidra, Puerto Rico	165	Owned
First Hospital Panamericano—San Juan	San Juan, Puerto Rico	45	Owned
First Hospital Panamericano—Ponce	Ponce, Puerto Rico	30	Owned
Forest View Hospital	Grand Rapids, Michigan	82	Owned
Fort Lauderdale Hospital	Fort Lauderdale, Florida	100	Leased
Foundations Behavioral Health	Doylestown, Pennsylvania	106	Leased
Foundations for Living	Mansfield, Ohio	84	Owned
Fox Run Hospital	St. Clairsville, Ohio	100	Owned
Fremont Hospital	Fremont, California	148	Owned
Friends Hospital	Philadelphia, Pennsylvania	219	Owned
Garfield Park Hospital	Chicago, Illinois	88	Owned
Glen Oaks Hospital	Greenville, Texas	54	Owned
Good Samaritan Counseling Center	Anchorage, Alaska	—	Owned
Gulf Coast Youth Services	Fort Walton Beach, Florida	24	Owned
Hampton Behavioral Health Center	Westhampton, New Jersey	110	Owned
Harbour Point (Pines)	Portsmouth, Virginia	186	Owned
Hartgrove Hospital	Chicago, Illinois	150	Owned
Havenwyck Hospital	Auburn Hills, Michigan	251	Owned
Heartland Behavioral Health Services	Nevada, Missouri	151	Owned
Hermitage Hall	Nashville, Tennessee	100	Owned
Heritage Oaks Hospital	Sacramento, California	125	Owned
Hickory Trail Hospital	DeSoto, Texas	86	Owned

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Name of Facility	Location	Number of Beds	Real Property Ownership Interest
Highlands Behavioral Health System	Highlands Ranch, Colorado	86	Owned
Hill Crest Behavioral Health Services	Birmingham, Alabama	219	Owned
Holly Hill Hospital	Raleigh, North Carolina	205	Owned
The Horsham Clinic	Ambler, Pennsylvania	206	Owned
Hughes Center	Danville, Virginia	56	Owned
Intermountain Hospital	Boise, Idaho	155	Owned
Kempsville Center of Behavioral Health	Norfolk, Virginia	82	Owned
KeyStone Center	Wallingford, Pennsylvania	145	Owned
Kingwood Pines Hospital	Kingwood, Texas	116	Owned
La Amistad Behavioral Health Services	Maitland, Florida	80	Owned
Lake Bridge Behavioral Health	Macon, Georgia	155	Owned
Lakeside Behavioral Health System	Memphis, Tennessee	319	Owned
Laurel Heights Hospital	Atlanta, Georgia	108	Owned
Laurel Oaks Behavioral Health Center	Dothan, Alabama	124	Owned
Laurel Ridge Treatment Center	San Antonio, Texas	250	Owned
Liberty Point Behavioral Health	Stauton, Virginia	50	Owned
Lighthouse Care Center of Augusta	Augusta, Georgia	115	Owned
Lighthouse Care Center of Conway	Conway, South Carolina	140	Owned
Lincoln Prairie Behavioral Health Center	Springfield, Illinois	97	Owned
Lincoln Trail Behavioral Health System	Radcliff, Kentucky	140	Owned
Mayhill Hospital	Denton, Texas	59	Leased
McDowell Center for Children	Dyersburg, Tennessee	32	Owned
The Meadows Psychiatric Center	Centre Hall, Pennsylvania	107	Owned
Meridell Achievement Center	Austin, Texas	134	Owned
Mesilla Valley Hospital	Las Cruces, New Mexico	120	Owned
Michiana Behavioral Health Center	Plymouth, Indiana	80	Owned
Midwest Center for Youth and Families	Kouts, Indiana	74	Owned
Millwood Hospital	Arlington, Texas	122	Leased
Mountain Youth Academy	Mountain City, Tennessee	72	Owned
Natchez Trace Youth Academy	Waverly, Tennessee	117	Owned
NDA Behavioral Health System	Mount Dora, Florida	132	Owned
Newport News Behavioral Health Center	Newport News, Virginia	108	Owned
North Spring Behavioral Healthcare	Leesburg, Virginia	82	Leased
North Star Hospital	Anchorage, Alaska	74	Owned
North Star Bragaw	Anchorage, Alaska	36	Owned
North Star DeBarr Residential Treatment Center	Anchorage, Alaska	60	Owned
North Star Palmer Residential Treatment Center	Palmer, Alaska	30	Owned
Northwest Academy	Bonners Perry, Idaho	82	Owned
Oak Plains Academy	Ashland City, Tennessee	90	Owned
Okaloosa Youth Academy	Crestview, Florida	163	Leased
Old Vineyard Behavioral Health	Winston-Salem, North Carolina	104	Owned
Palmetto Lowcountry Behavioral Health	North Charleston, South Carolina	108	Owned
Palmetto Pee Dee Behavioral Health	Florence, South Carolina	59	Leased
Palmetto Summerville	Summerville, South Carolina	60	Leased
Palm Shores Behavioral Health Center	Bradenton, Florida	62	Owned
Palo Verde Behavioral Health	Tucson, Arizona	48	Leased
Parkwood Behavioral Health System	Olive Branch, Mississippi	148	Owned
The Pavilion	Champaign, Illinois	103	Owned
Peachford Behavioral Health System of Atlanta	Atlanta, Georgia	246	Owned

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Name of Facility	Location	Number of Beds	Real Property Ownership Interest
Pembroke Hospital	Pembroke, Massachusetts	120	Owned
Pinnacle Pointe Hospital	Little Rock, Arkansas	124	Owned
Poplar Springs Hospital	Petersburg, Virginia	208	Owned
Prairie St John's	Fargo, North Dakota	142	Owned
Pride Institute	Eden Prairie, Minnesota	42	Owned
Provo Canyon School	Provo, Utah	274	Owned
Provo Canyon Behavioral Hospital	Orem, Utah	80	Owned
Psychiatric Institute of Washington	Washington, District of Columbia	124	Owned
Quail Run Behavioral Health	Phoenix, Arizona	102	Owned
The Recovery Center	Wichita Falls, Texas	34	Leased
The Ridge Behavioral Health System	Lexington, Kentucky	110	Owned
Rivendell Behavioral Health Services of Arkansas	Benton, Arkansas	77	Owned
Rivendell Behavioral Health Services of Kentucky	Bowling Green, Kentucky	125	Owned
River Crest Hospital	San Angelo, Texas	80	Owned
Riveredge Hospital	Forest Park, Illinois	210	Owned
River Oaks Hospital	New Orleans, Louisiana	126	Owned
River Park Hospital	Huntington, West Virginia	187	Owned
River Point Behavioral Health	Jacksonville, Florida	93	Owned
Rockford Center	Newark, Delaware	118	Owned
Rock River Residential Center (11)	Rockford, Illinois	59	Owned
Rolling Hills Hospital	Franklin, Tennessee	85	Owned
Roxbury	Shippensburg, Pennsylvania	112	Owned
Salt Lake Behavioral Health	Salt Lake City, Utah	118	Leased
San Marcos Treatment Center	San Marcos, Texas	265	Owned
SandyPines Hospital	Tequesta, Florida	130	Owned
Schick Shadel Hospital	Burin, Washington	60	Owned
Schick Shadel of Florida	Cooper City, Florida	60	Owned
Shadow Mountain Behavioral Health System	Tulsa, Oklahoma	249	Owned
Sierra Vista Hospital	Sacramento, California	120	Owned
St. Louis Behavioral Medicine Institute	St. Louis, Missouri	—	Owned
St. Simons by the Sea	St. Simons, Georgia	101	Owned
Spring Mountain Sahara	Las Vegas, Nevada	30	Owned
Spring Mountain Treatment Center	Las Vegas, Nevada	82	Owned
The Springs Community—Romney Marsh	Romney Marsh, UK	29	Owned
Springwoods	Fayetteville, Arkansas	80	Owned
Stonington Institute	North Stonington, Connecticut	68	Owned
Streamwood Behavioral Health	Streamwood, Illinois	178	Owned
Summit Oaks Hospital	Summit, New Jersey	126	Owned
SummitRidge	Lawrenceville, Georgia	86	Owned
Suncoast Behavioral Health Center	Bradenton, Florida	60	Owned
Tabley Nursing Home—Tabley	Tabley, UK	51	Leased
Talbott Recovery	Atlanta, Georgia	—	Owned
Texas NeuroRehab Center	Austin, Texas	151	Owned
Three Rivers Behavioral Health	West Columbia, South Carolina	118	Owned
Three Rivers Residential Treatment-Midlands Campus	West Columbia, South Carolina	59	Owned
Timberlawn Mental Health System	Dallas, Texas	144	Owned
Tupwood Gate Nursing Home	Caterham, UK	30	Owned
Turning Point Hospital	Moultrie, Georgia	59	Owned
Turning Point Youth Center	St. Johns, Michigan	60	Owned

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Name of Facility	Location	Number of Beds	Real Property Ownership Interest
Two Rivers Psychiatric Hospital	Kansas City, Missouri	105	Owned
University Behavioral Center	Orlando, Florida	112	Owned
University Behavioral Health of Denton	Denton, Texas	104	Owned
Upper East TN Juvenile Detention Facility	Johnson City, Tennessee	10	Owned
Valle Vista Hospital	Greenwood, Indiana	102	Owned
Valley Hospital	Phoenix, Arizona	122	Owned
Vines Hospital	Ocala, Florida	98	Owned
Virgin Islands Behavioral Services	St. Croix, Virgin Islands	30	Owned
Virginia Beach Psychiatric Center	Virginia Beach, Virginia	100	Owned
Wekiva Springs	Jacksonville, Florida	68	Owned
Wellstone Regional Hospital	Jeffersonville, Indiana	100	Owned
West Hills Hospital	Reno, Nevada	95	Owned
West Oaks Hospital	Houston, Texas	160	Owned
Westwood Lodge Hospital	Westwood, Massachusetts	130	Owned
Willow Springs Center	Reno, Nevada	116	Owned
Windmoor Healthcare	Clearwater, Florida	144	Owned
Windsor—Laurelwood Center	Willoughby, Ohio	160	Leased
Wyoming Behavioral Institute	Casper, Wyoming	129	Owned

Surgical Hospitals, Ambulatory Surgery Centers and Radiation Oncology Centers

Name of Facility	Location	Real Property Ownership Interest
Cancer Care Institute of Carolina	Aiken, South Carolina	Owned
Cornerstone Regional Hospital (5)	Edinburg, Texas	Leased
Northwest Texas Surgery Center (6)	Amarillo, Texas	Leased
Palms Westside Clinic ASC (8)	Royal Palm Beach, Florida	Leased
Temecula Valley Day Surgery and Pain Therapy Center (7)	Murrieta, California	Leased

(1) Desert Springs Hospital, Summerlin Hospital Medical Center, Valley Hospital Medical Center, Spring Valley Hospital Medical Center and Centennial Hills Hospital Medical Center are owned by limited liability companies ("LLCs") in which we hold controlling, majority ownership interests of approximately 72%. The remaining minority ownership interests in these facilities are held by unaffiliated third-parties. All hospitals are managed by us.

(2) We hold an 80% ownership interest in this facility through a general partnership interest in a limited partnership. The remaining 20% ownership interest is held by an unaffiliated third-party.

(3) Real property leased from Universal Health Realty Income Trust.

(4) Edinburg Regional Medical Center/Children's Hospital, McAllen Medical Center, McAllen Heart Hospital and South Texas Behavioral Health Center are consolidated under one license operating as the South Texas Health System.

(5) We manage and own a noncontrolling interest of approximately 50% in the entity that operates this facility.

(6) We own a majority interest in an LLC that owns and operates this center.

(7) We own minority interests in an LLC that owns and operates this center which is managed by a third-party.

(8) We own a noncontrolling ownership interest of approximately 50% in the entity that operates this facility that is managed by a third-party.

(9) We hold an 89% ownership interest in this facility through both general and limited partnership interests. The remaining 11% ownership interest is held by unaffiliated third parties.

(10) Land of this facility is leased.

(11) Facility scheduled to be closed during second quarter of 2015.

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We own or lease medical office buildings adjoining some of our hospitals. We believe that the leases on the facilities, medical office buildings and other real estate leased or owned by us do not impose any material limitation on our operations. The aggregate lease payments on facilities leased by us were $66 million in 2014, $60 million in 2013 and $53 million in 2012.

ITEM 3. ***Legal Proceedings***

We are subject to claims and suits in the ordinary course of business, including those arising from care and treatment afforded by our hospitals and are party to 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 2010 at several of our acute care facilities. The DOJ alleges that ICDs were implanted and billed by our facilities in contravention of a National Coverage 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 February, 2013, the OIG served a subpoena requesting various documents from January, 2008 to the date of the subpoena directed at Universal Health Services, Inc. ("UHS") concerning it and UHS of Delaware, Inc., and several UHS owned behavioral health facilities including: Keys of Carolina, Old Vineyard Behavioral Health, The Meadows Psychiatric Center, Streamwood Behavioral Health, Hartgrove Hospital, Rock River Academy and Residential Treatment Center, Roxbury Treatment Center, Harbor Point Behavioral Health Center, f/k/a, The Pines Residential Treatment Center, including the Crawford, Brighton and Kempsville campuses, Wekiva Springs Center and River Point Behavioral Health. Prior to receiving this subpoena: (i) the Keys of Carolina and Old Vineyard received notification during the second half of 2012 from the United States Department of Justice of its intent to proceed with an investigation following requests for documents for the period of January, 2007 to the date of the subpoenas from the North Carolina state Attorney General's Office; (ii) Harbor Point Behavioral Health Center received a subpoena in December, 2012 from the Attorney General of the Commonwealth of Virginia requesting various documents from July, 2006 to the date of the subpoena, and; (iii) The Meadows Psychiatric Center received a subpoena from the OIG in February, 2013 requesting certain documents from 2008 to the date of the subpoena. Unrelated to these matters, the Keys of Carolina was closed and the real property was sold in January, 2013. We were advised that a qui tam action had been filed against Roxbury Treatment Center but the government declined to intervene and the case was dismissed.

In April, 2013, the OIG served facility specific subpoenas on Wekiva Springs Center and River Point Behavioral Health requesting various documents from January, 2005 to the date of the subpoenas. In July, 2013, another subpoena was issued to Wekiva Springs Center and River Point Behavioral Health requesting additional records. In October, 2013, we were advised by the DOJ's Criminal Frauds Section that they received a referral from the DOJ Civil Division and opened an investigation of River Point Behavioral Health and Wekiva Springs Center. Subsequent subpoenas have since been issued to River Point Behavioral Health and Wekiva Springs Center requesting additional documentation. In April, 2014, the Centers for Medicare and Medicaid Services ("CMS") instituted a Medicare payment suspension at River Point Behavioral Health in accordance with federal regulations which implemented provisions of the Affordable Care Act regarding suspension of payments during certain investigations. The Florida Agency for Health Care Administration subsequently issued a Medicaid payment suspension for the facility. River Point Behavioral Health submitted a rebuttal statement disputing the basis of the suspension and requesting revocation of the suspension. In response, CMS has continued the payment suspension. River Point Behavioral Health has provided additional information to CMS in an effort to obtain relief from the payment suspension but the suspension remains in effect. In August 2014, we received notification from CMS that, effective September, 2014, the payment suspension was to be continued for another 180 days. We cannot predict if and/or when the facility's suspended payments will resume. However, if

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continued for a significant period of time, the payment suspension will likely have a material adverse effect on River Point Behavioral Health's future results of operations and financial condition. The operating results of River Point Behavioral Health did not have a material impact on our consolidated results of operations for the years ended December 31, 2014 or 2013.

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

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

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

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

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

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

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

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

Department of Justice Investigation of Friends Hospital:

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

Department of Justice Investigation of Riveredge Hospital:

In 2008, Riveredge Hospital in Chicago, Illinois received a subpoena from the DOJ requesting certain information from the facility. Additional requests for documents were also received from the DOJ in 2009 and 2010. The requested documents have been provided to the DOJ. All documents requested and produced pertained to the operations of the facility while under PSI's ownership prior to our acquisition. At present, we are uncertain as to the focus, scope or extent of the investigation, liability of the facility and/or potential financial exposure, if any, in connection with this matter.

General:

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 payment suspension, 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.

ITEM 4. ***Mine Safety Disclosures***

Not applicable.

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ITEM 5. ***Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***

Our Class B Common Stock is traded on the New York Stock Exchange. Shares of our Class A, Class C and Class D Common Stock are not traded in any public market, but are each convertible into shares of our Class B Common Stock on a share-for-share basis.

The table below sets forth, for the quarters indicated, the high and low reported closing sales prices per share reported on the New York Stock Exchange for our Class B Common Stock for the years ended December 31, 2014 and 2013:

	2014 High-Low Sales Price	2013 High-Low Sales Price
Quarter:		
1st	$ 85.80-$74.35	$64.38-$49.69
2nd	$ 98.75-$74.61	$71.20-$60.12
3rd	$114.84-$91.83	$74.99-$63.83
4th	$112.32-$97.81	$83.12-$75.67

The number of stockholders of record as of January 31, 2015, were as follows:

Class A Common	16
Class B Common	273
Class C Common	3
Class D Common	115

Stock Repurchase Programs

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. During July, 2014, our Board of Directors authorized a new stock repurchase program whereby, from time to time as conditions allow, we may spend up to $400 million to purchase shares of our Class B Common Stock on the open market or in negotiated private transactions. There is no expiration date for our stock repurchase programs. Upon approval of the new stock repurchase program, our previously announced stock repurchase program was cancelled. The following schedule provides information related to our stock repurchase program for the three months ended December 31, 2014. All of the shares repurchased during the fourth quarter of 2014 related to income tax withholding obligations resulting from the exercise of stock options and the vesting of restricted stock grants, or shares repurchased pursuant to our publicly announced stock repurchase program.

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During the period of October 1, 2014 through December 31, 2014, we repurchased the following shares:

	Additional Dollars Authorized For Repurchase (in thousands)	Total number of shares purchased	Total number of shares cancelled	Average price paid per share for forfeited restricted shares	Total Number of shares purchased as part of publicly announced programs	Average price paid per share for shares purchased as part of publicly announced program	Aggregate purchase price paid (in thousands)	Maximum number of dollars that may yet be purchased under the program (in thousands)
October, 2014	—	1,247	—	N/A	0	N/A	N/A	$374,789
November, 2014	—	222,206	—	N/A	221,500	$100.73	$22,312	$352,477
December, 2014	—	142,066	—	N/A	100,000	$104.28	$10,427	$342,050
Total October through December	—	365,519	—	N/A	321,500	$101.83	$32,739	

Dividends

During the two years ending December 31, 2014, dividends per share were declared and paid as follows:

	2014	2013
First quarter	$.05	$.05
Second quarter	$.05	$.05
Third quarter	$.10	$.05
Fourth quarter	$.10	$.05
Total	$.30	$.20

Our Credit Agreement contains covenants that include limitations on, among other things, dividends and stock repurchases (see below in *Capital Resources-Credit Facilities and Outstanding Debt Securities).*

Equity Compensation

Refer to Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters, of this report for information regarding securities authorized for issuance under our equity compensation plans.

Stock Price Performance Graph

The following graph compares the cumulative total stockholder return on our common stock with the cumulative total return on the stock included in the Standard & Poor's 500 Index and a Peer Group Index during the five year period ended December 31, 2014. The graph assumes an investment of $100 made in our common stock and each Index as of January 1, 2010 and has been weighted based on market capitalization. Note that our common stock price performance shown below should not be viewed as being indicative of future performance.

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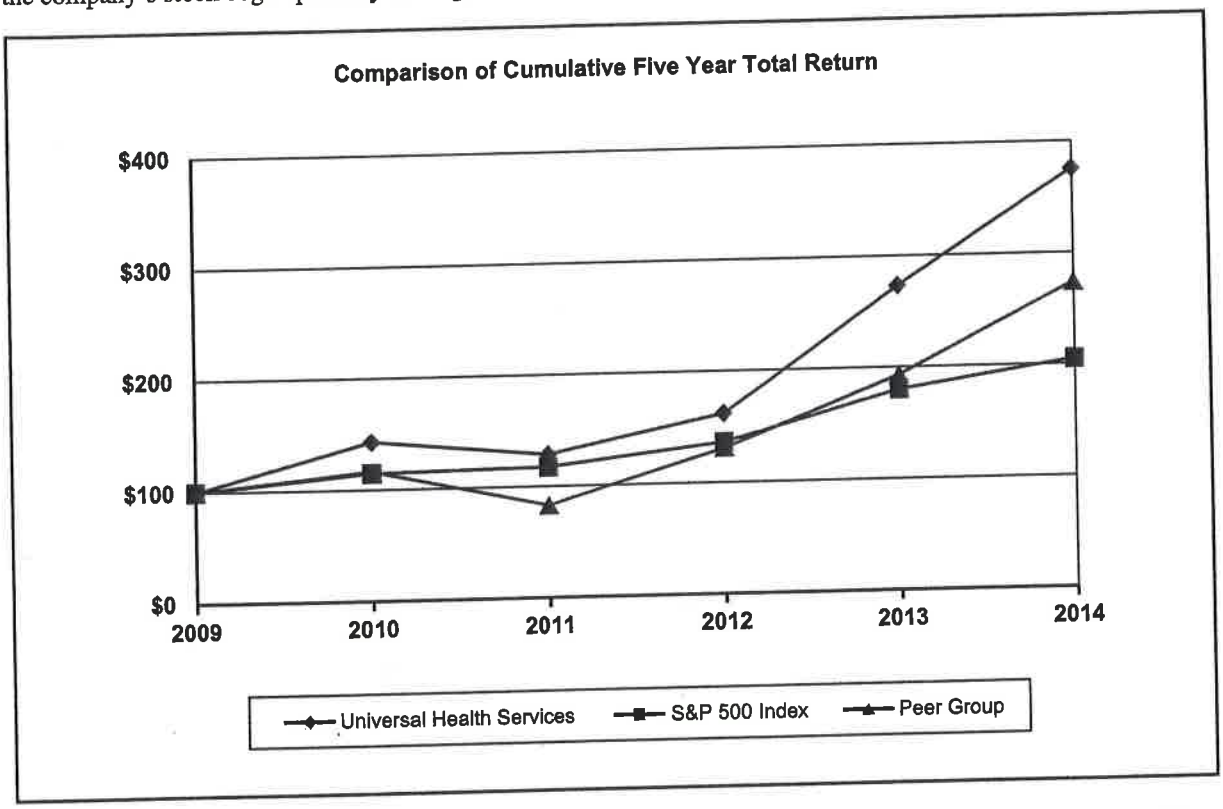
Companies in the peer group, which consist of companies in the S&P 500 Index or S&P MidCap 400 Index (in which we are also included), are as follows: Community Health Systems, Inc., Health Management Associates, Inc. (included until January, 2014 when it was acquired by Community Health Systems), LifePoint Hospitals, Inc., Tenet Healthcare Corporation and HCA Holdings, Inc. (included from March, 2011 at which time the company's stock began publicly trading).



Company Name / Index	2009	2010	2011	2012	2013	2014
Universal Health Services, Inc.	$100.00	$143.16	$128.70	$162.22	$273.44	$375.52
S&P 500 Index	$100.00	$115.06	$117.49	$136.30	$180.44	$205.14
Peer Group	$100.00	$116.70	$ 83.18	$131.17	$193.19	$273.77

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ITEM 6. *Selected Financial Data*

The following table contains our selected financial data for, or as of the end of, each of the five years ended December 31, 2014. You should read this table in conjunction with the consolidated financial statements and related notes included elsewhere in this report and in Part II, *Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations.*

	Year Ended December 31				
	2014	2013	2012	2011	2010
Summary of Operations (in thousands)					
Net revenues	$8,065,326	$7,283,822	$6,961,400	$6,760,222	$4,900,147
Income before income taxes	$ 929,667	$ 869,332	$ 763,663	$ 696,336	$ 428,097
Net income attributable to UHS	$ 545,343	$ 510,733	$ 443,446	$ 398,167	$ 230,183
Net margin	6.8%	7.0%	6.4%	5.9%	4.7%
Return on average equity	15.3%	16.8%	17.2%	18.1%	12.1%
Financial Data (in thousands)					
Cash provided by operating activities	$1,035,876	$ 884,241	$ 799,231	$ 710,683	$ 501,344
Capital expenditures, net (1)	$ 391,150	$ 358,493	$ 363,192	$ 285,682	$ 239,274
Total assets	$8,974,443	$8,311,723	$8,200,843	$7,665,245	$7,527,936
Long-term borrowings	$3,210,215	$3,209,762	$3,727,431	$3,651,428	$3,912,102
UHS's common stockholders' equity	$3,735,946	$3,249,979	$2,713,345	$2,296,352	$1,978,772
Percentage of total debt to total capitalization	47%	51%	58%	61%	66%
Operating Data—Acute Care Hospitals (2)					
Average licensed beds	5,776	5,652	5,563	5,567	5,530
Average available beds	5,571	5,429	5,338	5,265	5,224
Inpatient admissions	251,165	246,160	245,234	250,278	255,522
Average length of patient stay	4.6	4.5	4.5	4.5	4.4
Patient days	1,167,726	1,112,541	1,095,790	1,114,807	1,116,643
Occupancy rate for licensed beds	55%	54%	54%	55%	55%
Occupancy rate for available beds	57%	56%	56%	58%	59%
Operating Data—Behavioral Health Facilities (2)					
Average licensed beds	20,231	19,940	19,258	19,178	9,415
Average available beds	20,131	19,841	19,178	19,160	9,397
Inpatient admissions	426,510	401,565	373,437	351,086	166,310
Average length of patient stay	12.9	13.3	14.0	14.6	15.1
Patient days	5,518,660	5,354,334	5,212,800	5,130,245	2,503,770
Occupancy rate for licensed beds	75%	74%	74%	73%	73%
Occupancy rate for available beds	75%	74%	74%	73%	73%
Per Share Data					
Net income attributable to UHS—basic	$ 5.52	$ 5.21	$ 4.57	$ 4.09	$ 2.37
Net income attributable to UHS—diluted	$ 5.42	$ 5.14	$ 4.53	$ 4.04	$ 2.34
Dividends declared	$ 0.30	$ 0.20	$ 0.60	$ 0.20	$ 0.20
Other Information (in thousands)					
Weighted average number of shares outstanding—basic	98,826	98,033	96,821	97,199	96,786
Weighted average number of shares and share equivalents outstanding—diluted	100,544	99,361	97,711	98,537	97,973

(1) Amounts exclude non-cash capital lease obligations, if any.

(2) Excludes statistical information related to divested facilities and facilities held for sale.

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ITEM 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations*

Overview

Our principal business is owning and operating, through our subsidiaries, acute care hospitals, behavioral health centers, surgical hospitals, ambulatory surgery centers and radiation oncology centers. As of February 26, 2015, we owned and/or operated 24 acute care hospitals and 216 behavioral health centers located in 37 states, Washington, D.C., the United Kingdom, 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 late September, 2014, we acquired the stock of Cygnet Health Care Limited. Through this acquisition, we have added a total of 17 facilities located throughout the United Kingdom including 15 inpatient behavioral health hospitals and 2 nursing homes with a total of 723 beds.

Net revenues from our acute care hospitals, surgical hospitals, surgery centers and radiation oncology centers accounted for 51% of our consolidated net revenues in 2014, 49% in 2013 and 50% in 2012. Net revenues from our behavioral health care facilities accounted for 49% of our consolidated net revenues in 2014 and 50% during each of 2013 and 2012.

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

Forward-Looking Statements and Risk Factors

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

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

- our ability to comply with the existing laws and government regulations, and/or changes in laws and government regulations;

- an increasing number of legislative initiatives have recently been passed 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 based payors, including Medicare or Medicaid in the United States, and government based payors in the United Kingdom;
- 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;
- the outcome of known and unknown litigation, government investigations, false claim act allegations, and liabilities and other claims asserted against us and other matters as disclosed in *Item 3. Legal Proceedings*;
- the potential unfavorable impact on our business of deterioration in national, regional and local economic and business conditions, including a worsening of unfavorable credit market conditions;
- competition from other healthcare providers (including physician owned facilities) in certain markets;
- technological and pharmaceutical improvements that increase the cost of providing, or reduce the demand for healthcare;
- our ability to attract and retain qualified personnel, nurses, physicians and other healthcare professionals and the impact on our labor expenses resulting from a shortage of nurses and other healthcare professionals;
- demographic changes;
- our ability to successfully integrate and improve our recent acquisitions and the availability of suitable acquisitions and divestiture opportunities;
- as discussed below in *Sources of Revenue*, we receive revenues from various state and county based programs, including Medicaid in all the states in which we operate, (we receive Medicaid revenues in excess of $90 million annually from each of Texas, Washington, D.C., Pennsylvania, California, Illinois, Nevada, Virginia and Florida); CMS-approved Medicaid supplemental programs in certain states including Texas, Oklahoma, Illinois, Mississippi, Arkansas and California, and; state Medicaid disproportionate share hospital payments in certain states including Texas and South Carolina. We are therefore particularly sensitive to potential reductions in Medicaid and other state based revenue programs as well as regulatory, economic, environmental and competitive changes in those states. We can provide no assurance that reductions to revenues earned pursuant to these programs, particularly in the above-mentioned states, will not have a material adverse effect on our future results of operations;
- our ability to continue to obtain capital on acceptable terms, including borrowed funds, to fund the future growth of our business;
- some of our acute care facilities 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. Hospitals that do not qualify as a meaningful user of EHR by 2015 are subject to a reduced market basket update to the inpatient prospective payment system ("IPPS") standardized amount in 2015 and each subsequent fiscal year. We believe that all of our acute care hospitals have met the applicable meaningful use criteria and therefore are not subject to a reduced market basked update to the IPPS standardized amount in federal fiscal year 2015. However, under the HITECH Act, hospitals must continue to meet the applicable meaningful use criteria in each fiscal year or they will be subject to a market basket update reduction in a subsequent fiscal year. Failure of our acute care hospitals to continue to meet the applicable meaningful use criteria would have an adverse effect on our future net revenues and results of operations. There will likely be timing differences in the recognition of the incentive income and expenses recorded in connection with the implementation of the EHR applications which may cause material period-to-period changes in our future results of operations;

- in August, 2011, the Budget Control Act of 2011 (the "2011 Act") was enacted into law. The 2011 Act imposed annual spending limits for most federal agencies and programs aimed at reducing budget deficits by $917 billion between 2012 and 2021, according to a report released by the Congressional Budget Office. Among its other provisions, the law established a bipartisan Congressional committee, known as the Joint Select Committee on Deficit Reduction (the "Joint Committee"), which was tasked with making recommendations aimed at reducing future federal budget deficits by an additional $1.5 trillion over 10 years. The Joint Committee was unable to reach an agreement by the November 23, 2011 deadline and, as a result, across-the-board cuts to discretionary, national defense and Medicare spending were implemented on March 1, 2013 resulting in Medicare payment reductions of up to 2% per fiscal year (approximately $35 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 restructure the implemented Medicare payment reductions or what other federal budget deficit reduction initiatives may be proposed by Congress;

- our accounts receivable as of December 31, 2014 and 2013 include amounts due from Illinois of approximately $44 million and $49 million, respectively. Collection of the outstanding receivables continues to be delayed due to state budgetary and funding pressures. Approximately $23 million as of December 31, 2014 and $28 million as of December 31, 2013, of the receivables due from Illinois were outstanding in excess of 60 days, as of each respective date. In addition, our accounts receivable as of December 31, 2014 and 2013 includes approximately $102 million and $62 million due from Texas in connection with Medicaid supplemental payment programs. The $102 million due from Texas as of December 31, 2014 consists of $45 million related to uncompensated care program revenues, $33 million related to disproportionate share hospital program revenues and $24 million related to Delivery Service Reform Incentive Payment program ("DSRIP") revenues. Approximately $24 million of cash was received in January, 2015 from Texas related to the above-mentioned DSRIP receivables outstanding as of December 31, 2014. Although the accounts receivable due from Illinois and Texas could remain outstanding for the foreseeable future, since we expect to eventually collect all amounts due to us, no related reserves have been established in our consolidated financial statements. However, we can provide no assurance that we will eventually collect all amounts due to us from Illinois and/or Texas. Failure to ultimately collect all outstanding amounts due from these states would have an adverse impact on our future consolidated results of operations and cash flows. In September, 2014

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CMS deferred the federal matching funds on Texas Medicaid uncompensated care payments made to providers in certain counties in Texas. Although our hospitals located in Texas were not impacted by this deferral since they are not located in the impacted geographical areas, we can provide no assurance that our hospitals will not be impacted by future deferrals if CMS expands the deferrals to other counties in Texas. In January, 2015, CMS removed the aforementioned deferral but indicated they will continue their review and assessment of the underlying uncompensated care financing arrangements to ensure compliance with the applicable federal regulations and eligibility for federal matching funds;

- there have been several attempts in Congress to repeal or modify various provisions of the Patient Protection and Affordable Care Act (the "PPACA"). We cannot predict whether or not any of these proposed changes to the PPACA will become law and therefore can provide no assurance that changes to the PPACA, as currently implemented, will not have a material adverse effect on our future results of operations. In addition, a case currently pending before The Supreme Court of the United States, *King vs. Burwell*, challenges the federal government's ability to subsidize premiums paid by certain eligible individuals that obtain health insurance policies through federally facilitated exchanges. A number of our hospitals operate in states that utilize federally facilitated exchanges. The Supreme Court of the United States' decision in this case could result in an increased number of uninsured patients treated at our hospitals located in these states which would have an adverse impact on our future results of operations;
- the ability to obtain adequate levels of general and professional liability insurance on current terms;
- changes in our business strategies or development plans;
- fluctuations in the value of our common stock, and;
- other factors referenced herein or in our other filings with the Securities and Exchange Commission.

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

Critical Accounting Policies and Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires us to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes.

A summary of our significant accounting policies is outlined in Note 1 to the financial statements. We consider our critical accounting policies to be those that require us to make significant judgments and estimates when we prepare our financial statements, including the following:

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% of our net patient revenues during 2014, 38% during 2013 and 39% during 2012. Revenues from managed care entities, including health maintenance organizations and managed Medicare and Medicaid programs accounted for 50% of our net patient revenues during 2014 and 49% during each of 2013 and 2012.

We report net patient service revenue at the estimated net realizable amounts from patients and third-party payors and others for services rendered. We have agreements with third-party payors that provide for payments to us at amounts different from our established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments. Estimates of contractual allowances under managed care plans are based upon the payment terms specified in the related contractual agreements. We closely monitor our historical collection rates, as well as changes in applicable laws, rules and

regulations and contract terms, to assure that provisions are made using the most accurate information available. However, due to the complexities involved in these estimations, actual payments from payors may be different from the amounts we estimate and record.

We estimate our Medicare and Medicaid revenues using the latest available financial information, patient utilization data, government provided data and in accordance with applicable Medicare and Medicaid payment rules and regulations. The laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation and as a result, there is at least a reasonable possibility that recorded estimates will change by material amounts in the near term. Certain types of payments by the Medicare program and state Medicaid programs (e.g. Medicare Disproportionate Share Hospital, Medicare Allowable Bad Debts and Inpatient Psychiatric Services) are subject to retroactive adjustment in future periods as a result of administrative review and audit and our estimates may vary from the final settlements. Such amounts are included in accounts receivable, net, on our Consolidated Balance Sheets. The funding of both federal Medicare and state Medicaid programs are subject to legislative and regulatory changes. As such, we cannot provide any assurance that future legislation and regulations, if enacted, will not have a material impact on our future Medicare and Medicaid reimbursements. Adjustments related to the final settlement of these retrospectively determined amounts did not materially impact our results in 2014, 2013 and 2012. If it were to occur, each 1% adjustment to our estimated net Medicare revenues that are subject to retrospective review and settlement as of December 31, 2014, would change our after-tax net income by approximately $1 million.

We provide care to patients who meet certain financial or economic criteria without charge or at amounts substantially less than our established rates. Because we do not pursue collection of amounts determined to qualify as charity care, they are not reported in net revenues or in accounts receivable, net. See additional disclosure below in *Charity Care, Uninsured Discounts and Provision for Doubtful Accounts* for our estimated uncompensated care provided and estimated cost of providing uncompensated care.

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

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

A portion of the accounts receivable at our acute care facilities are comprised of Medicaid accounts that are pending approval from third-party payers but we also have smaller amounts due from other miscellaneous payers

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such as county indigent programs in certain states. Our patient registration process includes an interview of the patient or the patient's responsible party at the time of registration. At that time, an insurance eligibility determination is made and an insurance plan code is assigned. There are various pre-established insurance profiles in our patient accounting system which determine the expected insurance reimbursement for each patient based on the insurance plan code assigned and the services rendered. Certain patients may be classified as Medicaid pending at registration based upon a screening evaluation if we are unable to definitively determine if they are currently Medicaid eligible. When a patient is registered as Medicaid eligible or Medicaid pending, our patient accounting system records net revenues for services provided to that patient based upon the established Medicaid reimbursement rates, subject to the ultimate disposition of the patient's Medicaid eligibility. When the patient's ultimate eligibility is determined, reclassifications may occur which impacts the reported amounts in future periods for the provision for doubtful accounts and other accounts such as Medicaid pending. Although the patient's ultimate eligibility determination may result in amounts being reclassified among these accounts from period to period, these reclassifications did not have a material impact on our results of operations in 2014, 2013 or 2012 since our facilities make estimates at each financial reporting period to reserve for amounts that are deemed to be uncollectible.

We also provide discounts to uninsured patients (included in "uninsured discounts" amounts below) who do not qualify for Medicaid or charity care. Because we do not pursue collection of amounts classified as uninsured discounts, they are not reported in our net revenues or in our net accounts receivable. In implementing the discount policy, we first attempt to qualify uninsured patients for governmental programs, charity care or any other discount program. If an uninsured patient does not qualify for these programs, the uninsured discount is applied. Effective January 1, 2014, in response to market conditions and other considerations, we modified our uninsured discount policy and increased the discount to 60% of gross charges from 30% previously. Since we expect to collect only a small portion of amounts due from our uninsured patients, the increase in the uninsured discount in 2014 had no material impact on our net revenues, net income attributable to UHS or net accounts receivable, as compared to prior year periods. However, this change resulted in an increase in uninsured discounts and a decrease in the provision for doubtful accounts. Our accounts receivable are recorded net of allowance for doubtful accounts of $325 million and $395 million at December 31, 2014 and 2013, respectively.

Approximately 84% during 2014 and 90% during 2013 of our consolidated provision for doubtful accounts, was incurred by our acute care hospitals. Shown below is our payer mix concentrations and related aging of our billed accounts receivable, net of contractual allowances, for our acute care hospitals as of December 31, 2014 and 2013:

As of December 31, 2014:

(amounts in thousands)	0-60 days	61-120 days	121-180 days	Over 180 days
Medicare	$ 65,854	$ 3,988	$ 1,780	$ 9,138
Medicaid	11,049	7,226	4,306	11,354
Commercial insurance and other	283,565	96,973	46,344	111,875
Private pay	81,376	48,112	8,642	17,788
Total	$441,844	$156,299	$61,072	$150,155

As of December 31, 2013:

(amounts in thousands)	0-60 days	61-120 days	121-180 days	Over 180 days
Medicare	$ 66,125	$ 8,885	$ 2,983	$ 12,500
Medicaid	20,710	15,095	10,309	27,422
Commercial insurance and other	237,587	78,048	35,671	71,191
Private pay	143,683	96,294	20,983	4,354
Total	$468,105	$198,322	$69,946	$115,467

Accounting for Medicare and Medicaid Electronic Health Records Incentive 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 met the "meaningful use" criteria. Therefore, the majority of the Medicaid EHR incentive income recognition occurred in the period in which the applicable hospitals were deemed to have met initial "meaningful use" criteria. Upon meeting subsequent fiscal year "meaningful use" criteria, our hospitals may become entitled to additional Medicaid EHR incentive payments which will be recognized as incentive income in future periods. Medicaid EHR incentive payments received prior to our hospitals meeting the "meaningful use" criteria were included in other current liabilities (as deferred EHR incentive income) in our consolidated balance sheet.

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

Professional and General Liability and Workers Compensation Liability:

Effective November, 2010, excluding certain subsidiaries acquired since 2010 as discussed below, the vast majority of our subsidiaries are self-insured for professional and general liability exposure up to $10 million and $3 million per occurrence, respectively. Our subsidiaries were provided with several excess policies through commercial insurance carriers which provide for coverage in excess of the applicable per occurrence self-insured retention (either $3 million or $10 million) up to $250 million per occurrence and in the aggregate for claims incurred in 2014 and up to $200 million per occurrence and in the aggregate for claims incurred from 2011

through 2013. We remain liable for 10% of the claims paid pursuant to the commercial insurance coverage in excess of $10 million up to $60 million per occurrence and in the aggregate.

Since our acquisition of Psychiatric Solutions, Inc. ("PSI") in November, 2010, the former PSI subsidiaries are self-insured for professional and general liability exposure up to $3 million per occurrence. The nine behavioral health facilities acquired from Ascend Health Corporation ("Ascend") in October, 2012 have general and professional liability policies through commercial insurance carriers which provide for up to $12 million of aggregate coverage, subject to a $100,000 per occurrence deductible. The 17 facilities acquired from Cygnet Health Care Limited ("Cygnet"), consisting of 15 inpatient behavioral health hospitals and 2 nursing homes, have policies through a commercial insurance carrier located in the United Kingdom that provides for £10 million of professional liability coverage and £25 million of general liability coverage. The facilities acquired from PSI, Ascend and Cygnet, like our other facilities, are also provided excess coverage through commercial insurance carriers for coverage in excess of the underlying commercial policy limitations, as mentioned above.

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

As of December 31, 2014, the total accrual for our professional and general liability claims was $193 million, of which $51 million is included in current liabilities. As of December 31, 2013, the total accrual for our professional and general liability claims was $206 million, of which $44 million is included in current liabilities.

We recorded reductions to our professional and general liability self-insurance reserves (relating to prior years) amounting to $20 million during 2014, $81 million during 2013 and $27 million during 2012. The favorable changes recorded during 2014 and 2012 resulted from changes in our estimated future claims payments pursuant to a reserve analysis. The favorable change in our estimated future claims payments recorded during 2013, relating to years prior to 2013, were due primarily to: (i) an increased weighting given to company-specific metrics (to 100% from 75%), and decreased general industry metrics (to 0% from 25%), related to projected incidents per exposure, historical claims experience and loss development factors; (ii) historical data which measured the realized favorable impact of medical malpractice tort reform experienced in several states in which we operate, and; (iii) a decrease in claims related to certain higher risk specialties (such as obstetrical) due to a continuation of the company-wide patient safety initiative undertaken during the last several years. As the number of our facilities and our patient volumes have increased, thereby providing for a statistically significant data group, and taking into consideration our long-history of company-specific risk management programs and claims experience, our reserve analyses have included a greater emphasis on our historical professional and general liability experience which has developed favorably as compared to general industry trends.

As of December 31, 2014, the total accrual for our workers' compensation liability claims was $67 million, of which $32 million is included in current liabilities. As of December 31, 2013, the total accrual for our workers' compensation liability claims was $64 million, of which $34 million is included in current liabilities. During the last three years, adjustments recorded to our prior year reserves for workers' compensation claims did not have a material impact on our consolidated results of operations for the years ended December 31, 2014, 2013 or 2012.

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

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Below is a schedule showing the changes in our general and professional liability and workers' compensation reserves during the three years ended December 31, 2014 (amount in thousands):

	General and Professional Liability	Workers' Compensation	Total
Balance at January 1, 2012	$292,049	$ 64,926	$356,975
Plus: Accrued insurance expense, net of commercial premiums paid (a)	29,152	33,508	62,660
Less: Payments made in settlement of self-insured claims	(42,602)	(32,480)	(75,082)
Balance at January 1, 2013	278,599	65,954	344,553
Plus: Accrued insurance expense, net of commercial premiums paid (a)	(35,182)	31,361	(3,821)
Less: Payments made in settlement of self-insured claims	(37,127)	(33,517)	(70,644)
Balance at January 1, 2014	206,290	63,798	270,088
Plus: Accrued insurance expense, net of commercial premiums paid (a)	22,601	36,675	59,276
Less: Payments made in settlement of self-insured claims	(35,987)	(33,659)	(69,646)
Balance at December 31, 2014	$192,904	$ 66,814	$259,718

(a) General and professional liability amounts are net of adjustments recorded during each year, as discussed above.

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 PSI 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, subject to a $25,000 deductible. Non-critical flood losses have either a $250,000 or $500,000 deductible, based upon the location of the facility. Since certain of our facilities have been designated by our insurer as flood prone, we have elected to purchase policies from The National Flood Insurance Program to cover a substantial portion of the applicable deductible. Property insurance for the facilities acquired from Cygnet are provided on an all risk basis up to a £180 million limit that includes coverage for real and personal property as well as business interruption losses.

Long-Lived Assets: We review our long-lived assets, including intangible assets, for impairment whenever events or circumstances indicate that the carrying value of these assets may not be recoverable. The assessment of possible impairment is based on our ability to recover the carrying value of our asset based on our estimate of its undiscounted future cash flow. If the analysis indicates that the carrying value is not recoverable from future cash flows, the asset is written down to its estimated fair value and an impairment loss is recognized. Fair values are determined based on estimated future cash flows using appropriate discount rates.

Goodwill and Intangible Assets: Goodwill and indefinite-lived intangible assets are reviewed for impairment at the reporting unit level on an annual basis or sooner if the indicators of impairment arise. Our judgments regarding the existence of impairment indicators are based on market conditions and operational performance of each reporting unit. We have designated September 1st as our annual impairment assessment date and performed an impairment assessment as of September 1, 2014 which indicated no impairment of goodwill or indefinite-lived intangible assets. There were also no impairments during 2013 or 2012. Future changes in the

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estimates used to conduct the impairment review, including profitability and market value projections, could indicate impairment in future periods potentially resulting in a write-off of a portion or all of our goodwill or indefinite-lived intangible assets.

Income Taxes: Deferred tax assets and liabilities are recognized for the amount of taxes payable or deductible in future years as a result of differences between the tax bases of assets and liabilities and their reported amounts in the financial statements. We believe that future income will enable us to realize our deferred tax assets net of recorded valuation allowances relating to state net operating loss carry-forwards.

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

See *Provision for Income Taxes and Effective Tax Rates* below for discussion of our effective tax rates during each of the last three years.

Recent Accounting Pronouncements: For a summary of recent accounting pronouncements, please see *Note 1 to the Consolidated Financial Statements Accounting Standards* as included in this Report on Form 10-K for the year ended December 31, 2014.

Results of Operations

The following table summarizes our results of operations, and is used in the discussion below, for the years ended December 31, 2014, 2013 and 2012 (dollar amounts in thousands):

	Year Ended December 31,					
	2014		2013		2012	
	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$8,764,309		$8,411,038		$7,688,071	
Less: Provision for doubtful accounts	698,983		1,127,216		726,671	
Net revenues	8,065,326	100.0%	7,283,822	100.0%	6,961,400	100.0%
Operating charges:						
Salaries, wages and benefits	3,845,461	47.7%	3,604,620	49.5%	3,440,917	49.4%
Other operating expenses	1,782,981	22.1%	1,468,744	20.2%	1,376,122	19.8%
Supplies expense	895,693	11.1%	821,089	11.3%	799,621	11.5%
Depreciation and amortization	375,624	4.7%	337,172	4.6%	302,426	4.3%
Lease and rental expense	93,993	1.2%	97,758	1.3%	94,885	1.4%
Transaction costs	0	0.0%	0	0.0%	5,716	0.1%
Electronic health records incentive income	(27,902)	-0.3%	(61,024)	-0.8%	(30,038)	-0.4%
Costs related to extinguishment of debt	36,171	0.4%	0	0.0%	29,170	0.4%
Subtotal-operating expenses	7,002,021	86.8%	6,268,359	86.1%	6,018,819	86.5%
Income from operations	1,063,305	13.2%	1,015,463	13.9%	942,581	13.5%
Interest expense, net	133,638	1.7%	146,131	2.0%	178,918	2.6%
Income before income taxes	929,667	11.5%	869,332	11.9%	763,663	11.0%
Provision for income taxes	324,671	4.0%	315,309	4.3%	274,616	3.9%
Net income	604,996	7.5%	554,023	7.6%	489,047	7.0%
Less: Income attributable to noncontrolling interests	59,653	0.7%	43,290	0.6%	45,601	0.7%
Net income attributable to UHS	$ 545,343	6.8%	$ 510,733	7.0%	$ 443,446	6.4%

Year Ended December 31, 2014 as compared to the Year Ended December 31, 2013:

Net revenues increased 11% or $782 million to $8.07 billion during 2014 as compared to $7.28 billion during 2013. The increase was primarily attributable to:

- a $557 million or 8% 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;
- other combined net increase of $225 million consisting primarily of the net revenues generated during 2014 related to acquisitions made during the year including: (i) a commercial health insurer headquartered in Reno, Nevada; (ii) the 17 behavioral health facilities located in the United Kingdom acquired as part of our acquisition of Cygnet Health Care Limited, and; (iii) a 124-bed behavioral health care facility and outpatient treatment center located in Washington, D.C. Also contributing to the increase in net revenues was a full year of net revenues generated during 2014 at Temecula Valley Hospital, a 140-bed, newly constructed acute care facility that was completed and opened during the fourth quarter of 2013.

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Income before income taxes (before deduction for income attributable to noncontrolling interests) increased $60 million to $930 million during 2014 as compared to $869 million during 2013. Included in our income before income taxes during 2014, as compared to 2013, was the following:

a. an increase of $202 million at our acute care facilities as discussed below in Acute Care Hospital Services, excluding the EHR impact (as mentioned in f. below) and excluding the change resulting from the reductions to our prior year professional and general liability self-insurance reserves recorded during 2014 and 2013 (as mentioned in c. below);

b. an increase of $57 million at our behavioral health care facilities, as discussed below in Behavioral Health Services, excluding the change resulting from the reductions to our prior year professional and general liability self-insurance reserves during 2014 and 2013 (as mentioned in c. below);

c. a net decrease of $61 million resulting from the change in the reductions to our professional and general liability self-insurance reserves recorded during 2014 and 2013 based upon reserve analyses, as discussed above in *Professional and General Liability and Workers Compensation Liability* ($20 million reduction recorded during 2014 of which $11 million was applicable to our acute care hospitals and $9 million was applicable to our behavioral health care facilities, as compared to an $81 million reduction recorded during 2013 of which $63 million was applicable to our acute care hospitals and $18 million was applicable to our behavioral health care facilities);

d. a decrease of $48 million resulting from a charge incurred in connection with the settlement of the *Garden City Employees' Retirement System v. Psychiatric Solutions, Inc.* matter, a shareholder class action lawsuit filed in 2009 against PSI and certain of its former officers alleging their violations of federal securities laws. We assumed the defense and liability of this matter as a result of our acquisition of PSI in 2010. The charge incurred during 2014 is net of approximately $17 million of commercial insurance recoveries, net of related legal fees, that we were entitled to;

e. a decrease of $36 million recorded during 2014 in connection with the costs related to extinguishment of debt resulting primarily from the early redemption of our previously outstanding $250 million, 7.00% senior unsecured notes that were scheduled to mature in 2018 and the repayment of $550 million of borrowings pursuant to the terms of our previously outstanding Term Loan B facility which was scheduled to mature in 2016;

f. a decrease of $27 million related to the incentive income ($28 million in 2014 and $61 million in 2013), net of related expenses ($37 million in 2014 and $43 million in 2013), recorded during each year in connection with the implementation of EHR applications at our acute care hospitals;

g. an increase of $10 million due to the pre-tax gain realized during 2014 resulting from the divestiture of a non-operating investment (sold during the first quarter of 2014), and;

h. $37 million of other combined net decreases.

Net income attributable to UHS increased $35 million to $545 million during 2014 as compared to $511 million during 2013. The increase consisted of:

- an increase of $60 million in income before income taxes, as discussed above;
- a decrease of $16 million resulting from an increase in the income attributable to noncontrolling interests, and;
- a decrease of $9 million resulting from an increase in the provision for income taxes resulting primarily from: (i) the income tax provision on the $44 million increase in pre-tax income ($60 million increase in income before income taxes less the $16 million decrease in income resulting from an increase in the income attributable to noncontrolling interests), partially offset by; (ii) the income tax provision recorded during 2013 on the sale of Peak Behavioral Health Services (the tax basis gain realized on the sale in 2013 exceeded the gain recorded pursuant to generally accepted accounting principles), and; (iii) a decrease during 2014, as compared to 2013, to our blended effective state income tax rate.

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Year Ended December 31, 2013 as compared to the Year Ended December 31, 2012

Net revenues increased 5% or $322 million to $7.28 billion during 2013 as compared to $6.96 billion during 2012. The increase was primarily attributable to:

- a $239 million or 4% increase in net revenues generated at our acute care hospitals and behavioral health care facilities owned during both periods, and;
- other combined net increase of $83 million consisting primarily of the net revenues generated during the first ten months of 2013 at nine behavioral health facilities acquired from Ascend Health Corporation in October, 2012 (the operating results for these facilities for the months of November and December of 2013 and 2012 are included in our behavioral health care facilities-same facility basis results).

Income before income taxes (before deduction for income attributable to noncontrolling interests) increased $106 million to $869 million during 2013 as compared to $764 million during 2012. Included in our income before income taxes during 2013, as compared to 2012, was the following:

a. a decrease of $28 million at our acute care facilities as discussed below in *Acute Care Hospital Services*, excluding the impact of the applicable items mentioned in c., d., h., and j., below;

b. an increase of $57 million at our behavioral health facilities, as discussed below in *Behavioral Health Services,* excluding the impact of the applicable items mentioned in c., and i., below;

c. a net increase of $53 million resulting from reductions recorded during 2013 and 2012 to our professional and general liability self-insurance reserves, as discussed above in *Professional and General Liability and Workers Compensation Liability* ($81 million reduction recorded in 2013 of which $63 million was applicable to our acute care hospitals and $18 million was applicable to our behavioral health facilities, and $27 million reduction recorded during 2012 of which $23 million was applicable to our acute care hospitals and $4 million was applicable to our behavioral health facilities);

d. a decrease of $33 million (net of related expenses) resulting from the pre-tax income recorded during 2012 related to an agreement, which was part of an industry-wide settlement related to underpayments of Medicare inpatient prospective payments during a number of prior years, entered into 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;

e. a decrease of $26 million resulting from a gain realized on the sale of an acute care hospital (Auburn Regional Medical Center) which was sold during the fourth quarter of 2012;

f. an increase of $29 million resulting from the write-off deferred financing costs, during 2012, related to the portion of our previously outstanding Term Loan B credit facility that was extinguished during the third quarter of 2012;

g. an increase of $33 million due to a decrease in interest expense resulting primarily from a decrease in our average effective borrowing rate during 2013 as compared to 2012 (as discussed below in *Interest Expense*);

h. a net aggregate increase of $11 million resulting from the following unfavorable items recorded during 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);

i. a decrease of $14 million resulting from the 2011 portion, recorded in 2012, of net Medicaid supplemental reimbursements earned pursuant to new programs initiated in certain states in which we operate behavioral health facilities, most notably the Oklahoma Supplemental Hospital Offset Payment Program which was approved during 2012, retroactive to July 1, 2011;

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j. an increase of $16 million related to the incentive income ($61 million in 2013 and $50 million in 2012), net of related expenses ($43 million in 2013 and $28 million in 2012), recorded during the each year in connection with the implementation of EHR applications at our acute care hospitals, and;

k. $8 million of other combined net increases.

Net income attributable to UHS increased $67 million to $511 million during 2013 as compared to $443 million during 2012. The increase consisted of:

- an increase of $106 million in income before income taxes, as discussed above;
- an increase of $2 million resulting from a decrease in the income attributable to noncontrolling interests, and;
- a decrease of $41 million resulting from an increase in the provision for income taxes resulting primarily from the income tax provision on the $108 million increase in pre-tax income ($106 million increase in income before income taxes plus the $2 million increase in income resulting from a decrease in the income attributable to noncontrolling interests).

Acute Care Hospital Services

Year Ended December 31, 2014 as compared to the Year Ended December 31, 2013:

Acute Care Hospitals-Same Facility Basis

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 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 basis and is used in the discussions below for the years ended December 31, 2014 and 2013 (dollar amounts in thousands):

	Year Ended December 31, 2014		Year Ended December 31, 2013	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$4,504,887		$4,581,280	
Less: Provision for doubtful accounts	582,986		1,014,455	
Net revenues	3,921,901	100.0%	3,566,825	100.0%
Operating charges:				
Salaries, wages and benefits	1,684,286	42.9%	1,614,276	45.3%
Other operating expenses	799,805	20.4%	781,812	21.9%
Supplies expense	698,860	17.8%	641,078	18.0%
Depreciation and amortization	200,617	5.1%	191,274	5.4%
Lease and rental expense	50,367	1.3%	57,384	1.6%
Subtotal-operating expenses	3,433,935	87.6%	3,285,824	92.1%
Income from operations	487,966	12.4%	281,001	7.9%
Interest expense, net	4,305	0.1%	4,501	0.1%
Income before income taxes	483,661	12.3%	276,500	7.8%

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On a same facility basis during 2014, as compared to 2013, net revenues at our acute care hospitals increased $355 million or 10%. Income before income taxes increased $207 million or 75% to $484 million or 12.3% of net revenues during 2014 as compared to $277 million or 7.8% of net revenues during 2013.

The increased income before income taxes experienced at our acute care facilities during 2014, as compared to 2013, was due in part to improving general economic conditions as well as a decrease in the number of uninsured patients treated at our hospitals. The decrease in the number of uninsured patients treated at our acute care hospitals was due primarily to the favorable impact of the Affordable Care Act which includes the expansion of Medicaid in certain states in which we operate and the enrollment of patients in newly created commercial exchanges.

Inpatient admissions to these facilities increased 0.6% during 2014, as compared to 2013, while patient days increased 3.9%. Adjusted admissions (adjusted for outpatient activity) increased 3.1% and adjusted patient days increased 6.5% during 2014, as compared to 2013. The average length of inpatient stay at these facilities was 4.7 days during 2014 and 4.5 days during 2013. The occupancy rate, based on the average available beds at these facilities, was 58% during 2014 and 56% during 2013. On a same facility basis, net revenue per adjusted admission at these facilities increased 6.6% during 2014, as compared to 2013, and net revenue per adjusted patient day increased 3.3% during 2014, as compared to 2013.

All Acute Care Hospitals

The following table summarizes the results of operations for all our acute care operations during 2014 and 2013, 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).

	Year Ended December 31, 2014		Year Ended December 31, 2013	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$4,695,474		$4,592,102	
Less: Provision for doubtful accounts	590,384		1,015,733	
Net revenues	4,105,090	100.0%	3,576,369	100.0%
Operating charges:				
Salaries, wages and benefits	1,728,973	42.1%	1,635,428	45.7%
Other operating expenses	920,050	22.4%	727,224	20.3%
Supplies expense	709,776	17.3%	643,169	18.0%
Depreciation and amortization	253,769	6.2%	227,368	6.4%
Lease and rental expense	50,794	1.2%	57,512	1.6%
Electronic health records incentive income	(27,902)	-0.7%	(61,024)	-1.7%
Subtotal-operating expenses	3,635,460	88.6%	3,229,677	90.3%
Income from operations	469,630	11.4%	346,692	9.7%
Interest expense, net	4,302	0.1%	4,501	0.1%
Income before income taxes	465,328	11.3%	342,191	9.6%

During 2014, as compared to 2013, net revenues at our acute care hospitals increased $529 million or 15% to $4.11 billion due primarily to: (i) a $355 million, or 10%, increase same facility revenues, as discussed above, and; (ii) other combined net increase of $174 million consisting primarily of the net revenues generated during 2014 related to the acquisition of a commercial health insurer headquartered in Reno, Nevada and a full year of net revenues generated during 2014 at Temecula Valley Hospital, a 140-bed, newly constructed acute care facility that was completed and opened during the fourth quarter of 2013.

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Income before income taxes increased $123 million to $465 million or 11.3% of net revenues during 2014 as compared to $342 million or 9.6% of net revenues during 2013.

Included in these results are the following:

- the $207 million increase in income before income taxes experienced during 2014, as compared to 2013, at our acute care hospitals, on a same facility basis, as discussed above;
- a net decrease of $52 million net increase resulting from reductions to our professional and general liability self-insurance reserves attributable to our acute care hospitals recorded during 2014 ($11 million) and 2013 ($63 million), as discussed above in *Professional and General Liability and Workers Compensation Liability*;
- a net decrease of $27 million related to the incentive income ($28 million in 2014 and $61 million in 2013), net of related expenses ($37 million in 2014 and $43 million in 2013), recorded in connection with the implementation of EHR applications at our acute care hospitals, and;
- a net other combined decrease of $5 million consisting primarily of the decreased operating losses incurred at a Temecula Valley Hospital, offset by the operating losses incurred at a commercial health insurer acquired during 2014.

Uncompensated care (charity care and uninsured discounts):

The following table shows the amounts recorded at our acute care hospitals for charity care and uninsured discounts, based on charges at established rates, for the years ended December 31, 2014, 2013 and 2012:

	(dollar amounts in thousands)					
	2014		2013		2012	
	Amount	%	Amount	%	Amount	%
Charity care	$ 515,435	45%	$593,474	59%	$ 778,268	74%
Uninsured discounts	620,587	55%	405,296	41%	267,304	26%
Total uncompensated care	$1,136,022	100%	$998,770	100%	$1,045,572	100%

The provision for doubtful accounts at our acute care hospitals decreased to approximately $590 million during 2014 as compared to $1.02 billion during 2013. The decrease in the provision for doubtful accounts during 2014, as compared to 2013, was primarily due to the increase in the uninsured discount (effective January 1, 2014, as discussed above in *Charity Care, Uninsured discounts and Provision for Doubtful Accounts)*, and reclassifications among provision for doubtful accounts and other accounts such as Medicaid pending based upon our patients' ultimate eligibility determination, as discussed above.

The estimated cost of providing uncompensated care:

The estimated cost of providing uncompensated care, as reflected below, were based on a calculation which multiplied the percentage of operating expenses for our acute care hospitals to gross charges for those hospitals by the above-mentioned total uncompensated care amounts. The percentage of cost to gross charges is calculated based on the total operating expenses for our acute care facilities divided by gross patient service revenue for those facilities. An increase in the level of uninsured patients to our facilities and the resulting adverse trends in the provision for doubtful accounts and uncompensated care provided could have a material unfavorable impact on our future operating results.

	(amounts in thousands)		
	2014	2013	2012
Estimated cost of providing charity care	$ 78,475	$ 95,675	$131,890
Estimated cost of providing uninsured discounts related care	94,484	65,338	45,299
Estimated cost of providing uncompensated care	$172,959	$161,013	$177,189

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Year Ended December 31, 2013 as compared to the Year Ended December 31, 2012

Acute Care Hospitals-Same Facility Basis

The following table summarizes the results of operations for our acute care facilities on a same facility basis and is used in the discussions below for the years ended December 31, 2013 and 2012 (dollar amounts in thousands):

	Year Ended December 31, 2013		Year Ended December 31, 2012	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$4,581,280		$4,073,147	
Less: Provision for doubtful accounts	1,014,455		635,283	
Net revenues	3,566,825	100.0%	3,437,864	100.0%
Operating charges:				
Salaries, wages and benefits	1,614,276	45.3%	1,546,136	45.0%
Other operating expenses	781,812	21.9%	724,480	21.1%
Supplies expense	641,078	18.0%	624,950	18.2%
Depreciation and amortization	191,274	5.4%	188,243	5.5%
Lease and rental expense	57,384	1.6%	58,166	1.7%
Subtotal-operating expenses	3,285,824	92.1%	3,141,975	91.4%
Income from operations	281,001	7.9%	295,889	8.6%
Interest expense, net	4,501	0.1%	4,815	0.1%
Income before income taxes	276,500	7.8%	291,074	8.5%

On a same facility basis during 2013, as compared to 2012, net revenues at our acute care hospitals increased $129 million or 4%. Income before income taxes decreased $15 million or 5% to $277 million or 7.8% of net revenues during 2013 as compared to $291 million or 8.5% of net revenues during 2012.

Inpatient admissions to these facilities increased 0.2% during 2013, as compared to 2012, while patient days increased 1.4%. Adjusted admissions increased 1.0% and adjusted patient days increased 2.2% during 2013, as compared to 2012. The average length of inpatient stay at these facilities was 4.5 days during each of 2013 and 2012. The occupancy rate, based on the average available beds at these facilities, was 56% during each of 2013 and 2012. On a same facility basis, net revenue per adjusted admission at these facilities increased 2.7% during 2013, as compared to 2012, and net revenue per adjusted patient day increased 1.5% during 2013, as compared to 2012.

All Acute Care Hospitals

The following table summarizes the results of operations for all our acute care operations during 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).

	Year Ended December 31, 2013		Year Ended December 31, 2012	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$4,592,102		$4,096,699	
Less: Provision for doubtful accounts	1,015,733		635,283	
Net revenues	3,576,369	100.0%	3,461,416	100.0%
Operating charges:				
Salaries, wages and benefits	1,635,428	45.7%	1,560,468	45.1%
Other operating expenses	727,224	20.3%	704,108	20.3%
Supplies expense	643,169	18.0%	624,955	18.1%
Depreciation and amortization	227,368	6.4%	201,536	5.8%
Lease and rental expense	57,512	1.6%	58,187	1.7%
Electronic health records incentive income	(61,024)	-1.7%	(30,038)	-0.9%
Subtotal-operating expenses	3,229,677	90.3%	3,119,216	90.1%
Income from operations	346,692	9.7%	342,200	9.9%
Interest expense, net	4,501	0.1%	4,815	0.1%
Income before income taxes	342,191	9.6%	337,385	9.7%

During 2013, as compared to 2012, net revenues at our acute care hospitals increased $115 million or 3% to $3.58 billion due primarily to an increase in same facility revenues, as discussed above.

Income before income taxes increased $5 million to $342 million or 9.6% of net revenues during 2013 as compared to $337 million or 9.7% of net revenues during 2012.

Included in these results are the following:

- the $15 million decrease in income before income taxes experienced during 2013, as compared to 2012, at our acute care hospitals, on a same facility basis, as discussed above;
- a $40 million net increase resulting from reductions to our professional and general liability self-insurance reserves attributable to our acute care hospitals recorded during 2013 ($63 million) and 2012 ($23 million), as discussed above in *Professional and General Liability and Workers Compensation Liability*;
- a decrease of $33 million (net of related expenses) resulting from the pre-tax income recorded during 2012 related to an 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;
- a net aggregate increase of $11 million resulting from the following unfavorable items which were recorded during 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);
- a net increase of $16 million related to the incentive income ($61 million in 2013 and $30 million in 2012), net of related expenses ($43 million in 2013 and $28 million in 2012), recorded in connection with the implementation of EHR applications at our acute care hospitals, and;

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- a net other combined decrease of $14 million consisting primarily of the operating losses incurred at a Temecula Valley Hospital that was completed and opened in October of 2013.

Behavioral Health Care Services

Year Ended December 31, 2014 as compared to the Year Ended December 31, 2013

Behavioral Health Care Facilities-Same Facility Basis

The following table summarizes the results of operations for our behavioral health care facilities, on a same facility basis, and is used in the discussions below for the years ended December 31, 2014 and 2013 (dollar amounts in thousands):

	Year Ended December 31, 2014		Year Ended December 31, 2013	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$3,962,209		$3,764,435	
Less: Provision for doubtful accounts	107,498		111,308	
Net revenues	3,854,711	100.0%	3,653,127	100.0%
Operating charges:				
Salaries, wages and benefits	1,863,978	48.4%	1,785,006	48.9%
Other operating expenses	731,173	19.0%	669,587	18.3%
Supplies expense	178,810	4.6%	172,638	4.7%
Depreciation and amortization	109,479	2.8%	100,360	2.7%
Lease and rental expense	40,273	1.0%	38,182	1.0%
Subtotal-operating expenses	2,923,713	75.8%	2,765,773	75.7%
Income from operations	930,998	24.2%	887,354	24.3%
Interest expense, net	724	0.0%	2,079	0.1%
Income before income taxes	930,274	24.1%	885,275	24.2%

On a same facility basis during 2014, as compared to 2013, net revenues at our behavioral health care facilities increased $202 million or 6% to $3.85 billion during 2014 as compared to $3.65 billion during 2013. Income before income taxes increased $45 million or 5% to $930 million or 24.1% of net revenues during 2014 as compared to $885 million or 24.2% of net revenues during 2013.

Inpatient admissions and adjusted admissions to these facilities each increased 4.7% during 2014, as compared to 2013, while patient days and adjusted patient days each increased 1.7%. The average length of patient stay at these facilities was 12.7 days during 2014 and 13.1 days during 2013. The occupancy rate, based on the average available beds at these facilities, was 75% during each of 2014 and 2013. On a same facility basis, net revenue per adjusted admission at these facilities decreased 0.3% during 2014, as compared to 2013, and net revenue per adjusted patient day increased 2.7% during 2014, as compared to 2013.

All Behavioral Health Care Facilities

The following table summarizes the results of operations for all our behavioral health care facilities during 2014 and 2013 which includes our behavioral health results on a same facility basis, as well as the impact of the facilities acquired or opened within the previous twelve months and the impact of the other items as mentioned below (dollar amounts in thousands):

	Year Ended December 31, 2014		Year Ended December 31, 2013	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$4,054,437		$3,779,237	
Less: Provision for doubtful accounts	108,970		111,270	
Net revenues	3,945,467	100.0%	3,667,967	100.0%
Operating charges:				
Salaries, wages and benefits	1,917,927	48.6%	1,799,589	49.1%
Other operating expenses	742,145	18.8%	654,937	17.9%
Supplies expense	182,673	4.6%	173,932	4.7%
Depreciation and amortization	114,599	2.9%	102,469	2.8%
Lease and rental expense	42,138	1.1%	39,092	1.1%
Subtotal-operating expenses	2,999,482	76.0%	2,770,019	75.5%
Income from operations	945,985	24.0%	897,948	24.5%
Interest expense, net	1,917	0.0%	2,079	0.1%
Income before income taxes	944,068	23.9%	895,869	24.4%

During 2014, as compared to 2013, net revenues at our behavioral health care facilities increased 8% or $278 million to $3.95 billion during 2014 as compared to $3.67 billion during 2013. The increase in net revenues was attributable to:

- a $202 million or 6% increase in same facility revenues, as discussed above;
- a $65 million increase related to 2014 acquisitions including the following: (i) the 17 behavioral health facilities located in the United Kingdom acquired as part of our acquisition of Cygnet Health Care Limited, and; (ii) a 124-bed behavioral health care facility and outpatient treatment center located in Washington, D.C, and;
- $11 million of other combined increases.

Income before income taxes increased $48 million or 5% to $944 million or 23.9% of net revenues during 2014 as compared to $896 million or 24.4% of net revenues during 2013. The increase in income before income taxes at our behavioral health facilities was attributable to:

- a $45 million increase at our behavioral health facilities on a same facility basis, as discussed above;
- an $11 million increase related to the acquisition of the facilities from Cygnet Health Care Limited and the 124-bed behavioral health care facility and outpatient treatment center located in Washington, D.C.;
- a $9 million net decrease resulting from reductions to our professional and general liability self-insurance reserves applicable to our behavioral health facilities recorded during 2014 ($9 million) and 2013 ($18 million), as discussed above in *Professional and General Liability and Workers Compensation Liability*, and;
- a $1 million other combined net increase.

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Year Ended December 31, 2013 as compared to the Year Ended December 31, 2012

Behavioral Health Care Facilities-Same Facility Basis

The following table summarizes the results of operations for our behavioral health care facilities, on a same facility basis, and is used in the discussions below for the years ended December 31, 2013 and 2012 (dollar amounts in thousands):

	Year Ended December 31, 2013		Year Ended December 31, 2012	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$3,612,023		$3,488,872	
Less: Provision for doubtful accounts	104,069		90,574	
Net revenues	3,507,954	100.0%	3,398,298	100.0%
Operating charges:				
Salaries, wages and benefits	1,714,109	48.9%	1,685,266	49.6%
Other operating expenses	641,473	18.3%	601,442	17.7%
Supplies expense	165,675	4.7%	167,065	4.9%
Depreciation and amortization	96,934	2.8%	91,886	2.7%
Lease and rental expense	33,693	1.0%	32,507	1.0%
Subtotal-operating expenses	2,651,884	75.6%	2,578,166	75.9%
Income from operations	856,070	24.4%	820,132	24.1%
Interest expense, net	2,079	0.1%	1,816	0.1%
Income before income taxes	853,991	24.3%	818,316	24.1%

On a same facility basis during 2013, as compared to 2012, net revenues at our behavioral health care facilities increased $110 million or 3% to $3.51 billion during 2013 as compared to $3.40 billion during 2012. Income before income taxes increased $36 million or 4% to $854 million or 24.3% of net revenues during 2013 as compared to $818 million or 24.1% of net revenues during 2012.

Inpatient admissions to these facilities increased 3.2% during 2013, as compared to 2012, while patient days increased 0.7%. Adjusted admissions increased 3.5% and adjusted patient days increased 1.0% during 2013, as compared to 2012. The average length of patient stay at these facilities was 13.4 days during 2013 and 13.7 days during 2012. The occupancy rate, based on the average available beds at these facilities, was 75% during 2013 and 74% during 2012. On a same facility basis, net revenue per adjusted admission at these facilities decreased 0.3% during 2013, as compared to 2012, and net revenue per adjusted patient day increased 2.2% during 2013, as compared to 2012.

All Behavioral Health Care Facilities

The following table summarizes the results of operations for all our behavioral health care facilities for 2013 and 2012, including, for the period of January through October of 2013, the nine facilities acquired in October, 2012 from Ascend Health Corporation (the operating results for these facilities for November and December of 2013 and 2012 are included in the same facility results discussed above), as well as the impact of other items as mentioned below (dollar amounts in thousands):

	Year Ended December 31, 2013		Year Ended December 31, 2012	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$3,779,237		$3,551,511	
Less: Provision for doubtful accounts	111,270		91,370	
Net revenues	3,667,967	100.0%	3,460,141	100.0%
Operating charges:				
Salaries, wages and benefits	1,799,589	49.1%	1,717,751	49.6%
Other operating expenses	654,937	17.9%	603,700	17.4%
Supplies expense	173,932	4.7%	169,552	4.9%
Depreciation and amortization	102,469	2.8%	94,049	2.7%
Lease and rental expense	39,092	1.1%	34,569	1.0%
Subtotal-operating expenses	2,770,019	75.5%	2,619,621	75.7%
Income from operations	897,948	24.5%	840,520	24.3%
Interest expense, net	2,079	0.1%	1,917	0.1%
Income before income taxes	895,869	24.4%	838,603	24.2%

During 2013, as compared to 2012, net revenues at our behavioral health care facilities increased 6% or $208 million to $3.67 billion during 2013 as compared to $3.46 billion during 2012. The increase in net revenues was attributable to:

- a $110 million increase in same facility revenues, as discussed above;
- a $137 million increase related to the 9 facilities acquired from Ascend Health Corporation in October, 2012 (consisting of the net revenues generated at the facilities during January through October of 2013, offset by the net revenues generated at the facilities during the partial month of October, 2012);
- a $14 million decrease due to the revenues recorded during 2012 representing the 2011 portion of the net Medicaid supplemental reimbursements earned pursuant to the Oklahoma Supplemental Hospital Offset Payment Program as well as similar programs in Ohio and Indiana, and;
- $25 million of other combined decreases resulting primarily from the divestiture, closure or operational wind-down of certain non-strategic behavioral health facilities/schools.

Income before income taxes increased $57 million or 7% to $896 million or 24.4% of net revenues during 2013, as compared to $839 million or 24.2% of net revenues during 2012. The increase in income before income taxes at our behavioral health facilities was attributable to:

- a $36 million increase at our behavioral health facilities on a same facility basis, as discussed above;
- a $14 million decrease resulting from the revenues recorded during 2012 representing the 2011 portion of the net Medicaid supplemental reimbursements earned pursuant to the Oklahoma Supplemental Hospital Offset Payment Program as well as similar programs in Ohio and Indiana;

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- a $14 million net favorable increase resulting from reductions to our professional and general liability self-insurance reserves applicable to our behavioral health facilities recorded during 2013 ($18 million) and 2012 ($4 million), as discussed above in *Professional and General Liability and Workers Compensation Liability*, and;
- a $21 million of other combined net increases, including the income generated at the nine facilities acquired from Ascend Health Corporation in October, 2012.

Sources of Revenue

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

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

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

The following tables show the approximate percentages of net patient revenue during the past three years (excludes sources of revenues for all periods presented for divested facilities which are reflected as discontinued operations in our Consolidated Financial Statements) for: (i) our Acute Care and Behavioral Health Care Facilities Combined; (ii) our Acute Care Facilities, and; (iii) our Behavioral Health Care Facilities. Net patient revenue is defined as revenue from all sources after deducting contractual allowances and discounts from established billing rates, which we derived from various sources of payment for the years indicated.

Acute Care and Behavioral Health Care Facilities Combined	Percentage of Net Patient Revenues		
	2014	2013	2012
Third Party Payors:			
Medicare	21%	23%	24%
Medicaid	15%	15%	15%
Managed Care (HMO and PPOs)	50%	49%	49%
Other Sources	14%	13%	12%
Total	100%	100%	100%

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Acute Care Facilities	Percentage of Net Patient Revenues		
	2014	2013	2012
Third Party Payors:			
Medicare	24%	27%	28%
Medicaid	8%	8%	7%
Managed Care (HMO and PPOs)	61%	59%	58%
Other Sources	7%	6%	7%
Total	100%	100%	100%

Behavioral Health Care Facilities	Percentage of Net Patient Revenues		
	2014	2013	2012
Third Party Payors:			
Medicare	18%	19%	19%
Medicaid	22%	22%	23%
Managed Care (HMO and PPOs)	39%	40%	40%
Other Sources	21%	19%	18%
Total	100%	100%	100%

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

Under the Medicare program, for inpatient services, our general acute care hospitals receive reimbursement under the inpatient prospective payment system ("IPPS"). Under the IPPS, hospitals are paid a predetermined fixed payment amount for each hospital discharge. The fixed payment amount is based upon each patient's Medicare severity diagnosis related group ("MS-DRG"). Every MS-DRG is assigned a payment rate based upon the estimated intensity of hospital resources necessary to treat the average patient with that particular diagnosis. The MS-DRG payment rates are based upon historical national average costs and do not consider the actual costs incurred by a hospital in providing care. This MS-DRG assignment also affects the predetermined capital rate paid with each MS-DRG. The MS-DRG and capital payment rates are adjusted annually by the predetermined geographic adjustment factor for the geographic region in which a particular hospital is located and are weighted based upon a statistically normal distribution of severity. While we generally will not receive payment from Medicare for inpatient services, other than the MS-DRG payment, a 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, 2014, CMS published its IPPS 2015 payment rule which provides for a 2.9% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments and Health Care Reform mandated adjustments are considered, without consideration for the decreases related to the required Medicare Disproportionate Share Hospital ("DSH") payment changes and increase to the Medicare Outlier threshold, the

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overall increase in IPPS payments would approximate 0.6%. Including the estimated decrease to our DSH payments (–1.9%) and Medicare Outlier threshold (–0.6%), we estimate our overall decrease from the IPPS 2015 rule (covering the period of October 1, 2014 through September 30, 2015) will approximate (–1.9%), or approximately $13 million annually. This projected impact from the IPPS 2015 rule includes both the impact of the American Taxpayer Relief Act of 2012 documentation and coding adjustment and the required changes to the DSH payments related to the traditional Medicare fee for service, however, it excludes the impact of the sequestration reductions related to the Budget Control Act of 2011, as discussed below.

In August, 2013, CMS published its final IPPS 2014 payment rule which 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) approximated 1.0%. This projected impact from the IPPS 2014 final rule includes both the impact of the ATRA of 2012 documentation and coding adjustment and the required changes to the 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. The final rule also expands CMS's policy under which it defines inpatient admissions to include the use of an objective time of care standard. Specifically, it would require Medicare's external review contractors to presume that hospital inpatient admissions are reasonable and necessary when beneficiaries receive a physician order for admission and receive medically necessary services for at least two midnights (the "Two Midnight" rule). Correspondingly, under the final rule, CMS presumes that hospital services spanning less than two midnights should have been provided on an outpatient basis and paid under Medicare Part B unless the medical record contains clear documentation supporting the physician's order and an expectation that the Medicare beneficiary would need medically necessary care for more than two midnights, or is receiving services which CMS designates as inpatient only. Our acute care hospitals have begun to comply with the Two Midnight rule and, although we are unable to determine the ultimate impact at this time, its application could have a material unfavorable impact on our future results of operations. Excluding the potential impact of the Two Midnight rule, we do not expect the final IPPS 2014 payment rule to have a material impact on our future results of operations. In February, 2014, CMS extended by an additional six months a policy under which Recovery Auditor Contractors and other Medicare review contractors will not conduct post-payment patient status reviews of inpatient hospital claims with dates of admission on or after October 1, 2013 through September 30, 2014. Due to the continued delay in awarding contracts to new Recovery Audit Contractors, beginning in August, 2014, CMS initiated modifications to the current Recovery Auditor Contractor agreements to allow the restart of some reviews.

In August, 2012, 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) approximated 1.8%. The 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, 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 $35 million annual reduction to our Medicare net revenues effective as of April 1, 2013) with a uniform percentage reduction across all Medicare programs.

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On January 2, 2013 ATRA was enacted which, among other things, includes a requirement for CMS to recoup $11 billion from hospitals from Medicare IPPS rates during federal fiscal years 2014 to 2017. The recoupment relates to IPPS documentation and coding adjustments for the period 2008 to 2013 for which adjustments were not previously applied by CMS. Both the 2014 and 2015 IPPS final rules include a -0.8% recoupment adjustment. CMS expects to make similar adjustments in federal fiscal years 2016 and 2017 in order to recover the entire $11 billion. This adjustment is reflected in the 2014 and 2015 IPPS estimated impact amounts noted above.

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

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

In October, 2014, CMS published its Medicare Outpatient Prospective Payment System ("OPPS") final rule for 2015. The proposed hospital market basket increase is 2.9%. The Medicare statute requires a productivity adjustment reduction of 0.5% and 0.2% reduction to the 2015 OPPS market basket resulting in a 2015 OPPS market basket update at 2.2%. In the final rule, CMS will reduce the 2015 Medicare rates for both hospital-based and community mental health center partial hospitalization programs. When other statutorily required adjustments, hospital patient service mix and the aforementioned partial hospitalization rates are considered, we estimate that our overall Medicare OPPS for 2015 will aggregate to a net increase of 0.2%. Excluding the behavioral health division partial hospitalization rate impact, our Medicare OPPS payment increase for 2015 is estimated to be 1.5%.

In December, 2013, CMS published its annual final OPPS rule for 2014. The final hospital market basket increase is 2.5%. The Medicare statute requires a productivity adjustment reduction of 0.5% and 0.3% reduction to the 2014 OPPS market basket reducing the final 2014 OPPS market basket update to 1.7%. In the final rule, CMS reduced 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 increase of 1.4%. Excluding the behavioral health partial hospitalization rate impact, our Medicare OPPS payment increase for 2014 is estimated to be 2.5%.

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 was 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 implemented 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

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patient service mix and the aforementioned partial hospitalization rates are considered, the 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 was approximately 1.7%.

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

We receive Medicaid revenues in excess of $90 million annually from each of Texas, Washington, D.C., Pennsylvania, California, Illinois, Nevada, Virginia and Florida, making us particularly sensitive to reductions in Medicaid and other state based revenue programs as well as regulatory, economic, environmental and competitive changes in those states. Based upon the state budgets for those states for the 2015 fiscal year (which generally began at various times during the second half of 2014), we estimate that, on a blended basis, our aggregate Medicaid rates were relatively unchanged from the 2014 fiscal year rates.

The Affordable Care Act substantially increases the federally and state-funded Medicaid insurance program, and authorizes states to establish federally subsidized non-Medicaid health plans for low-income residents not eligible for Medicaid starting in 2014. However, the Supreme Court has struck down portions of the Affordable Care Act requiring states to expand their Medicaid programs in exchange for increased federal funding. Accordingly, there can be no assurance that states in which we operate will expand Medicaid coverage to individuals at 133% of the federal poverty level. Facilities in states not opting to expand Medicaid coverage under the Affordable Care Act may be additionally penalized by corresponding reductions to Medicaid disproportionate share hospital payments, as discussed below. We can provide no assurance that further reductions to Medicaid revenues, particularly in the above-mentioned states, will not have a material adverse effect on our future results of operations.

Texas Uncompensated Care/Upper Payment Limit Payments:

Certain of our acute care hospitals located in various counties of Texas (Hidalgo, Maverick, Potter and Webb) participate in Medicaid supplemental payment Section 1115 Waiver indigent care programs. Section 1115 Waiver Uncompensated Care ("UC") payments replace the former Upper Payment Limit ("UPL") payments. These hospitals also have affiliation agreements with third-party hospitals to provide free hospital and physician care to qualifying indigent residents of these counties. Our hospitals receive both supplemental payments from the Medicaid program and indigent care payments from third-party, affiliated hospitals. The supplemental payments are contingent on the county or hospital district making an Inter-Governmental Transfer ("IGT") to the state Medicaid program while the indigent care payment is contingent on a transfer of funds from the applicable affiliated hospitals. However, the county or hospital district is prohibited from entering into an agreement to condition any IGT on the amount of any private hospital's indigent care obligation. We recorded net revenues/ benefit from UPL and affiliated hospital indigent care revenues of $68 million during 2014, $61 million during 2013 and $25 million during 2012, net of provider taxes (of $17 million in 2014, $10 million in 2013 and $0 in 2012). If the applicable hospital district or county makes IGTs consistent with 2014 levels, and without giving effect to potential reductions resulting from the February, 2015, THHSC proposed rule, which is discussed below, we believe we would be entitled to aggregate net revenues/benefit earned pursuant to these programs of approximately $58 million during 2015, net of provider taxes (of $11 million). On February 6, 2015, THHSC published a proposed rule that would shift $136 million in funding from the private hospital UC pool to the large public hospital UC pool for the 2014 UC program year only. THHSC has not provided an estimated impact from this proposed shift due to the fact that certain UC data elements are not yet available. As such, we are unable to estimate the impact of this proposed rule change.

On September 30, 2014, CMS notified the Texas Health and Human Services Commission that it was deferring the federal matching funds (approximately $75 million) on Texas Medicaid UC payments made to providers in certain counties. A deferral results in CMS withholding funds from the state representing the federal portion of Medicaid payments the state has previously made to providers. A deferral goes into effect when CMS questions the basis for all or part of the amount of Medicaid payments made to certain providers, and remains in place subject to CMS's final determination. Our Texas hospitals are not located in the geographic areas impacted by this deferral. On January 7, 2015, CMS removed the aforementioned deferral but indicated they will continue their review and assessment of the underlying UC financing arrangements as to ensure their compliance with the applicable federal regulations and eligibility for federal matching dollars.

For state fiscal year 2015, 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, UC payments and Delivery System Reform Incentive Payments ("DSRIP"). During the first year of transition, which commenced on October 1, 2011, THHSC made payments to Medicaid UPL recipient providers that received payments during the state's prior fiscal year. During demonstration years two through five (October 1, 2012 through September 30, 2016), THHSC has, and will continue to, make incentive payments under the program after certain qualifying criteria are met by hospitals. Supplemental payments are also subject to an aggregate statewide caps based on CMS approved Medicaid waiver amounts.

Texas Delivery System Reform Incentive Payments:

In addition, the Texas Medicaid Section 1115 Waiver includes a DSRIP pool to incentivize hospitals and other providers to transform their service delivery practices to improve quality, health status, patient experience, coordination, and cost-effectiveness. DSRIP pool payments are incentive payments to hospitals and other providers that develop programs or strategies to enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. In May, 2014, CMS formally approved specific DSRIP projects for certain of our hospitals for demonstration years 3 to 5 (our facilities did not materially participate in the DSRIP pool during demonstration years 1 or 2). DSRIP payments are contingent on the hospital meeting certain pre-determined milestones, metrics and clinical outcomes. Additionally, DSRIP payments are contingent on a governmental entity providing an IGT for the non-federal share component of the DSRIP payment. THHSC generally approves DSRIP reported metrics, milestones and clinical outcomes on a semi-annual basis in June and December. In connection with the DSRIP program and THHSC's approval for specific programs at certain of our hospitals and availability of a governmental IGT, we recorded approximately $17 million of net revenues/benefit during 2014 applicable to the period of October 1, 2013 through September 30, 2014, net of provider taxes (of $8 million). Although we can provide no assurance that we will ultimately qualify for additional DSRIP revenues, subject to CMS's approval and other conditions as outlined above, we estimate that we may be entitled to additional DSRIP net revenues/benefit of approximately $25 million during 2015, net of provider taxes (of $15 million).

Texas and South Carolina Medicaid Disproportionate Share Hospital Payments:

Hospitals that have an unusually large number of low-income patients (i.e., those with a Medicaid utilization rate of at least one standard deviation above the mean Medicaid utilization, or having a low income patient utilization rate exceeding 25%) are eligible to receive a 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 2014 DSH fiscal year (covering the period of October 1, 2013 through September 30,

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2014). In September, 2013, the THHSC published its 2013 final DSH rule that included changes that resulted in approximately $9 million of additional reimbursements to our acute care facilities located in Texas applicable to the state's 2013 fiscal year (which were included in our 2013 pre-tax consolidated financial results). In connection with these DSH programs, included in our financial results was an aggregate of $49 million during 2014, $54 million during 2013 and $47 million during 2012. Assuming that the Texas and South Carolina programs are renewed for each state's 2015 and 2016 fiscal years, at amounts similar to the 2014 fiscal year estimates, we estimate our aggregate reimbursements pursuant to these programs to be approximately $49 million during 2015.

The Affordable Care Act provides for a significant reduction in Medicaid disproportionate share payments beginning in federal fiscal year 2016 (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 September, 2013 CMS final rule, our Medicaid DSH payments in Texas and South Carolina could be reduced by approximately 4% in the 2016 federal fiscal year. This statutorily required reduction was originally scheduled to be implemented in federal fiscal year 2014 but was delayed to FFY 2017 by subsequent federal legislation.

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 ("Rider 86") passed in May, 2013 authorized $160 million for 2014 and $140 million for 2015, respectively, for the non-federal DSH share. Furthermore, in June, 2014, THHSC proposed certain changes to DSH reimbursement methodology as a result of Rider 86. We expect the 2015 DSH year amounts, to be comparable to the 2014 DSH year amounts.

Various Other State Medicaid Supplemental Payment Programs:

We incur health-care related taxes ("Provider Taxes") imposed by states in the form of a licensing fee, assessment or other mandatory payment which are related to: (i) healthcare items or services; (ii) the provision of, or the authority to provide, the health care items 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 funds as part of their respective state Medicaid programs. We derive a related Medicaid reimbursement benefit from assessed Provider Taxes in the form of Medicaid claims based payment increases and/or lump sum Medicaid supplemental payments. Including the impact of the programs in various states applicable to each year, and excluding the impact of various programs in Texas, as discussed above, and the Nevada SPA, as discussed below, we earned an aggregate net revenues/benefit from Medicaid supplemental payments of approximately $71 million during 2014, $69 million during 2013 and $58 million during 2012 (of which $12 million related to 2011), net of Provider Taxes (of $112 million in 2014, $74 million in 2013 and $93 million in 2012). We estimate that our aggregate net revenues/ benefit from Provider Tax programs will approximate $70 million during 2015, net of Provider Taxes (of $111 million). These amounts include the impact of the CMS approved California provider tax and related Medicaid supplemental payment programs, which did not have a material impact on our operating results. The aggregate net benefit is earned from multiple states and therefore no particular state's portion is individually material to our consolidated financial statements. However, Provider Taxes are governed by both federal and state laws and are subject to future legislative changes that, if reduced from current rates in several states, could have a material adverse impact on our consolidated future results of operations.

In Nevada, CMS approved a state plan amendment ("SPA") in August, 2014 that implemented a hospital supplemental payment program retroactive to January 1, 2014 and effective to June 30, 2015. Included in our 2014 results of operations was approximately $10 million of net revenues earned in connection with this program. We estimate that our reimbursements pursuant to this program will approximate $7 million during 2015.

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As outlined above, we receive substantial reimbursement from multiple states in connection with various supplemental Medicaid payment programs. Failure to renew these programs beyond their scheduled termination dates, failure of the public hospitals to provide the necessary IGTs for the states' share of the DSH programs, failure of our hospitals that currently receive supplemental Medicaid revenues to qualify for future funds under these programs, or reductions in reimbursements, could have a material adverse effect on our future results of operations.

HITECH Act: In July 2010, the Department of Health and Human Services ("HHS") published final regulations implementing the health information technology ("HIT") provisions of the American Recovery and Reinvestment Act (referred to as the "HITECH Act"). The final regulation defines the "meaningful use" of Electronic Health Records ("EHR") and establishes the requirements for the Medicare and Medicaid EHR payment incentive programs. The final rule established an initial set of standards and certification criteria. The implementation period for these new Medicare and Medicaid incentive payments started in federal fiscal year 2011 and can end as late as 2016 for Medicare and 2021 for the state Medicaid programs. State Medicaid program participation in this federally funded incentive program is voluntary but all of the states in which our eligible hospitals operate have chosen to participate. Our acute care hospitals may qualify for these EHR incentive payments upon implementation of the EHR application assuming they meet the "meaningful use" criteria. The government's ultimate goal is to promote more effective (quality) and efficient healthcare delivery through the use of technology to reduce the total cost of healthcare for all Americans and utilizing the cost savings to expand access to the healthcare system.

Pursuant to HITECH Act regulations, hospitals that do not qualify as a meaningful user of EHR by 2015 are subject to a reduced market basket update to the IPPS standardized amount in 2015 and each subsequent fiscal year. We believe that all of our acute care hospitals have met the applicable meaningful use criteria and therefore are not subject to a reduced market basked update to the IPPS standardized amount in federal fiscal year 2015. However, under the HITECH Act, hospitals must continue to meet the applicable meaningful use criteria in each fiscal year or they will be subject to a market basket update reduction in a subsequent fiscal year. Failure of our acute care hospitals to continue to meet the applicable meaningful use criteria would have an adverse effect on our future net revenues and results of operations.

Our 2014 consolidated results of operations includes an unfavorable pre-tax impact of approximately $8 million consisting of approximately $28 million of EHR incentive income less approximately $37 million of depreciation and amortization expense, plus approximately $1 million of net expense attributable to noncontrolling interests. Our 2013 consolidated results of operations includes a favorable pre-tax impact of approximately $19 million consisting of approximately $61 million of EHR incentive income less approximately $10 million of salaries, wages, benefits and other operating expenses, approximately $33 million of depreciation and amortization expense, plus approximately $1 million of net expense attributable to noncontrolling interests. Our 2012 consolidated results of operations includes a favorable pre-tax impact of approximately $3 million consisting of approximately $30 million of EHR incentive income less approximately $15 million of salaries, wages, benefits and other operating expenses, approximately $13 million of depreciation and amortization expense, plus approximately $1 million of net expense attributable to noncontrolling interests.

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

Managed Care: A significant portion of our net patient revenues are generated from managed care companies, which include health maintenance organizations, preferred provider organizations and managed Medicare (referred to as Medicare Part C or Medicare Advantage) and Medicaid programs. In general, we expect the percentage of our business from managed care programs to continue to grow. The consequent growth in

managed care networks and the resulting impact of these networks on the operating results of our facilities vary among the markets in which we operate. Typically, we receive lower payments per patient from managed care payors than we do from traditional indemnity insurers, however, during the past few years we have secured price increases from many of our commercial payors including managed care companies.

Commercial Insurance: Our hospitals also provide services to individuals covered by private health care insurance. Private insurance carriers typically make direct payments to hospitals or, in some cases, reimburse their policy holders, based upon the particular hospital's established charges and the particular coverage provided in the insurance policy. Private insurance reimbursement varies among payors and states and is generally based on contracts negotiated between the hospital and the payor.

Commercial insurers are continuing efforts to limit the payments for hospital services by adopting discounted payment mechanisms, including predetermined payment or DRG-based payment systems, for more inpatient and outpatient services. To the extent that such efforts are successful and reduce the insurers' reimbursement to hospitals and the costs of providing services to their beneficiaries, such reduced levels of reimbursement may have a negative impact on the operating results of our hospitals.

Other Sources: Our hospitals provide services to individuals that do not have any form of health care coverage. Such patients are evaluated, at the time of service or shortly thereafter, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other state assistance programs, as well as our local hospitals' indigent and charity care policy. Patients without health care coverage who do not qualify for Medicaid or indigent care write-offs are offered substantial discounts in an effort to settle their outstanding account balances.

Sources of Revenues and Health Care Reform: Given increasing budget deficits, the federal government and many states are currently considering additional ways to limit increases in levels of Medicare and Medicaid funding, which could also adversely affect future payments received by our hospitals. In addition, the uncertainty and fiscal pressures placed upon the federal government as a result of, among other things, 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. Medicare, Medicaid and other health care industry changes which are scheduled to be implemented at various times during this decade are noted below.

Implemented Medicare Reductions and Reforms:

- The Reconciliation Act reduced the market basket update for inpatient and outpatient hospitals and inpatient behavioral health facilities by 0.25% in each of 2010 and 2011, by 0.10% in each of 2012 and 2013 and 0.30% in 2014.
- The Affordable Care Act implemented certain reforms to Medicare Advantage payments, effective in 2011.
- A Medicare shared savings program, effective in 2012.
- A hospital readmissions reduction program, effective in 2012.
- A value-based purchasing program for hospitals, effective in 2012.
- A national pilot program on payment bundling, effective in 2013.
- Reduction to Medicare disproportionate share hospital ("DSH") payments, effective in 2014, as discussed above.

Medicaid Revisions:

- Expanded Medicaid eligibility and related special federal payments, effective in 2014.
- The Affordable Care Act (as amended by subsequent federal legislation) requires annual aggregate reductions in federal DSH funding from federal fiscal year ("FFY") 2017 through FFY 2024. The aggregate annual reduction amounts are:

  $1.8 billion for FFY 2017

  $4.7 billion for FFY 2018

  $4.7 billion for FFY 2019

  $4.7 billion for FFY 2020

  $4.8 billion for FFY 2021

  $5.0 billion for FFY 2022

  $5.0 billion for FFY 2023

  $4.4 billion for FFY 2024

Health Insurance Revisions:

- Large employer insurance reforms, effective in 2015.
- Individual insurance mandate and related federal subsidies, effective in 2014.
- Federally mandated insurance coverage reforms, effective in 2010 and forward.

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

Value-Based Purchasing:

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

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

The Affordable Care Act also required HHS to implement a value-based purchasing program for inpatient hospital services which became effective on October 1, 2012. The Affordable Care Act requires HHS to reduce inpatient hospital payments for all discharges by a percentage beginning at 1% in FFY 2013 and increasing by

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0.25% each fiscal year up to 2% in FFY 2017 and subsequent years. HHS will pool the amounts 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 2015 IPPS final rule, CMS will fund the value-based purchasing program by reducing base operating DRG payment amounts to participating hospitals by 1.5%.

Readmission Reduction Program:

In the Affordable Care Act, Congress also mandated implementation of the hospital readmission reduction program ("HRRP"). The HRRP assesses penalties on hospitals having excess readmission rates when compared to expected rates, effective for discharges beginning October 1, 2012. In the fiscal year 2013 IPPS final rule, CMS finalized certain policies with regard to payment under the HRRP, including which hospitals are subject to the HRRP, the methodology to calculate the hospital readmission payment adjustment factor, and what portion of the IPPS payment is used to calculate the readmission adjustment factor. In the fiscal year 2014 IPPS final rule, CMS finalized revisions to the three 30-day admission measures in the program—heart failure, myocardial infarction, and pneumonia—to exclude planned readmissions. Under the Affordable Care Act, beginning in fiscal year 2015, the maximum reduction in payments under the HRRP will increase from 2% to 3%. CMS will expand the program and add two readmission measures, one, acute exacerbation of chronic obstructive pulmonary disease (COPD) and, two, patients admitted for elective total hip arthroplasty (THA) and total knee arthroplasty (TKA). In the fiscal year 2015 IPPS final rule, CMS added readmissions for coronary artery bypass graft (CABG) surgical procedures beginning in fiscal year 2017. We do not believe impact of HRRP for federal fiscal year 2014 had or 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

Combined net revenues and income/losses before income taxes from our surgical hospitals, ambulatory surgery centers and radiation oncology centers did not have a material impact on our consolidated results of operations during 2014, 2013 or 2012.

Interest Expense

Below is a schedule of our interest expense during 2014, 2013 and 2012 (amounts in thousands):

	2014	2013	2012
Revolving credit & demand notes (a.)	$ 2,984	$ 3,463	$ 5,766
$400 million, 7.125% Senior Notes due 2016	28,496	28,496	28,496
$250 million, 7.00% Senior Notes due 2018 (a.)	10,208	17,500	17,500
$300 million, 3.75% Senior Notes due 2019 (a.)	4,500	—	—
$300 million, 3.75% Senior Notes due 2022 (a.)	5,700	—	—
Term loan facility A/new (a.)	12,507	—	—
Term loan facility A/original (a.)	9,769	18,994	22,298
Term loan facility A2 (a.) (b.)	8,747	16,625	5,204
Term loan facility B/B1 (a.) (b.) (c.)	8,009	21,569	48,208
Accounts receivable securitization program (a.)	2,446	2,548	2,662
Subtotal-revolving credit, demand notes, senior notes, term loan facilities and accounts receivable securitization program	93,366	109,195	130,134
Interest rate swap expense, net	19,063	19,183	20,628
Amortization of financing fees	15,400	21,783	27,107
Other combined interest expense	6,346	6,645	6,800
Capitalized interest on major projects	—	(4,921)	(5,666)
Interest income	(537)	(5,754)	(85)
Interest expense, net	$133,638	$146,131	$178,918

(a.) As discussed below in *Capital Resources-Credit Facilities and Outstanding Debt Securities*, during the third quarter of 2014, we completed the following financing transactions:

- On August 7, 2014, we entered into a Fourth Amendment to our credit agreement dated as of November 15, 2010, as amended on March 15, 2011, September 21, 2012 and May 16, 2013, among UHS, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders ("Credit Agreement"). The Credit Agreement, as amended, which is scheduled to mature in August, 2019, consists of: (i) an $800 million revolving credit facility, and; (ii) a $1.775 billion term loan A facility which combined our previously outstanding term loan A and term loan A2 facilities (which were scheduled to mature in 2016);
- Repaid $550 million of outstanding borrowings pursuant to our previously outstanding term loan B facility which was scheduled to mature in 2016;
- Increased the borrowing capacity on our existing $275 million accounts receivable securitization program ("Securitization") to $360 million effective August 1, 2014. The Securitization, the terms of which remain the same as the previous agreement, is scheduled to mature in October, 2016;
- Issued $300 million aggregate principal amount of 3.750% senior secured notes due in 2019;
- Issued $300 million aggregate principal amount of 4.750% senior secured notes due in 2022, and;
- Redeemed our previously outstanding $250 million, 7.00% senior unsecured notes due in 2018 on July 31, 2014 for an aggregate price equal to 104.56% of the principal amount (resulting in payment of an $11 million make-whole premium).

As discussed below in *Costs Related to Early Extinguishment of Debt*, in connection with these financing transactions, our 2014 results of operations included a $36 million pre-tax charge incurred for the costs related to the extinguishment of debt.

(b.) In September, 2012, we completed a second amendment to our credit agreement dated November, 15, 2010, as amended. The second amendment provided for a $900 million term loan A2, which was

subsequently combined into our new term loan A facility during the third quarter of 2014, as discussed above. In September, 2012, we used $700 million of the term loan A2 proceeds to repay our then outstanding, higher priced term loan B facility. The remainder of the term loan A2 proceeds was used to pay transaction-related fees and expenses and to repay other floating rate debt.

(c.) In May, 2013 we completed a third amendment to our credit agreement dated November 15, 2010, as amended. The third amendment provided for a reduction in the interest rates payable in connection with certain borrowings outstanding at that time under the credit agreement. Specifically, we replaced our then outstanding $745.9 million senior secured term loan B with a new senior secured term loan B1 in the same amount on substantially the same terms as the term loan B, other than lower interest rates.

Interest expense decreased $12 million during 2014 to $134 million as compared to $146 million during 2013. The decrease was due primarily to: (i) a $16 million decrease in aggregate interest expense on our revolving credit, demand notes, senior notes, term loan facilities and accounts receivable securitization program due primarily to a decrease in our average outstanding borrowings as well as a decrease in our aggregate average cost of borrowings pursuant to these facilities, as discussed below; (ii) a $6 million decrease in amortization and financing fees, resulting primarily from the write-off of certain deferred financing costs and original issue discounts in connection with the financing transactions during the third quarter of 2014, as discussed above, partially offset by; (iii) $5 million of capitalized interest recorded on major projects during 2013, and; (iv) a $5 million decrease in interest income, primarily related to the interest income received from Illinois during 2013 related to delayed cash remittances to us.

The aggregate average outstanding borrowings under our revolving credit, demand notes, senior notes, term loan facilities and accounts receivable securitization program were approximately $3.2 billion during 2014 and approximately $3.5 billion during 2013. The average effective interest rate on these facilities, excluding the amortization of deferred financing costs and original issue discounts and designated interest rate swap expense was 2.9% during 2014 and 3.1% during 2013. The average effective interest rate on these facilities, including amortization of deferred financing costs and original issue discounts and designated interest rate swap expense was 3.9% during 2014 and 4.2% during 2013.

Interest expense decreased $33 million during 2013 to $146 million as compared to $179 million during 2012. The decrease was due primarily to: (i) a $21 million decrease in aggregate interest expense on our revolving credit, demand notes, senior notes, term loan facilities and accounts receivable securitization program due primarily to a decrease in our aggregate average cost of borrowings pursuant to these facilities, as discussed below; (ii) a $5 million decrease in the amortization of financing fees, and; (iii) other combined net decrease of $7 million consisting primarily of interest earned by us on delayed cash remittances paid to us from Illinois.

The aggregate average outstanding borrowings under our revolving credit, demand notes, senior notes, term loan facilities and accounts receivable securitization program were approximately $3.5 billion during each of 2013 and 2012. The average effective interest rate on these facilities, excluding the amortization of deferred financing costs and original issue discounts and designated interest rate swap expense was 3.1% during 2013 and 3.7% during 2012. The average effective interest rate on these facilities, including amortization of deferred financing costs and original issue discounts and designated interest rate swap expense was 4.2% during 2013 and 4.9% during 2012.

Costs Related to Early Extinguishment of Debt

As discussed above, in connection with various financing transactions completed during 2014, as discussed below in *Capital Resources-Credit Facilities and Outstanding Debt Securities,* our 2014 results of operations include a $36 million pre-tax charge incurred for the costs related to the extinguishment of debt. This charge consisted of the write-off of deferred charges ($20 million) and original issue discount on the extinguished debt ($5 million) as well as the make-whole premium paid ($11 million) on the early redemption of the $250 million, 7.00% senior unsecured notes. During 2012, in connection with the extinguishment of a portion of our previously

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outstanding 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. There were no costs related to early extinguishment of debt incurred during 2013.

Transaction Costs

There were no material transaction fees incurred in 2014 or 2013. During 2012, we incurred approximately $6 million of transaction costs in connection with our acquisition of 9 behavioral health facilities acquired from Ascend Health Corporation in October, 2012. These costs consisted primarily of legal, investment banking and consulting fees.

Provision for Income Taxes and Effective Tax Rates

The effective tax rates, as calculated by dividing the provision for income taxes by income before income taxes, were as follows for each of the years ended December 31, 2014, 2013 and 2012 (dollar amounts in thousands):

	2014	2013	2012
Provision for income taxes	$324,671	$315,309	$274,616
Income before income taxes	929,667	869,332	763,663
Effective tax rate	34.9%	36.3%	36.0%

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

The effective tax rates, as calculated by dividing the provision for income taxes by the difference in income before income taxes, minus net income attributable to noncontrolling interests, were as follows for each of the years ended December 31, 2014, 2013 and 2012 (dollar amounts in thousands):

	2014	2013	2012
Provision for income taxes	$324,671	$315,309	$274,616
Income before income taxes	929,667	869,332	763,663
Less: Net income attributable to noncontrolling interests	(59,653)	(43,290)	(45,601)
Income before income taxes and after net income attributable to noncontrolling interests	870,014	826,042	718,062
Effective tax rate	37.3%	38.2%	38.2%

The impact of the discrete tax items did not have a material impact on our provision for income taxes during 2014, 2013 or 2012. The decrease in the effective tax rate during 2014, as compared to 2013 and 2012, was due primarily to: (i) a decrease in our blended effective state income tax rate during 2014; (ii) the income tax

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provision recorded during 2013 on the sale of Peak Behavioral Health Services which was divested in May, 2013 (the tax basis gain realized on the sale of Peak Behavioral Health Services exceeded the gain recorded pursuant to generally accepted accounting principles), and; (iii) a decrease to our federal income tax provision relating to 2013 that was recorded during 2014.

We consider the undistributed earnings of certain of our foreign subsidiaries as of December 31, 2014, to be indefinitely reinvested and, accordingly, no U.S. income taxes have been provided thereon. As of December 31, 2014, the amount of cash associated with indefinitely reinvested foreign earnings was approximately $12 million.

Discontinued Operations

There were no material divestitures during 2014.

In connection with the receipt of antitrust clearance from the Federal Trade Commission ("FTC") in connection with our acquisition of Ascend Health Corporation in October of 2012, we agreed to certain conditions, including the divestiture of Peak Behavioral Health Services ("Peak"), a 104-bed behavioral health care facility located in Santa Teresa, New Mexico. The divestiture of Peak was completed during the second quarter of 2013 for total cash proceeds of approximately $24 million resulting in a pre-tax gain of approximately $3 million which is included in our 2013 consolidated financial statements.

In October of 2012, we completed the divestiture of Auburn Regional Medical Center ("Auburn"), a 159-bed acute care hospital located in Auburn, Washington, for total cash proceeds of approximately $93 million. This divestiture resulted in a pre-tax gain of $26 million which was included in our 2012 consolidated financial statements.

In connection with the receipt of antitrust clearance from the FTC in connection with our acquisition of PSI in November, 2010, we agreed to divest three former PSI facilities (which were divested during 2011) as well as one of our legacy behavioral health facilities in Puerto Rico, which we divested in 2012.

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

	2013	2012
Net revenues	$ 7,813	$95,226
Income (loss) from discontinued operations, before income taxes	932	(3,472)
Gain on divestiture	3,080	26,419
Income from discontinued operations, before income tax expense	4,012	22,947
Income tax expense	(1,506)	(8,688)
Income from discontinued operations, net of income taxes	$ 2,506	$14,259

Effects of Inflation and Seasonality

Seasonality—Our acute care services business is typically seasonal, with higher patient volumes and net patient service revenue in the first and fourth quarters of the year. This seasonality occurs because, generally, more people become ill during the winter months, which results in significant increases in the number of patients treated in our hospitals during those months.

Inflation—Inflation has not had a material impact on our results of operations over the last three years. However, since the healthcare industry is very labor intensive and salaries and benefits are subject to inflationary

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pressures, as are supply and other costs, we cannot predict the impact that future economic conditions may have on our ability to contain future expense increases. Our ability to pass on increased costs associated with providing healthcare to Medicare and Medicaid patients is limited due to various federal, state and local laws which have been enacted that, in certain cases, limit our ability to increase prices. We believe, however, that through adherence to cost containment policies, labor management and reasonable price increases, the effects of inflation on future operating margins should be manageable.

Liquidity

Year ended December 31, 2014 as compared to December 31, 2013:

Net cash provided by operating activities

Net cash provided by operating activities was $1.04 billion during 2014 as compared to $884 million during 2013. The net increase of $152 million was primarily attributable to the following:

- a favorable change of $108 million due to an increase in net income plus/minus depreciation and amortization expense, stock-based compensation expense, net gains on sales of assets and businesses, and write-off of deferred financing costs related to extinguishment of debt;
- a $56 million unfavorable change in accounts receivable;
- a $48 million favorable change in other working capital accounts due primarily to an increase in accrued compensation and accounts payable;
- a favorable change of $64 million in accrued insurance expense, net of commercial premiums paid, due primarily to an $81 million reduction recorded during 2013, as compared to $20 million during 2014, to our professional and general liability self-insurance reserves, based upon reserve analyses, and;
- $12 million of other combined net unfavorable changes.

Days sales outstanding ("DSO"): Our DSO are calculated by dividing our net revenue by the number of days in the year. The result is divided into the accounts receivable balance the end of the year. Our DSO were 58 days at December 31, 2014 and 56 days at each of December 31, 2013 and 2012.

Net cash used in investing activities

Net cash used in investing activities was $833 million during 2014 and $383 million during 2013.

2014:

The $833 million of net cash used in investing activities during 2014 consisted of $431 million spent/ reserved related to the acquisition of businesses and property, $391 million spent on capital expenditures, $13 million spent in connection with the purchase and implementation of an electronic health records application ("EHR"), $12 million spent to increase investments of insurance subsidiary, net of $15 million received from the sale of assets and businesses.

2014 Acquisitions of Assets and Businesses:

During 2014 we spent $431 million to:

- acquire the stock of Cygnet Health Care Limited ("Cygnet") which consists of 17 facilities located throughout the United Kingdom including 15 inpatient behavioral health hospitals and 2 nursing homes with a total of 723 beds (during the third quarter);
- acquire and fund the required capital reserves related to Prominence Health Plan, a commercial health insurer headquartered in Reno, Nevada (during the second quarter);
- acquire the Psychiatric Institute of Washington, a 124-bed behavioral health care facility and outpatient treatment center located in Washington, D.C. (during the second quarter);

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- acquire the operations of Palo Verde Behavioral Health, a 48-bed behavioral health facility in Tucson, Arizona (during the first quarter);
- acquire the real property of The Bridgeway, a 103-bed behavioral health care facility located in North Little Rock, Arkansas, that was previously leased from Universal Health Realty Income Trust (during the fourth quarter);
- acquire the previously leased real property of Cygnet Hospital-Harrow, a 44-bed behavioral health care facility located in the United Kingdom, the operations of which were acquired as part of our acquisition of Cygnet (during the fourth quarter), and;
- acquire physician practices.

2014 Capital Expenditures:

During 2014 we spent $391 million to finance capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities, including additional capacity added to certain of our behavioral health facilities that have operated near full capacity.

2014 Divestiture of Assets and Businesses:

During 2014 we received $15 million in connection with the divestiture of a non-operating investment (during the first quarter) and the real property of a closed behavioral health facility (during the second quarter).

2013:

The $383 million of net cash used in investing activities during 2013 consisted of $358 million spent on capital expenditures, $13 million spent on the acquisition of property and businesses, $37 million received from the sale of assets and businesses and $50 million spent in connection with the purchase and implementation of an EHR application.

2013 Capital Expenditures:

During 2013, we spent $358 million to finance capital expenditures including the construction costs related to: (i) the newly constructed Temecula Valley Hospital, a 140-bed acute care facility located in Temecula, California, that was completed and opened in October, 2013; (ii) the construction costs related to Austin Oaks Hospital, 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) capital expenditures related to equipment renovations and new projects at various existing facilities.

2013 Acquisitions of Assets and Businesses:

During 2013, we spent $13 million for the purchase of real property located in Pennsylvania, Nevada and Arizona.

2013 Divestiture of Assets and Businesses:

During 2013, we received $37 million in connection with the divestiture of Peak Behavioral Health Services and certain other assets and real property including three previously closed behavioral health care facilities.

Net cash used in financing activities

Net cash used in financing activities was $187 million during 2014 and $507 million during 2013.

2014:

The $187 million of net cash used in financing activities during 2014 consisted of the following:

- generated $830 million of proceeds from additional borrowings pursuant to: (i) the issuance in August of 2014 of $300 million aggregate principal amount of 3.750% senior secured notes due 2019 and the issuance of $300 million aggregate principal amount of 4.750% senior secured notes due 2022; (ii) $140 million from new borrowings pursuant to our revolving credit facility, and; (iii) $90 million of proceeds from new borrowings pursuant to our accounts receivable securitization program;
- spent $879 million on net repayments of debt due primarily to repayments pursuant to our: (i) previously outstanding term loan B facility ($550 million); (ii) previously outstanding $250 million, 7% senior unsecured notes ($250 million); (iii) previously outstanding term loan term loan A and A2 facilities ($36 million); (iv) short-term, on-demand line of credit ($25 million); (v) new term loan A facility ($11 million), and; (vi) various other debt facilities ($7 million);
- spent $101 million to repurchase shares of our Class B Common Stock in connection with: (i) open market purchases pursuant to our $400 million stock repurchase program ($58 million), and; (ii) income tax withholding obligations related to stock-based compensation programs ($43 million);
- generated $34 million of excess income tax benefits related to stock-based compensation;
- spent $15 million in financing costs in connection with the various financing transactions as discussed below in *Credit Facilities and Outstanding Debt Securities*;
- spent $30 million to pay quarterly cash dividends of $.05 per share during each of the first and second quarters and $.10 per share during the third and fourth quarters;
- spent $34 million to pay profit distributions related to noncontrolling interests in majority owned businesses, and;
- generated $7 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

2013:

The $507 million of net cash used in financing activities consisted of the following:

- spent $440 million on net repayments of debt due to repayments pursuant to our previously outstanding Term Loan A and A2 facilities ($72 million), previously outstanding Term Loan B ($196 million), revolving credit ($150 million), accounts receivable securitization ($9 million) and other debt facilities ($13 million);
- generated $16 million of proceeds from a short-term, on-demand facility and other debt;
- spent $61 million to pay profit distributions related to noncontrolling interests in majority owned businesses;
- spent $27 million to repurchase shares of our Class B Common Stock (in connection with income tax withholdings related to employee stock-based incentive compensation programs);
- spent $20 million to pay quarterly cash dividends of $.05 per share;
- generated $20 million of excess income tax benefits related to stock-based compensation, and;
- generated $6 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

Year ended December 31, 2013 as compared to December 31, 2012:

Net cash provided by operating activities

Net cash provided by operating activities was $884 million during 2013 and $799 million during 2012. The net increase of $85 million was primarily attributable to the following:

- a favorable change of $93 million due to an increase in net income plus/minus depreciation and amortization expense, stock-based compensation expense, costs related to extinguished debt and gains on sales of assets and businesses;
- a $62 million unfavorable change in accrued insurance expense, net of payments made in settlement of self-insurance claims, due primarily to the above-mentioned reductions to our professional and general liability self-insurance reserves recorded during 2013 and 2012 ($81 million during 2013 as compared to $27 million recorded during 2012);
- a $41 million favorable change in accrued and deferred income taxes (due in part to the tax treatment related to the above-mentioned 2013 reduction to our professional and general liability self-insurance reserves);
- a $22 million unfavorable change in other assets and deferred charges;
- a $21 million favorable change in accounts receivable, and;
- $14 million of other combined net favorable changes.

Net cash used in investing activities

Net cash used in investing activities was $383 million during 2013 as compared to $790 million during 2012. The factors contributing to the $383 million of net cash used in investing activities during 2013 are detailed above.

2012:

The $790 million of net cash used in investing activities during 2012 consisted of $363 million spent on capital expenditures, $528 million spent on acquisitions, $149 million received from the sale of assets and businesses, $54 million spent in connection with the purchase and implementation of EHR applications, and $6 million received from a deposit returned to us in connection with the termination of an agreement to purchase an acute care hospital located in Texas.

2012 Capital Expenditures:

During 2012, we spent $363 million to finance capital expenditures, including the following: (i) construction costs related to multiple expansion and renovation projects at various existing acute care hospitals and behavioral health facilities; (ii) construction costs related to the newly constructed Temecula Valley Hospital, and; (iii) capital expenditures for equipment at various existing facilities.

2012 Acquisitions of Assets and Businesses:

During 2012, we spent $528 million to acquire the following assets and businesses:

- spent $503 million to acquire 9 behavioral health care facilities from Ascend Health Corporation in October, 2012, and;
- spent $25 million in connection with the acquisition of physician practices and various real property.

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2012 Divestiture of Assets and Businesses:

During 2012, we received $149 million from the divestiture of assets and businesses, including the following:

- received $93 million for the sale of Auburn Regional Medical Center, a 159-bed acute care hospital located in Auburn, Washington (sold in October, 2012);
- received $50 million for the sale of the Hospital San Juan Capestrano, a 108-bed acute care hospital located in Rio Piedras, Puerto Rico (sold in January, 2012 pursuant to our above-mentioned agreement with the Federal Trade Commission in connection with our acquisition of PSI in November, 2010), and;
- received an aggregate of $6 million for the sale of the real property of two non-operating behavioral health facilities and our majority ownership interest in an outpatient surgery center located in Puerto Rico.

Net cash used in/provided by financing activities

Net cash used in financing activities was $507 million during 2013 and $27 million during 2012. The factors contributing to the $507 million of net cash used in financing activities during 2013 are detailed above.

2012:

The $27 million of net cash used in financing activities consisted of the following:

- spent $850 million on net repayments of debt due to repayments pursuant to our previously outstanding Term Loan A and A2 facilities ($42 million), previously outstanding Term Loan B ($713 million), revolving credit ($91 million) and other debt facilities ($4 million);
- generated $914 million of proceeds from $900 million of borrowings pursuant to our previously outstanding Term Loan A2 facility, $9 million of borrowings pursuant to our accounts receivable securitization program and $5 million of borrowings pursuant to a short-term, on-demand facility;
- spent $27 million to pay profit distributions related to noncontrolling interests in majority owned businesses;
- spent $19 million to repurchase shares of our Class B Common Stock (in connection with income tax withholdings related to employee stock-based incentive compensation programs);
- spent $58 million to pay quarterly cash dividends of $.05 per share and a special dividend of $.40 per share in December, 2012;
- generated $16 million of excess income tax benefits related to stock-based compensation;
- spent $8 million in financing costs in connection with the amendment to our credit facility (which includes our existing revolving credit agreement, previously outstanding Term Loan A and A2 and Term Loan B facilities) which was completed during in March, 2012, and;
- generated $5 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

2015 Expected Capital Expenditures:

During 2015, we expect to spend approximately $375 million to $400 million on capital expenditures which includes expenditures for capital equipment, renovations, new projects at existing hospitals and construction of new facilities. Approximately $155 million of our 2015 expected capital expenditures relates to completion of projects that are in progress as of December 31, 2014. We believe that our capital expenditure program is adequate to expand, improve and equip our existing hospitals. We expect to finance all capital expenditures and acquisitions with internally generated funds and/or additional funds, as discussed below.

Capital Resources

Credit Facilities and Outstanding Debt Securities

During the third quarter of 2014, we completed the following financing transactions:

- On August 7, 2014, we entered into a Fourth Amendment (the "Fourth Amendment") to our credit agreement dated as of November 15, 2010, as amended on March 15, 2011, September 21, 2012 and May 16, 2013, among UHS, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders ("Credit Agreement"). The Credit Agreement, as amended, which is scheduled to mature in August, 2019, consists of: (i) an $800 million revolving credit facility ($140 million of borrowings outstanding as of December 31, 2014), and; (ii) a $1.775 billion term loan A facility ($1.764 billion of borrowings outstanding as of December 31, 2014) which combined our previously outstanding term loan A and term loan A2 facilities which were scheduled to mature in 2016;
- Repaid $550 million of outstanding borrowings pursuant to our previously outstanding term loan B facility which was scheduled to mature in 2016;
- Increased the borrowing capacity on our existing accounts receivable securitization program ("Securitization") to $360 million from $275 million, effective August 1, 2014. The Securitization, the terms of which remain the same as the previous agreement, as discussed below, is scheduled to mature in October, 2016;
- Issued $300 million aggregate principal amount of 3.750% senior secured notes due in 2019 (see below for additional disclosure);
- Issued $300 million aggregate principal amount of 4.750% senior secured notes due in 2022 (see below for additional disclosure);
- Redeemed our previously outstanding $250 million, 7.00% senior unsecured notes due in 2018 on July 31, 2014 for an aggregate price equal to 104.56% of the principal amount.

In connection with these transactions, our 2014 results of operations included a $36 million pre-tax charge incurred for the costs related to the extinguishment of debt. This charge consisted of the write-off of deferred charges ($20 million) and original issue discount on the extinguished debt ($5 million) as well as the make-whole premium paid ($11 million) on the early redemption of the $250 million, 7.00% senior unsecured notes.

Borrowings under the Credit Agreement bear interest at either (1) the ABR rate which is defined as the rate per annum equal to, at our election: the greatest of (a) the lender's prime rate, (b) the weighted average of the federal funds rate, plus 0.5% and (c) one month LIBOR rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.50% to 1.25% for revolving credit and term loan-A borrowings, or (2) the one, two, three or six month LIBOR rate (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.50% to 2.25% for revolving credit and term loan-A borrowings. As of December 31, 2014, the applicable margins were 0.50% for ABR-based loans, 1.50% for LIBOR-based loans under the revolving credit and term loan-A facilities.

As of December 31, 2014, we had $140 million of outstanding borrowings pursuant to the terms of our $800 million revolving credit facility and we had $640 million of available borrowing capacity, net of $500,000 of outstanding borrowings pursuant to a short-term, on-demand credit facility and $20 million of outstanding letters of credit. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Credit Agreement is secured by certain assets of the Company and our material subsidiaries and guaranteed by our material subsidiaries.

Pursuant to the terms of the Fourth Amendment to our Credit Agreement, term loan-A quarterly installment payments of approximately: (i) $11 million commenced during the fourth quarter of 2014 and are scheduled to continue through September, 2016, and; (ii) $22 million are scheduled from the fourth quarter of 2016 through June, 2019. Prior to commencement of the Fourth Amendment, we made scheduled principal payments of $36 million on the term loan-A and term loan A2 facilities during 2014 and $72 million during 2013.

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As discussed above, on August 1, 2014, our accounts receivable securitization program ("Securitization"), with a group of conduit lenders and liquidity banks which is scheduled to mature in October, 2016, was amended to increase the borrowing capacity to $360 million from $275 million. Substantially all of the patient-related accounts receivable of our acute care hospitals ("Receivables") serve as collateral for the outstanding borrowings. We have accounted for this Securitization as borrowings. We maintain effective control over the Receivables since, pursuant to the terms of the Securitization, the Receivables are sold from certain of our subsidiaries to special purpose entities that are wholly-owned by us. The Receivables, however, are owned by the special purpose entities, can be used only to satisfy the debts of the wholly-owned special purpose entities, and thus are not available to us except through our ownership interest in the special purpose entities. The wholly-owned special purpose entities use the Receivables to collateralize the loans obtained from the group of third-party conduit lenders and liquidity banks. The group of third-party conduit lenders and liquidity banks do not have recourse to us beyond the assets of the wholly-owned special purpose entities that securitize the loans. At December 31, 2014, we had $330 million of outstanding borrowings and $30 million of additional capacity pursuant to the terms of our accounts receivable securitization program.

On August 7, 2014, we issued $300 million aggregate principal amount of 3.750% Senior Secured Notes due 2019 (the "2019 Notes") and $300 million aggregate principal amount of 4.750% Senior Secured Notes due 2022 (the "2022 Notes", and together with the 2019 Notes, the "New Senior Secured Notes"). The New Senior Secured Notes were offered only to qualified institutional buyers under Rule 144A and to non-U.S. persons outside the United States in reliance on Regulation S under the Securities Act of 1933, as amended (the "Securities Act"). The New Senior Secured Notes have not been registered under the Securities Act and may not be offered or sold in the United States absent registration or an applicable exemption from registration requirements. Interest is payable on the New Senior Secured Notes on February 1 and August 1 of each year to the holders of record at the close of business on the January 15 and July 15 immediately preceding the related interest payment dates, commencing on February 1, 2015 until the maturity date of August 1, 2019 for the 2019 Notes and August 1, 2022 for the 2022 Notes.

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

On July 31, 2014, we redeemed the $250 million, 7.00% senior unsecured notes (the "Unsecured Notes"), which were scheduled to mature on October 1, 2018, at a redemption price equal to 104.56% of the principal amount of the Unsecured Notes resulting in a make-whole premium payment of approximately $11 million. The Unsecured Notes were issued on September 29, 2010 and registered in April, 2011. Interest on the Unsecured Note was payable semiannually in arrears on April 1st and October 1st of each year.

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

The average amounts outstanding during each of years 2014, 2013 and 2012 under the current and prior Credit Agreements, demand notes and accounts receivable securitization programs was $2.4 billion, $2.9 billion and $2.9 billion, respectively, with corresponding interest rates of 1.8%, 2.2% and 2.9%, respectively, including commitment and facility fees. The maximum amounts outstanding at any month-end were $2.65 billion in 2014, $3.00 billion in 2013 and $3.06 billion in 2012. The effective interest rate on our current and prior Credit Agreements, accounts receivable securitization programs, and demand notes, which includes the respective interest expense, commitment and facility fees, designated interest rate swaps expense and amortization of deferred financing costs and original issue discounts, was 3.2% in 2014, 3.6% in 2013 and 4.5% in 2012.

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Our Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens and indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage and minimum interest coverage ratios. We are in compliance with all required covenants as of December 31, 2014.

The carrying value of our debt at December 31, 2014 and 2013 was $3.3 billion. The fair values of our debt at December 31, 2014 and 2013 were $3.3 billion and $3.4 billion, respectively. The fair value of our debt was computed based upon quotes received from financial institutions. We consider these to be "level 2" in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with debt instruments.

Our total debt as a percentage of total capitalization was 47% at December 31, 2014 and 51% at December 31, 2013.

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 $360 million accounts receivable securitization program, as well as access to the capital markets, provide us with sufficient capital resources to fund our operating, investing and financing requirements for the next twelve months. However, in the event we need to access the capital markets or other sources of financing, there can be no assurance that we will be able to obtain financing on acceptable terms or within an acceptable time. Our inability to obtain financing on terms acceptable to us could have a material unfavorable impact on our results of operations, financial condition and liquidity.

Contractual Obligations and Off-Balance Sheet Arrangements

As of December 31, 2014 we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds which totaled $94 million consisting of: (i) $73 million related to our self-insurance programs, and; (ii) $21 million of other debt and public utility guarantees.

Obligations under operating leases for real property, real property master leases and equipment amount to $335 million as of December 31, 2014. The real property master leases are leases for buildings on or near hospital property for which we guarantee a certain level of rental income. We sublease space in these buildings and any amounts received from these subleases are offset against the expense. In addition, we lease three hospital facilities from the Trust with terms expiring in 2016. These leases contain up to three 5-year renewal options. We also lease the real property of certain facilities as indicated in *Item 2. Properties,* as included herein.

The following represents the scheduled maturities of our contractual obligations as of December 31, 2014:

	Payments Due by Period (dollars in thousands)				
	Total	Less than 1 year	2-3 years	4-5 years	After 5 years
Long-term debt obligations (a)	$3,278,534	$ 68,319	$ 878,112	$2,016,805	$315,298
Estimated future interest payments on debt outstanding as of December 31, 2014 (b)	404,926	112,568	136,820	102,541	52,997
Construction commitments (c)	151,000	62,000	84,000	5,000	0
Purchase and other obligations (d)	205,275	40,805	81,170	83,300	0
Operating leases (e)	335,023	58,904	80,662	48,169	147,288
Estimated future payments for defined benefit pension plan, and other retirement plan (f)	250,818	9,021	14,853	15,799	211,145
Health and dental unpaid claims (g)	57,651	57,651	0	0	0
Total contractual cash obligations	$4,683,227	$409,268	$1,275,617	$2,271,614	$726,728

(a) Reflects borrowings outstanding as of December 31, 2014 as discussed in Note 4 to the Consolidated Financial Statements.

(b) Assumes that all debt outstanding as of December 31, 2014, including borrowings under our Credit Agreement, demand note and accounts receivable securitization program, remain outstanding until the final maturity of the debt agreements at the same interest rates (some of which are floating) which were in effect as of December 31, 2014. We have the right to repay borrowings upon short notice and without penalty, pursuant to the terms of the Credit Agreement, demand note and accounts receivable securitization program. Also includes the impact of various interest rate swap and cap agreements in effect as of December 31, 2014, as calculated to maturity dates utilizing the applicable floating interest rates in effect as of December 31, 2014.

(c) Estimated construction cost of a newly constructed acute care hospital located in Henderson, Nevada. We are required to build this hospital pursuant to an agreement with a third party. In addition to this new hospital project, we had various other projects under construction as of December 31, 2014 with estimated additional cost to complete and equip of approximately $155 million. Because we can terminate substantially all of the related construction contracts at any time without paying a termination fee, these costs are excluded from the above table except for the amount contractually committed to a third-party.

(d) Consists of: (i) $87 million related to long-term contracts with third-parties consisting primarily of certain revenue cycle data processing services for our acute care facilities; (ii) $116 million related to the future expected costs to be paid to a third-party vendor in connection with the on-going operation of an electronic health records application for each of our acute care facilities, and; (iii) a $2 million liability for physician commitments expected to be paid in the future.

(e) Reflects our future minimum operating lease payment obligations related to our operating lease agreements outstanding as of December 31, 2014 as discussed in Note 7 to the Consolidated Financial Statements. Some of the lease agreements provide us with the option to renew the lease and our future lease obligations would change if we exercised these renewal options.

(f) Consists of $234 million of estimated future payments related to our non-contributory, defined benefit pension plan (estimated through 2089), as disclosed in *Note 8 to the Consolidated Financial Statements*, and $17 million of estimated future payments related to another retirement plan liability. Included in our other non-current liabilities as of December 31, 2014 was an $11 million liability recorded in connection with the non-contributory, defined benefit pension plan and included in other non-current liabilities as of December 31, 2014 was a $14 million liability recorded in connection with the other retirement plan.

(g) Consists of accrued and unpaid estimated claims expense incurred in connection with our commercial health insurer (Prominence Health Plan) and self-insured employee benefit plans.

As of December 31, 2014, the total accrual for our professional and general liability claims was $193 million, of which $51 million is included in other current liabilities and $142 million is included in other non-current liabilities. We exclude the $193 million for professional and general liability claims from the contractual obligations table because there are no significant contractual obligations associated with these liabilities and because of the uncertainty of the dollar amounts to be ultimately paid as well as the timing of such payments. Please see *Self-Insured/Other Insurance Risks* above for additional disclosure related to our professional and general liability claims and reserves.

In connection with five acute care facilities (and one additional facility currently under construction) located in Las Vegas, Nevada, the minority ownership interests of which are reflected as redeemable noncontrolling interests on our Consolidated Balance Sheet, the outside owners have certain "put rights" that, if exercisable, and if exercised, require us to purchase the minority member's interests at fair market value. The put rights are exercisable upon the occurrence of: (i) certain specified financial conditions falling below established thresholds; (ii) breach of the management contract by the managing member (a subsidiary of ours), or; (iii) if the minority member's ownership percentage is reduced to less than certain thresholds. In connection with a behavioral health care facility located in Philadelphia, Pennsylvania and acquired by us as part of the PSI acquisition, the minority ownership interest of which is 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

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put option requires us to purchase the minority member's interest at fair market value. We exclude the approximate amount that we may be required to pay to repurchase these minority ownership interests from the contractual obligations table because of the uncertainty as to: (i) whether or not the put rights, if exercisable, will actually be exercised; (ii) the dollar amounts that would be paid if the put rights were exercised, and; (iii) the timing of such payments.

Additionally, the table above does not include $2 million of the total unrecognized tax benefits for uncertain tax positions as of December 31, 2014. Due to the high degree of uncertainty regarding the timing of potential cash flows, we cannot reasonably estimate the settlement periods for which the amounts may be utilized.

ITEM 7A. ***Quantitative and Qualitative Disclosures About Market Risk***

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

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

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

The fair value of interest rate swap agreements approximates the amount at which they could be settled, based on estimates obtained from the counterparties. We assess the effectiveness of our hedge instruments on a quarterly basis. We performed periodic assessments of the cash flow hedge instruments during 2014 and 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 December 31, 2014, 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 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. The three-month LIBOR never reached 7.00% during the term of the cap, which expired in December, 2013, and therefore no payment was made to us.

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We also entered into six forward starting interest rate swaps in 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 $75 million, $25 million and $100 million became effective in December, 2011 and had corresponding fixed rates of 1.32%, 1.96% and 2.50%. The $75 million, $25 million, and $100 million interest rate swaps matured in December, 2012, December, 2013, and December, 2014, respectively.

During 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%.

During the fourth quarter of 2007, we entered into two interest rate swaps whereby we paid a fixed rate on a total notional principal amount of $150 million and received three-month LIBOR. Each of the two interest rate swaps, which are now expired, had an initial notional principal amount of $75 million. The fixed rate payable on one of the interest rate swaps was 4.87% and it matured in October, 2011. The fixed rate payable on the other interest rate swap, on which the notional principal amount reduced to $50 million in October, 2010, was 4.76% and it matured in October, 2012.

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 a liability of $6 million at December 31, 2014, all of which is included in other current liabilities. At December 31, 2013, the fair value of our interest rate swaps was a liability of $24 million, of which $19 million was included in other current liabilities and $5 million was included in other noncurrent liabilities on the accompanying balance sheet.

The table below presents information about our long-term financial instruments that are sensitive to changes in interest rates as of December 31, 2014. For debt obligations, the table presents principal cash flows and related weighted-average interest rates by contractual maturity dates.

Maturity Date, Fiscal Year Ending December 31
(dollars in thousands)

	2015	2016	2017	2018	2019	Thereafter	Total
Long-term debt:							
Fixed rate:							
Debt	$ 18,146	$401,970	$ 1,925	$ 2,132	$ 301,392	$315,298	$1,040,863
Average interest rates	5.5%	5.5%	4.4%	4.4%	4.4%	5.0%	4.9%
Variable rate:							
Debt	$ 50,173	$385,467	$88,750	$88,750	$1,624,531		$2,237,671
Average interest rates	1.6%	1.6%	1.7%	1.7%	1.7%		1.7%
Interest rate swaps:							
Notional amount	$825,000						$ 825,000
Average interest rates	2.3%						2.3%

As calculated based upon our variable rate debt outstanding as of December 31, 2014 that is subject to interest rate fluctuations, each 1% change in interest rates would impact our pre-tax income by approximately $14 million.

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ITEM 8. ***Financial Statements and Supplementary Data***

Our Consolidated Balance Sheets, Consolidated Statements of Income, Consolidated Statements of Changes in Equity and Consolidated Statements of Cash Flows, together with the reports of PricewaterhouseCoopers LLP, independent registered public accounting firm, are included elsewhere herein. Reference is made to the "Index to Financial Statements and Financial Statement Schedule."

ITEM 9. ***Changes in and Disagreements with Accountants on Accounting and Financial Disclosure***

None.

ITEM 9A. ***Controls and Procedures.***

As of December 31, 2014, under the supervision and with the participation of our management, including our Chief Executive Officer ("CEO") and Chief Financial Officer ("CFO"), we performed an evaluation of the effectiveness of our disclosure controls and procedures as defined in Rule 13a-15(e) or Rule 15d-15(e) of the Securities Exchange Act of 1934, as amended. Based on this evaluation, the CEO and CFO have concluded that our disclosure controls and procedures are effective to ensure that material information is recorded, processed, summarized and reported by management on a timely basis in order to comply with our disclosure obligations under the Securities Exchange Act of 1934, as amended, and the SEC rules thereunder.

Changes in Internal Control Over Financial Reporting

There have been no changes in our internal control over financial reporting or in other factors during the fourth quarter of 2014 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Management's Report on Internal Control Over Financial Reporting

Management is responsible for establishing and maintaining an adequate system of internal control over our financial reporting. In order to evaluate the effectiveness of internal control over financial reporting, as required by Section 404 of the Sarbanes-Oxley Act, management has conducted an assessment, including testing, using the criteria on *Internal Control—Integrated Framework (2013)*, issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). Our system of internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation and fair presentation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles. Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness of internal control over financial reporting to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

We have excluded the acquisitions made during 2014, including Cygnet Health Care Limited, Prominence Health Plan and the Psychiatric Institute of Washington, from the assessment of internal control over financial reporting as of December 31, 2014 because they were acquired by us in purchase business combinations at various times during 2014. These facilities/businesses represented approximately 6% of our consolidated total assets and 2% of our consolidated net revenues as of, and for the year ended, December 31, 2014.

Based on its assessment, management has concluded that we maintained effective internal control over financial reporting as of December 31, 2014, based on criteria in *Internal Control—Integrated Framework (2013)*, issued by the COSO. The effectiveness of the Company's internal control over financial reporting as of December 31, 2014 has been audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm as stated in its report which appears herein.

ITEM 9B ***Other Information***

None.

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PART III

ITEM 10. *Directors, Executive Officers and Corporate Governance*

There is hereby incorporated by reference the information to appear under the captions "Election of Directors", "Section 16(a) Beneficial Ownership Reporting Compliance" and "Corporate Governance" in our Proxy Statement, to be filed with the Securities and Exchange Commission within 120 days after December 31, 2014. See also "Executive Officers of the Registrant" appearing in Item 1 hereof.

ITEM 11. *Executive Compensation*

There is hereby incorporated by reference the information to appear under the caption "Executive Compensation" in our Proxy Statement to be filed with the Securities and Exchange Commission within 120 days after December 31, 2014.

ITEM 12. *Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters*

There is hereby incorporated by reference the information to appear under the caption "Security Ownership of Certain Beneficial Owners and Management" and "Executive Compensation" in our Proxy Statement, to be filed with the Securities and Exchange Commission within 120 days after December 31, 2014.

ITEM 13. *Certain Relationships and Related Transactions, and Director Independence*

There is hereby incorporated by reference the information to appear under the captions "Certain Relationships and Related Transactions" and "Corporate Governance" in our Proxy Statement, to be filed with the Securities and Exchange Commission within 120 days after December 31, 2014.

ITEM 14. *Principal Accountant Fees and Services.*

There is hereby incorporated by reference the information to appear under the caption "Relationship with Independent Auditors" in our Proxy Statement, to be filed with the Securities and Exchange Commission within 120 days after December 31, 2014.

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PART IV

ITEM 15. ***Exhibits and Financial Statement Schedules***

(a) Documents filed as part of this report:

(1) Financial Statements:

See "Index to Financial Statements and Financial Statement Schedule."

(2) Financial Statement Schedules:

See "Index to Financial Statements and Financial Statement Schedule."

(3) Exhibits:

3.1 Registrant's Restated Certificate of Incorporation, and Amendments thereto, previously filed as Exhibit 3.1 to Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 1997, are incorporated herein by reference.

3.2 Bylaws of Registrant, as amended, previously filed as Exhibit 3.2 to Registrant's Annual Report on Form 10-K for the year ended December 31, 1987, is incorporated herein by reference.

3.3 Amendment to the Registrant's Restated Certificate of Incorporation previously filed as Exhibit 3.1 to Registrant's Current Report on Form 8-K dated July 3, 2001 is incorporated herein by reference.

4.1 Form of Indenture dated January 20, 2000, between Universal Health Services, Inc. and J.P. Morgan Trust Company, National Association (as successor to Bank One Trust Company, N.A.), Trustee previously filed as Exhibit 4.1 to Registrant's Registration Statement on Form S-3/A (File No. 333-85781), dated February 1, 2000, is incorporated herein by reference.

4.2 Supplemental Indenture between Universal Health Services, Inc. and J.P. Morgan Trust Company, National Association, dated as of June 20, 2006, previously filed as Exhibit 4.2 to Registrant's Registration Statement on Form S-3 (File No. 333-135277) dated June 23, 2006, is incorporated herein by reference.

4.3 Form of Debt Security, previously filed as Exhibit 4.1 to Registrant's Registration Statement on Form S-3 (File No. 333-135277) dated June 23, 2006, is incorporated herein by reference.

4.4 Form of 7.125% Notes due 2016, previously filed as Exhibit 4.1 to Registrant's Current Report on Form 8-K dated June 30, 2006, is incorporated herein by reference.

4.5 Officer's Certificate relating to the 7.125% Notes due 2016, previously filed as Exhibit 4.1 to Registrant's Current Report on Form 8-K dated June 30, 2006, is incorporated herein by reference.

4.6 Form of Note, previously filed as Exhibit 4.1 to the Company's Current Report on Form 8-K dated May 30, 2008, is incorporated herein by reference.

4.7 Officers' Certificate, previously filed as Exhibit 4.2 to the Company's Current Report on Form 8-K dated May 30, 2008, is incorporated herein by reference.

4.8 Indenture, dated as of August 7, 2014, among Universal Health Services, Inc., its subsidiaries specified therein, MUFG Union Bank, N.A., as Trustee, JPMorgan Chase Bank, N.A., as Collateral Agent (including forms of the 3.750% Senior Secured Notes due 2019 and the 4.750% Senior Secured Notes due 2022), previously filed as Exhibit 4.1 to the Registrant's Current Report on Form 8-K dated August 12, 2014, is incorporated herein by reference.

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4.9 Second Supplement Indenture, dated as of November 15, 2010, to the Indenture, dated January 20, 2000, between Universal Health Services, Inc. and the Bank of New York Mellon Trust company, N.A., as Trustee, previously filed as Exhibit 4.2 to the Registrant's Current Report on Form 8-K dated November 17, 2010, is incorporated herein by reference.

4.10 Third Supplemental Indenture, dated as of August 7, 2014, to Indenture, dated as of January 20, 2000, between Universal Health Services, Inc. and The Bank of New York Mellon Trust Company, N.A., as Trustee, previously filed as Exhibit 10.3 to the Registrant's Current Report on Form 8-K dated August 12, 2014, is incorporated herein by reference.

10.1* Employment Agreement, dated as of July 24, 2013, by and between Universal Health Services, Inc. and Alan B. Miller, previously filed as Exhibit 10.1 to Registrant's Current Report on Form 8-K dated July 26, 2013, is incorporated herein by reference.

10.2 Advisory Agreement, dated as of December 24, 1986, between Universal Health Realty Income Trust and UHS of Delaware, Inc., previously filed as Exhibit 10.2 to Registrant's Current Report on Form 8-K dated December 24, 1986, is incorporated herein by reference.

10.3 Agreement, dated December 4, 2014, to renew Advisory Agreement, dated as of December 24, 1986, between Universal Health Realty Income Trust and UHS of Delaware, Inc.

10.4 Form of Leases, including Form of Master Lease Document for Leases, between certain subsidiaries of the Registrant and Universal Health Realty Income Trust, filed as Exhibit 10.3 to Amendment No. 3 of the Registration Statement on Form S-11 and Form S-2 of Registrant and Universal Health Realty Income Trust (Registration No. 33-7872), is incorporated herein by reference.

10.5 Corporate Guaranty of Obligations of Subsidiaries Pursuant to Leases and Contract of Acquisition, dated December 24, 1986, issued by Registrant in favor of Universal Health Realty Income Trust, previously filed as Exhibit 10.5 to Registrant's Current Report on Form 8-K dated December 24, 1986, is incorporated herein by reference.

10.6* Universal Health Services, Inc. Executive Retirement Income Plan dated January 1, 1993, previously filed as Exhibit 10.7 to Registrant's Annual Report on Form 10-K for the year ended December 31, 2002, is incorporated herein by reference.

10.7 Asset Purchase Agreement dated as of February 6, 1996, among Amarillo Hospital District, UHS of Amarillo, Inc. and Universal Health Services, Inc., previously filed as Exhibit 10.28 to Registrant's Annual Report on Form 10-K for the year ended December 31, 1995, is incorporated herein by reference.

10.8 Agreement of Limited Partnership of District Hospital Partners, L.P. (a District of Columbia limited partnership) by and among UHS of D.C., Inc. and The George Washington University, previously filed as Exhibit 10.1 to Registrant's Quarterly Report on Form 10-Q for the quarters ended March 30, 1997, and June 30, 1997, is incorporated herein by reference.

10.9 Contribution Agreement between The George Washington University (a congressionally chartered institution in the District of Columbia) and District Hospital Partners, L.P. (a District of Columbia limited partnership), previously filed as Exhibit 10.3 to Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 1997, is incorporated herein by reference.

10.10 Valley/Desert Contribution Agreement dated January 30, 1998, by and among Valley Hospital Medical Center, Inc. and NC-DSH, Inc. previously filed as Exhibit 10.30 to Registrant's Annual Report on Form 10-K for the year ended December 31, 1997, is incorporated herein by reference.

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10.11 Summerlin Contribution Agreement dated January 30, 1998, by and among Summerlin Hospital Medical Center, L.P. and NC-DSH, Inc., previously filed as Exhibit 10.31 to Registrant's Annual Report on Form 10-K for the year ended December 31, 1997, is incorporated herein by reference.

10.12* Amended and Restated Universal Health Services, Inc. Supplemental Deferred Compensation Plan dated as of January 1, 2002, previously filed as Exhibit 10.29 to Registrant's Annual Report on Form 10-K for the year ended December 31, 2002, is incorporated herein by reference.

10.13* Universal Health Services, Inc. Employee Stock Purchase Plan, previously filed as Exhibit 4.1 to Registrant's Registration Statement on Form S-8 (File No. 333-122188), dated January 21, 2005 is incorporated herein by reference.

10.14* Universal Health Services, Inc. Second Amended and Restated 2005 Stock Incentive Plan, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated May 18, 2011, is incorporated herein by reference.

10.15* Form of Stock Option Agreement, previously filed as Exhibit 10.4 to Registrant's Current Report on Form 8-K, dated June 8, 2005, is incorporated herein by reference.

10.16* Form of Stock Option Agreement for Non-Employee Directors, previously filed as Exhibit 10.2 to Registrant's Current Report on Form 8-K, dated October 3, 2005, is incorporated herein by reference.

10.17 Amendment No. 1 to the Master Lease Document, between certain subsidiaries of Universal Health Services, Inc. and Universal Health Realty Income Trust, dated April 24, 2006, previously filed as Exhibit 10.29 to the Registrant's Annual Report on Form 10-K for the year ended December 31, 2006, is incorporated herein by reference.

10.18* Universal Health Services, Inc. 2010 Employees' Restricted Stock Purchase Plan, previously filed as Exhibit 10.1 to the Registrant's Current Report on Form 8-K dated May 20, 2010, is incorporated herein by reference.

10.19* Universal Health Services, Inc. 2010 Executive Incentive Plan, previously filed as Exhibit 10.2 to the Registrant's Current Report on Form 8-K dated May 20, 2010, is incorporated herein by reference.

10.20 Omnibus Amendment to Receivables Sale Agreements, dated as of October 27, 2010, previously filed as Exhibit 10.1 to the Registrant's Current Report on Form 8-K dated November 2, 2010, is incorporated herein by reference.

10.21 Amended and Restated Credit and Security Agreement, dated as of October 27, 2010, previously filed as Exhibit 10.2 to the Registrant's Current Report on Form 8-K dated November 2, 2010, is incorporated herein by reference.

10.22 Second Amendment to Amended and Restated Credit and Security Agreement, dated as of October 25, 2013, previously filed as Exhibit 10.1 to the Registrant's Current Report on Form 8-K dated October 30, 2013, is incorporated herein by reference.

10.23 Third Amendment to Amended and Restated Credit and Security Agreement, dated as of August 1, 2014, previously filed as Exhibit 10.1 to the Registrant's Current Report on Form 8-K dated August 4, 2014, is incorporated herein by reference.

10.24 Assignment and Assumption Agreement, dated as of October 27, 2010, previously filed as Exhibit 10.3 to the Registrant's Current Report on Form 8-K dated November 2, 2010, is incorporated herein by reference.

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10.25 Credit Agreement, dated as of November 15, 2010, by and among Universal Health Services, Inc., JPMorgan Chase Bank, N.A. and the various financial institutions as are or may become parties thereto, as Lenders, SunTrust Bank, The Royal Bank of Scotland, Plc, Bank of Tokyo-Mitsubishi UFJ Trust Company and Credit Agricole Corporate and Investment Bank, as co-documentation agents, Deutsche Bank Securities Inc. and Bank of America N.A. as co-syndication agents, and JPMorgan Chase Bank, N.A., as administrative agent for the Lenders and as collateral agent for the secured parties, previously filed as Exhibit 10.1 to the Registrant's Current Report on Form 8-K dated November 17, 2010, is incorporated herein by reference.

10.26 First Amendment, dated as of March 15, 2011, to the Credit Agreement, dated as of November 15, 2010, by and among Universal Health Services, Inc., JPMorgan Chase Bank, N.A. and the various financial institutions as are or may become parties thereto, as Lenders, certain banks as co-documentation agents, and as co-syndication agents, and JPMorgan Chase Bank, N.A., as administrative agent for the Lenders and as collateral agent for the secured parties, previously filed as Exhibit 10.1 to the Registrant's Current Report on Form 8-K dated March 15, 2011, is incorporated herein by reference.

10.27 Credit Agreement, dated as of November 15, 2010 and amended and restated as of September 21, 2012, by and among Universal Health Services, Inc. (the borrower), the several lenders from time to time parties thereto, Credit Agricole Corporate and Investment Bank, Mizuho Corporate Bank LTD., Royal Bank of Canada and The Royal Bank of Scotland PLC (as co-documentation agents), Bank of Tokoyo-Mitsubishi UFJ Trust Company, Bank of America N.A. and Suntrust Bank (as co-syndication agents), and JPMorgan Chase Bank, N.A. (as administrative agent), previously filed as Exhibit 10.1 to the Registrant's Current Report on Form 8-K dated September 26, 2012, is incorporated herein by reference.

10.28 Second Amendment, dated as of September 21, 2012, to the Credit Agreement, dated as of November 15, 2010 (as amended from time to time), among Universal Health Services, Inc., a Delaware corporation, the several banks and other financial institutions from time to time parties thereto, JPMorgan Chase Bank, N.A., as administrative agent and the other agents party thereto, previously filed as Exhibit 10.2 to the Registrant's Current Report on Form 8-K dated September 26, 2012, is incorporated herein by reference.

10.29 Third Amendment, dated as of May 16, 2013, to the Credit Agreement, dated as of November 15, 2010, as amended from time to time, among Universal Health Services, Inc., a Delaware corporation, the several banks and other financial institutions from time to time parties thereto, JPMorgan Chase Bank, N.A., as administrative agent and the other agents party thereto, previously filed as Exhibit 10.1 to the Registrant's Current Report on Form 8-K dated May 17, 2013, is incorporated herein by reference.

10.30 Fourth Amendment, dated as of August 7, 2014, to the Credit Agreement, dated as of November 15, 2010, as previously amended from time to time, by and among Universal Health Services, Inc., the several banks and other financial institutions from time to time parties thereto, JPMorgan Chase Bank, N.A., as administrative agent and the other agents party thereto, previously filed as Exhibit 10.1 to the Registrant's Current Report on Form 8-K dated August 12, 2014, is incorporated herein by reference.

10.31 Credit Agreement, dated as of November 15, 2010 and amended and restated as of August 7, 2014, by and among Universal Health Services, Inc., the several banks and other financial institutions from time to time parties thereto, JPMorgan Chase Bank, N.A., as administrative agent and the other agents party thereto, previously filed as Exhibit 10.2 to the Registrant's Current Report on Form 8-K dated August 12, 2014, is incorporated herein by reference.

10.32* Form of Supplemental Life Insurance Plan and Agreement Part A: Alan B. Miller 1998 Dual Life Insurance Trust (effective December 9, 2010, by and between Universal Health Services, Inc., a Delaware corporation (the "Company"), and Anthony Pantaleoni as Trustee), previously filed as Exhibit 10.1 to the Registrant's Current Report on Form 8-K dated December 10, 2010, is incorporated herein by reference.

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10.33* Form of Supplemental Life Insurance Plan and Agreement Part B: Alan B. Miller 2002 Trust (effective December 9, 2010, by and between Universal Health Services, Inc., a Delaware corporation (the "Company"), and Anthony Pantaleoni as Trustee), previously filed as Exhibit 10.2 to the Registrant's Current Report on Form 8-K dated December 10, 2010, is incorporated herein by reference.

10.34* Universal Health Services, Inc. Termination, Assignment and Release Agreement (effective December 9, 2010, by and between Universal Health Services, Inc., a Delaware corporation (the "Company"), Anthony Pantaleoni as Trustee of the Alan B. Miller 1998 Dual Life Insurance Trust, and Alan B. Miller, Executive), previously filed as Exhibit 10.3 to the Registrant's Current Report on Form 8-K dated December 10, 2010, is incorporated herein by reference.

10.35* Universal Health Services, Inc. Termination, Assignment and Release Agreement (effective December 9, 2010, by and between Universal Health Services, Inc., a Delaware corporation (the "Company"), Anthony Pantaleoni as Trustee of the Alan B. Miller 2002 Trust, and Alan B. Miller, Executive), previously filed as Exhibit 10.4 to the Registrant's Current Report on Form 8-K dated December 10, 2010, is incorporated herein by reference.

10.36 Collateral Agreement, dated as of August 7, 2014, among Universal Health Services, Inc., the subsidiary guarantors party thereto, MUFG Union Bank, N.A., as 2014 Trustee, The Bank of New York Mellon Trust Company, N.A., as 2006 Trustee, and JPMorgan Chase Bank, N.A., as collateral agent, previously filed as Exhibit 10.4 to the Registrant's Current Report on Form 8-K dated August 12, 2014, is incorporated herein by reference.

11 Statement regarding computation of per share earnings is set forth in Note 1 of the Notes to the Consolidated Financial Statements.

21 Subsidiaries of Registrant.

23.1 Consent of Independent Registered Public Accounting Firm-PricewaterhouseCoopers LLP.

31.1 Certification from the Company's Chief Executive Officer Pursuant to Rule 13a-14(a)/15(d)-14(a) of the Securities Exchange Act of 1934.

31.2 Certification from the Company's Chief Financial Officer Pursuant to Rule 13a-14(a)/15(d)-14(a) of the Securities Exchange Act of 1934.

32.1 Certification from the Company's Chief Executive Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

32.2 Certification from the Company's Chief Financial Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

101.INS XBRL Instance Document

101.SCH XBRL Taxonomy Extension Schema Document

101.CAL XBRL Taxonomy Extension Calculation Linkbase Document

101.DEF XBRL Taxonomy Extension Definition Linkbase Document

101.LAB XBRL Taxonomy Extension Label Linkbase Document

101.PRE XBRL Taxonomy Extension Presentation Linkbase Document

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* Management contract or compensatory plan or arrangement.

Exhibits, other than those incorporated by reference, have been included in copies of this Annual Report filed with the Securities and Exchange Commission. Stockholders of the Company will be provided with copies of those exhibits upon written request to the Company.

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SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

UNIVERSAL HEALTH SERVICES, INC.

By: /s/ ALAN B. MILLER
Alan B. Miller
Chairman of the Board
and Chief Executive Officer

February 26, 2015

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

Signatures	Title	Date
/s/ ALAN B. MILLER **Alan B. Miller**	Chairman of the Board and Chief Executive Officer (Principal Executive Officer)	February 26, 2015
/s/ MARC D. MILLER **Marc D. Miller**	Director and President	February 26, 2015
/s/ LAWRENCE S. GIBBS **Lawrence S. Gibbs**	Director	February 26, 2015
/s/ JOHN H. HERRELL **John H. Herrell**	Director	February 26, 2015
/s/ ROBERT H. HOTZ **Robert H. Hotz**	Director	February 26, 2015
/s/ EILEEN C. MCDONNELL **Eileen C. McDonnell**	Director	February 26, 2015
/s/ ANTHONY PANTALEONI **Anthony Pantaleoni**	Director	February 26, 2015
/s/ STEVE FILTON **Steve Filton**	Senior Vice President, Chief Financial Officer and Secretary (Principal Financial and Accounting Officer)	February 26, 2015

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UNIVERSAL HEALTH SERVICES, INC.

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of Universal Health Services, Inc.:

In our opinion, the consolidated financial statements listed in the accompanying index present fairly, in all material respects, the financial position of Universal Health Services, Inc. and its subsidiaries at December 31, 2014 and 2013, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2014 in conformity with accounting principles generally accepted in the United States of America. In addition, in our opinion, the financial statement schedule listed in the accompanying index presents fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2014, based on criteria established in *Internal Control—Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these financial statements, financial statement schedule, and for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in Item 9A as *Management's Report on Internal Control over Financial Reporting*. Our responsibility is to express opinions on these financial statements, on the financial statement schedule, and on the Company's internal control over financial reporting based on our integrated audits. We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

As described in *Management's Report on Internal Control over Financial Reporting*, management has excluded Cygnet Health Care Limited, Prominence Health Plan, and the Psychiatric Institute of Washington, from its assessment of internal control over financial reporting as of December 31, 2014 because the entities were acquired by the Company in purchase business combinations during 2014. We have also excluded Cygnet Health Care Limited, Prominence Health Plan, and the Psychiatric Institute of Washington from our audit of internal control over financial reporting. Cygnet Health Care Limited, Prominence Health Plan, and the Psychiatric Institute of Washington are wholly-owned subsidiaries whose total assets and total net revenues represent 6% and 2%, respectively, of the related consolidated financial statement amounts as of and for the year ended December 31, 2014.

/s/ PricewaterhouseCoopers LLP

Philadelphia, Pennsylvania
February 26, 2015

SUPPLEMENTAL #1

May 22, 2015

11:56 am

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

	Year Ended December 31,		
	2014	2013	2012
	(in thousands, except per share data)		
Net revenues before provision for doubtful accounts	$8,764,309	$8,411,038	$7,688,071
Less: Provision for doubtful accounts	698,983	1,127,216	726,671
Net revenues	8,065,326	7,283,822	6,961,400
Operating charges:			
Salaries, wages and benefits	3,845,461	3,604,620	3,440,917
Other operating expenses	1,782,981	1,468,744	1,376,122
Supplies expense	895,693	821,089	799,621
Depreciation and amortization	375,624	337,172	302,426
Lease and rental expense	93,993	97,758	94,885
Transaction costs	0	0	5,716
Electronic health records incentive income	(27,902)	(61,024)	(30,038)
Costs related to extinguishment of debt	36,171	0	29,170
	7,002,021	6,268,359	6,018,819
Income from operations	1,063,305	1,015,463	942,581
Interest expense, net	133,638	146,131	178,918
Income before income taxes	929,667	869,332	763,663
Provision for income taxes	324,671	315,309	274,616
Net income	604,996	554,023	489,047
Less: Net income attributable to noncontrolling interests	59,653	43,290	45,601
Net income attributable to UHS	$ 545,343	$ 510,733	$ 443,446
Basic earnings per share attributable to UHS	$ 5.52	$ 5.21	$ 4.57
Diluted earnings per share attributable to UHS	$ 5.42	$ 5.14	$ 4.53
Weighted average number of common shares—basic	98,826	98,033	96,821
Add: Other share equivalents	1,718	1,328	890
Weighted average number of common shares and equivalents—diluted	100,544	99,361	97,711

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

SUPPLEMENTAL #1

May 22, 2015

11:56 am

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

	Year Ended December 31,		
	2014	2013	2012
Net income	$604,996	$554,023	$489,047
Other comprehensive income (loss):			
Unrealized derivative gains (losses) on cash flow hedges	17,668	16,963	6,677
Amortization of terminated hedge	(336)	(336)	(336)
Minimum pension liability	(14,270)	14,657	4,986
Foreign currency translation adjustment	(2,431)	0	0
Other comprehensive income (loss) before tax	631	31,284	11,327
Income tax (benefit) expense related to items of other comprehensive income	1,053	11,940	4,306
Total other comprehensive income (loss), net of tax	(422)	19,344	7,021
Comprehensive income	604,574	573,367	496,068
Less: Comprehensive income attributable to noncontrolling interests	59,653	43,290	45,601
Comprehensive income attributable to UHS	$544,921	$530,077	$450,467

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

Supplemental #2
-Original-

Lakeside Behavioral Health Systems

CN1505-019

TRAUGER & TUKE
ATTORNEYS AT LAW
THE SOUTHERN TURF BUILDING
222 FOURTH AVENUE NORTH
NASHVILLE, TENNESSEE 37219-2117
TELEPHONE (615) 256-8585
TELECOPIER (615) 256-7444

SUPPLEMENTAL #2
May 29, 2015
2:31 pm

May 29, 2015

VIA HAND DELIVERY

Mr. Phillip Earhart
Health Services Development Examiner
State of Tennessee
Health Services & Development Agency
502 Deaderick Street, 9th Floor
Nashville, TN 37243

RE: Response to Supplemental Questions #2 re: Lakeside Behavioral Health System Construction of new 48 bed Geriatric Building Certificate of Need – CN1505-019

Dear Mr. Earhart,

Enclosed please find a Supplemental Response #2, in triplicate, to be filed on behalf of my client UHS of Lakeside, LLC, d/b/a Lakeside Behavioral Health System. Please date stamp the additional enclosed copy of the Response and return it to me.

Thank you for your assistance.

Very truly yours,

Byron R. Trauger

BRT:kmn

Enclosures

cc: Ms. Joy Golden (via email)

SUPPLEMENTAL #2

May 29, 2015
2:31 pm

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Shelby

NAME OF FACILITY: UHS of Lakeside, LLC, d/b/a Lakeside Behavioral Health System

I, Anna Joy Golden, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Anna Joy Golden / CEO
Signature/Title
Managing Director

Sworn to and subscribed before me, a Notary Public, this the 29th day of May, 2015, witness my hand at office in the County of Shelby, State of Tennessee.

Gail Outland
NOTARY PUBLIC

My commission expires My Commission Expires: September 21, 2015.

GAIL OUTLAND
STATE OF TENNESSEE NOTARY PUBLIC
SHELBY COUNTY

HF-0043

Revised 7/02

SUPPLEMENTAL #2
May 29, 2015
2:31 pm

May 29, 2015

Phillip M. Earhart, HSD Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Re: CON Application CN1505-019
Lakeside Behavioral Health System

Dear Mr. Earhart:

This letter responds to your request dated May 28, 2015, for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

1. **Section C, Need, Item 4.A.**

   Your response to this item using 2017 as the projected year is noted. However, please use 2019 as the projected year. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the following table and include data for each county in your proposed service area.
   RESPONSE: The following page now represents current year 2015 and projected year 2019 data on each Tennessee county in proposed service area.

2. **Section C, Need, Item 6**

   The average annual occupancy for the Geriatric program for 2012-2104 is incorrect in Table Eight on page 35 of the original application. Please revise and submit a replacement page.

   The Hospital Projections portion of table eight on page 35 is misleading. The average annual occupancy of 91.7% and 93.9% actually represents the occupancy in Year One and Year Two for the entire 261 bed hospital, not on admission growth. Please replace the Hospital Projection portion of table eight with the projection for the 48 geriatric beds mentioned in the LOI and include in the replacement page for page 35.
   RESPONSE:
   Table adjusted to reflect the 48-bed geriatric project.

Demograhic Characteristics of Tennessee Service area - Ages 65 and up
Lakeside Behavioral Health System
2015 Current - 2019 Projected Year

Demographic	Benton County	Carroll County	Chester County	Crockett County	Decatur County	Dyer County	Fayette County	Gibson County	Hardeman County	Hardin County	Haywood County
STATE OF TENNESSEE											
Current Year (2015) Age 65+	3,763	5,628	2,824	2,566	2,583	6,424	7,271	8,875	4,308	5,508	2,821
Projected Year (2019) Age 65+	3,898	5,828	2,951	2,673	2,657	6,925	8,408	9,353	4,631	5,900	3,136
Age 65+,% Change	3.6%	3.6%	4.5%	4.2%	2.9%	7.8%	15.6%	5.4%	7.5%	7.1%	11.2%
Age 65+, % Total (2015)	23.2%	20.1%	16.1%	17.6%	21.7%	16.8%	17.4%	17.3%	16.4%	21.1%	15.6%
CY, Total Population	16,208	28,012	17,593	14,611	11,883	38,246	41,835	51,412	26,231	26,075	18,044
PY, Total Population	16,071	27,781	18,151	14,715	12,156	38,482	45,963	52,350	26,035	26,310	18,032
Total Population % Change	-0.8%	-0.8%	3.2%	0.7%	2.3%	0.6%	9.9%	1.8%	-0.7%	0.9%	-0.1%
TennCare Enrollees	3,954	7,536	3,847	3,880	2,765	10,332	6,782	12,859	6,936	7,053	5,784
TennCare Enrollees as a % of Total Population	24.4%	26.9%	21.9%	26.6%	23.3%	27.0%	16.2%	25.0%	26.4%	27.0%	32.1%
Median Age	45	42	36	39	44	39	41	39	39	43	39
Median Household Income	$33,033	$35,049	$41,875	$36,066	$36,258	$38,953	$56,618	$38,343	$30,973	$33,622	$34,542
Population % Below Poverty Level	23.0%	19.2%	19.4%	21.1%	19.6%	17.7%	16.4%	19.8%	27.3%	21.4%	21.9%

2015 Current - 2019 Projected Year

Demographic	Henderson County	Henry County	Lake County	Lauderdale County	Madison County	McNairy County	Obion County	Shelby County	Tipton County	Weakley County	Service Area	Tennessee
STATE OF TENNESSEE												
Current Year (CY) Age 65+	4,892	7,033	1,162	3,922	14,747	5,194	5,995	112,753	8,414	5,933	222,616	1,012,937
Projected Year (PY) Age 65+	5,371	7,351	1,250	4,292	16,289	5,568	6,347	129,543	9,778	6,292	488,127	1,134,565
Age 65+,% Change	9.8%	4.5%	7.6%	9.4%	10.5%	7.2%	5.9%	14.9%	16.2%	6.1%	119.3%	12.0%
Age 65+, % Total (2015)	17.3%	21.5%	12.0%	14.4%	14.8%	19.4%	19.1%	11.9%	13.0%	15.3%	13.9%	16.5%
CY, Total Population	28,279	32,766	9,676	27,264	99,971	26,755	31,365	946,559	64,759	38,790	1,596,334	6,649,438
PY, Total Population	28,743	33,015	9,411	27,135	101,279	27,509	31,218	956,200	68,477	39,709	1,618,742	6,894,997
Total Population % Change	1.6%	0.8%	-2.7%	-0.5%	1.3%	2.8%	-0.5%	1.0%	5.7%	2.4%	1.4%	3.[illegible]%
TennCare Enrollees	6,954	7,841	2,163	7,749	23,892	7,529	7,670	257,872	13,213	7,039	413,650	1,399,007
TennCare Enrollees as a % of Total Population	24.6%	23.9%	22.4%	28.4%	23.9%	28.1%	24.5%	27.2%	20.4%	18.1%	25.9%	21.[illegible]%
Median Age	39	44	38	36	36	41	41	34	36	37	39	38
Median Household Income	$38,280	$36,950	$27,115	$32,326	$41,617	$33,452	$39,467	$46,250	$52,423	$35,273	$38,023	$44,298
Population % Below Poverty Level	19.1%	19.2%	44.8%	28.7%	18.4%	21.5%	19.7%	21.8%	14.3%	21.0%	21.5%	17.8%

Source: 1) Tennessee Dept. of Health, Division of Policy, Planning and Assessment, Office of Health Statistics 2)Surburban Stats.org/Tennessee Population by County/Age 3) TN Dept. of Health Statistics Web Page

May 29, 2015 2:23 pm

SUPPLEMENTAL #2

SUPPLEMENTAL #2

May 29, 2015
2:31 pm

Acute IP Beds	2012	2013	2014	% Change 12-14	Year One	Year Two
Geriatric (65+)						
Beds	48	48	48	0.0%	48	48
Admissions	494	446	506	2.4%	542	612
Average Daily Census (ADC)	24.4	27.8	28.9	18.5%	30.9	34.9
Average Length of Stay (ALOS)	18.0	22.8	20.8	15.7%	20.8	20.8
% Occupancy	50.8%	57.9%	60.1%	18.5%	64.3%	72.6%

3. **Section C. (Economic Feasibility) Item 4**

The geriatric Projected Data Chart for the volume growth is noted. However, please provide a Projected Data Chart representing the 48 geriatric psychiatric beds that is mentioned in the letter of intent. Please revise any other portions of the application that represents the revised Projected Data Chart for 48 geriatric beds and submit replacement pages.
RESPONSE: The following chart represents the 48-bed geriatric bed project.

SUPPLEMENTAL #2

May 29, 2015
2:31 pm

PROJECTED DATA Geriatric Only

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

Financial Data in Thousands			Year One	Year Two
A. Utilization Data (Specify unit of measure) Pt Days		Pt Days	11,265	12,725
B. Revenue from Services to Patients				
1 Inpatient Services			$15,650.95	$17,701.86
2 Outpatient Services				
3 Emergency Services				
4 Other Operating Revenue (Specify)				
	Gross Operating Revenue		$15,650.95	$17,701.86
C. Deductions from Gross Operating Revenue				
1 Contractual Adjustments			$8,070.10	$9,094.09
2 Provision for Charity Care			$0.00	$0.00
3 Provisions for Bad Debt			$274.85	$286.96
	Total Deductions		$8,344.96	$9,381.05
NET OPERATING REVENUE			$7,305.99	$8,320.81
D. Operating Expenses				
1 Salaries and Wages			$2,710.17	$2,803.68
2 Physician's Salaries and Wages			$49.72	$49.72
3 Supplies			$446.68	$502.18
4 Taxes			$0.00	$0.00
5 Depreciation			$493.00	$493.00
6 Rent			$37.08	$37.08
7 Interest, other than Capital			$0.00	$0.00
8 Management Fees:			$0.00	$0.00
a.	Fees to Affiliates		$157.57	$157.57
b.	Fees to Non-Affiliates		$0.00	$0.00
9 Other Expenses (Specify) Purchased Services, Maintenance, Travel, Insurance			$1,089.62	$1,140.29
	Total Operating Expenses		$4,983.84	$5,183.52
E. Other Revenue (Expenses) – Net (Specify)			$0.00	$0.00
NET OPERATING INCOME (LOSS)			$2,322.15	$3,137.29
F. Capital Expenditures				
1 Retirement of Principal				
2 Interest			$334.39	$334.39
	Total Capital Expenditures		$334.39	$334.39
NET OPERATING INCOME (LOSS)			$1,987.75	$2,802.90

SUPPLEMENTAL #2

May 29, 2015
2:31 pm

4. **Section C. (Economic Feasibility) Item 5**

Please provide the project's average gross charge, average deduction from operating revenue and average net charge for the projected data chart representing the 48 bed geriatric beds. Please revise table sixteen and resubmit.
RESPONSE: Revised table 16 for 48-bed geriatric project.

Average Charges, Deductions, Net Charges, Net Operating Income		
	Year One	**Year Two**
Patient Days	11,265	12,725
Admissions or Discharges	542	612
Average Gross IP Charge Per Day	$1,389	$1,391
Average Gross IP Charge Per Admission	$28,876	$28,925
Average Deduction from Operating Revenue per day	$741	$737
Average Deduction from Operating Revenue per Admission	$15,397	$15,329
Average Net Charge (Net Operating Revenue) Per Day	$649	$654
Average Net Charge (Net Operating Revenue) Per Admission	$13,480	$13,596
Average Net Operating Income after Expenses, Per Day	$176	$220
Average Net Operating Income after Expenses, Per Admission	$3,667	$4,580

Source: Lakeside corporate management

5. **Section C. (Economic Feasibility) Item 9.**

Please revise the Year One Gross Revenue and percentages for TennCare and Medicare representing the 48 geriatric beds that is subject to the proposed project.
RESPONSE: Revised chart for 48-bed geriatric project.

Medicare and TennCare/Medicaid Revenues, Year One		
	Medicare	TennCare/Medicaid
Gross Revenue	$11,486,960	$1,326,060
Percent of Gross Revenue	73%	8.5%

Source: Lakeside corporate management

6. **Section C. Orderly Development, Item 7.d**

The summary for the 9/11/2013 Joint Commission Survey and the Tennessee Department of Mental Health and Substance Abuse Services survey dated 11/14/2014 are noted. However, as previously requested please provide a copy of the actual survey with patient identifying information blackened.
RESPONSE: Full survey copies are attached.

SUPPLEMENTAL #2

May 29, 2015
2:31 pm

Thank you for your assistance in explaining the additional information requested. Please advise if any further clarification is needed.

Respectfully,

Anna Joy Golden, MSN, RN
CEO/Managing Director
Lakeside Behavioral Health System
2911 Brunswick Road
Memphis, TN 38133
901-377-4774

SUPPLEMENTAL #2
May 29, 2015
2:31 pm

SUPPLEMENTAL – 2
CN150-019

6. Section C. Orderly Development, Item 7.d

Joint Commission Accreditation Survey
and
Tennessee Department of Mental Health and Substance Abuse Services Survey

The Joint Commission

SUPPLEMENTAL #2

May 29, 2015
2:31 pm

September 11, 2013

Anna J. Golden, RN
CEO
Lakeside Behavioral Health System, LLC
2911 Brunswick Road
Memphis, TN 38133

Joint Commission ID #: 1646
Program: Behavioral Health Care Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 09/11/2013

Dear Ms. Golden:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Behavioral Health Care

This accreditation cycle is effective beginning June 04, 2013. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

The Joint Commission

SUPPLEMENTAL #2

May 29, 2015
2:31 pm

September 11, 2013

Anna J. Golden, RN
CEO
Lakeside Behavioral Health System, LLC
2911 Brunswick Road
Memphis, TN 38133

Joint Commission ID #: 1646
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 09/11/2013

Dear Ms. Golden:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning June 06, 2013. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

The Joint Commission

SUPPLEMENTAL #2

May 29, 2015
2:31 pm

Lakeside Behavioral Health System, LLC
2911 Brunswick Road
Memphis, TN 38133

Organization Identification Number: 1646

Program(s)	**Survey Date(s)**
Hospital Accreditation Behavioral Health Care Accreditation	06/03/2013-06/05/2013

Executive Summary

Hospital Accreditation :	As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report. You will have follow-up in the area(s) indicated below: • Evidence of Standards Compliance (ESC)
Behavioral Health Care Accreditation :	As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report. You will have follow-up in the area(s) indicated below: • Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EM.02.02.13	EP5
	MM.04.01.01	EP8
	PC.03.05.11	EP1

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.03.01.01	EP2
	IC.01.03.01	EP4
	IC.02.01.01	EP1
	IM.04.01.01	EP1
	MM.08.01.01	EP3
	MS.01.01.01	EP3,EP16
	MS.06.01.05	EP6,EP7
	PC.01.02.05	EP1
	PC.01.03.01	EP22
	RC.01.01.01	EP19
Program:	Behavioral Health Care Accreditation Program	
Standards:	CTS.02.02.01	EP1
	CTS.03.01.03	EP2,EP3

CoP: §482.13 **Tag:** A-0115 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.13 Condition of Participation: Patient's Rights

A hospital must protect and promote each patient's rights.

CoP Standard	Tag	Corresponds to	Deficiency
§482.13(e)(14)	A-0182	HAP - PC.03.05.11/EP1	Standard

CoP: §482.22 **Tag:** A-0338 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.22 Condition of Participation: Medical staff

The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.22(c)(5)(i)	A-0358	HAP - MS.01.01.01/EP16	Standard

CoP: §482.23 **Tag:** A-0385 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.23 Condition of Participation: Nursing Services

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

CoP Standard	Tag	Corresponds to	Deficiency
§482.23(b)(4)	A-0396	HAP - PC.01.02.05/EP1	Standard

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(b)	A-0438	HAP - IM.04.01.01/EP1	Standard
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Standard

CoP: §482.42 **Tag:** A-0747 **Deficiency:** Standard

Corresponds to: HAP - IC.01.03.01/EP4, IC.02.01.01/EP1

Text: §482.42 Condition of Participation: Infection Control

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

CoP: §482.61 **Tag:** B103 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.61 Condition of Participation: Special medical record requirements for psychiatric hospitals.

The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.

CoP Standard	Tag	Corresponds to	Deficiency
§482.61(c)(1)(iii)	B122	HAP - PC.01.03.01/EP22	Standard

CoP: §482.12 **Tag:** A-0043 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.12 Condition of Participation: Governing Body

There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. The governing body (or the persons legally responsible for the conduct of the hospital and carrying out the functions specified in this part that pertain to the governing body) must include a member, or members, of the hospital's medical staff.

CoP Standard	Tag	Corresponds to	Deficiency
§482.12(a)(6)	A-0050	HAP - MS.06.01.05/EP7	Standard

Chapter: Emergency Management

Program: Hospital Accreditation

Standard: EM.02.02.13

ESC 45 days

Standard Text: During disasters, the hospital may grant disaster privileges to volunteer licensed independent practitioners.
Note: A disaster is an emergency that, due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety, or security functions.

Primary Priority Focus Area: Credentialed Practitioners

Element(s) of Performance:

5. Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following:
- A current picture identification card from a health care organization that clearly identifies professional designation
- A current license to practice
- Primary source verification of licensure
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group
- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
- Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster

Scoring
Category : A
Score : Insufficient Compliance

Observation(s):

EP 5
Observed in Review of Medical Staff Bylaws at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site. This organization's Medical Staff Bylaws only require 1 form of identification for privileging of LIPs in a Disaster instead of two - a government picture ID and a medical license for example.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.03.01.01

ESC 60 days

Standard Text: Staff and licensed independent practitioners are familiar with their roles and responsibilities relative to the environment of care.

Primary Priority Focus Area: Communication

Element(s) of Performance:

2. Staff and licensed independent practitioners can describe or demonstrate actions to take in the event of an environment of care incident. (See also EC.02.03.01, EP 10 and HR.01.04.01, EP 1)

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in Tracer Activities at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site.
West Building - 2nd floor; During an interview with a staff on the 2nd floor Adult unit, it was learned that the staff was unable to describe or demonstrate Hospital's fire plan or the appropriate action taken during a fire.The staff could not identify the nearest fire pull box, fire extinguisher or smoke barrier.

Observed in Tracer Activities at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site.
West Building - Kitchen; It was learned during an interview with a staff in the kitchen that the staff was unable to describe or demonstrate the proper usage of portable fire extinguishers. Staff was not familiar with the "K" type extinguisher or fixed suppression system.

Observed in Tracer Activities at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site.
East Building - During an interview with a staff on the 1st floor Adult unit, it was learned that the staff was unable to describe or demonstrate Hospital's fire plan or the appropriate action taken during a fire.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.01.03.01

ESC 60 days

Standard Text: The hospital identifies risks for acquiring and transmitting infections.

Primary Priority Focus Area: Infection Control

Element(s) of Performance:

4. The hospital reviews and identifies its risks at least annually and whenever significant changes occur with input from, at a minimum, infection control personnel, medical staff, nursing, and leadership. (See also NPSG.07.03.01, EP 1)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control
This Condition is NOT MET as evidenced by:
Observed in Infection Control System Tracer at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site for the Psychiatric Hospital deemed service.
The organization has determined goals for the current year but they are not based on a current risk assessment. There has been a recent change in census as well as the population served relative to the closing of a downtown hospital. The impact of this has not been re-evaluated since the original assessment in 2012 which exactly mirrored the one completed in 2011.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.01.01

ESC 60 days

Standard Text: The hospital implements its infection prevention and control plan.

Primary Priority Focus Area: Infection Control

Element(s) of Performance:

1. The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 1
§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control
This Condition is NOT MET as evidenced by:
Observed in West Unit at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site for the Psychiatric Hospital deemed service.
In the storage area where clean linen is kept, it was observed that the bottom rack was open and therefore the linen was exposed to what was on the floor below.

Observed in Bridges Unit at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site for the Psychiatric Hospital deemed service.
Another observation was made of a linen cart with an open exposed bottom. In addition the linen was covered but in a room with the housekeeping cart and shelves loaded with patient belongings from home.

Chapter: Information Management

Program: Hospital Accreditation

Standard: IM.04.01.01

ESC 60 days

Standard Text: The hospital maintains accurate health information.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

1. The hospital has processes to check the accuracy of health information.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.24(b) - (A-0438) - §482.24(b) Standard: Form and Retention of Record

The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.
This Standard is NOT MET as evidenced by:
Observed in Record Review at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site for the Psychiatric Hospital deemed service.
The discharge summary of a 15 year old female was dictated and / or transcribed referring to a "15 year old African American male". All other gender references were specific to a female.

Chapter:	Medical Staff
Program:	Hospital Accreditation
Standard:	MS.01.01.01 ESC 60 days
Standard Text:	Medical staff bylaws address self-governance and accountability to the governing body.
Primary Priority Focus Area:	Credentialed Practitioners

Element(s) of Performance:

3. Every requirement set forth in Elements of Performance 12 through 36 is in the medical staff bylaws. These requirements may have associated details, some of which may be extensive; such details may reside in the medical staff bylaws, rules and regulations, or policies. The organized medical staff adopts what constitutes the associated details, where they reside, and whether their adoption can be delegated. Adoption of associated details that reside in medical staff bylaws cannot be delegated. For those Elements of Performance 12 through 36 that require a process, the medical staff bylaws include at a minimum the basic steps, as determined by the organized medical staff and approved by the governing body, required for implementation of the requirement. The organized medical staff submits its proposals to the governing body for action. Proposals become effective only upon governing body approval. (See the 'Leadership' (LD) chapter for requirements regarding the governing body's authority and conflict management processes.)
Note: If an organization is found to be out of compliance with this Element of Performance, the citation will occur at the appropriate Element(s) of Performance 12 through 36.

Scoring Category : A
Score : Insufficient Compliance

16. For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The requirements for completing and documenting medical histories and physical examinations. The medical history and physical examination are completed and documented by a physician, an oralmaxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy. (For more information on performing the medical history and physical examination, refer to MS.03.01.01, EPs 6 -11.)
Note 1: The definition of 'physician' is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).
Note 2: The requirements referred to in this element of performance are, at a minimum, those described in the element of performance and Standard PC.01.02.03, EPs 4 and 5.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
Observed in Medical Staff Bylaws Review at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site.
A finding was entered at EP 16 as the Bylaws don't include the requirements for completion of the H&Ps.

EP 16
§482.22(c)(5)(i) - (A-0358) - (i) A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.
This Standard is NOT MET as evidenced by:
Observed in Medical Staff Bylaws Review at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site for the Psychiatric Hospital deemed service.
The requirements for completing H&Ps are contained in this organization's Rules and Regulations, not the Bylaws.

Chapter:	Medical Staff
Program:	Hospital Accreditation
Standard:	MS.06.01.05 ESC 60 days
Standard Text:	The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidence-based process.
Primary Priority Focus Area:	Credentialed Practitioners

Element(s) of Performance:

6. An applicant submits a statement that no health problems exist that could affect his or her ability to perform the privileges requested.
Note: The applicant's ability to perform privileges requested must be evaluated. This evaluation is documented in the individual's credentials file. Such documentation may include the applicant's statement that no health problems exist that could affect his or her practice.
Documentation regarding an applicant's health status and his or her ability to practice should be confirmed. Initial applicants may have their health status confirmed by the director of a training program, the chief of services, or the chief of staff at another hospital at which the applicant holds privileges, or a by currently licensed doctor of medicine or osteopathy approved by the organized medical staff.
In instances where there is doubt about an applicant's ability to perform privileges requested, an evaluation by an external and internal source may be required. The request for an evaluation rests with the organized medical staff.

Scoring Category : A
Score : Insufficient Compliance

7. The hospital queries the National Practitioner Data Bank (NPDB) when clinical privileges are initially granted, at the time of renewal of privileges, and when a new privilege(s) is requested.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 6
Observed in Credentialing and Privileging at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site.
A health statement was not obtained prior to an ARNP being reprivileged.

EP 7
§482.12(a)(6) - (A-0050) - [The governing body must:]

(6) Ensure the criteria for selection are individual character, competence, training, experience, and judgment; and
This Standard is NOT MET as evidenced by:
Observed in Credentialing and Privileging at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site for the Psychiatric Hospital deemed service.
A query of the NPDB was not completed prior to an ARNP being reprivileged.

Chapter: Medication Management
Program: Hospital Accreditation
Standard: MM.04.01.01
Standard Text: Medication orders are clear and accurate.
Primary Priority Focus Area: Medication Management

ESC 45 days

Element(s) of Performance:

8. The hospital prohibits summary (blanket) orders to resume previous medications.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 8
Observed in Individual Tracer at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site.
On admission, an order written on the record of a bipolar patient in a very manic phase stated the patient "may take own medications". No specific medication was identified which violates the organization's policy number 61 titled: Medication Ordering, Dispensing, and Administration. .

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.08.01.01

Standard Text: The hospital evaluates the effectiveness of its medication management system. Note: This evaluation includes reconciling medication information. (Refer to NPSG.03.06.01 for more information)

Primary Priority Focus Area: Quality Improvement Expertise/Activities

Element(s) of Performance:

3. The hospital compares data over time to identify risk points, levels of performance, patterns, trends, and variations of its medication management system.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
Observed in Medication Management Tracer at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site.
In meeting with the Risk Manager and the Pharmacy Director it was learned that this organization is collecting ADR and Med Error Data and reporting it quarterly. They have yet to aggregate and trend over time for the purpose of identifying system risk points and opportunities for PI of the system

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Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.02.05

Standard Text: Qualified staff or licensed independent practitioners assess and reassess the patient.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

1. Based on the initial assessment, a registered nurse determines the patient's need for nursing care, as required by hospital policy and law and regulation.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.23(b)(4) - (A-0396) - (4) The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site for the Psychiatric Hospital deemed service.
The Initial Nursing Care Plan was not done until the day after admission.

Observed in Individual Tracer at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site for the Psychiatric Hospital deemed service.
The nurse had listed a problem on the patient's Initial Care Plan on the day of admission, but no nursing interventions were listed for this problem 5 days after admission.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.03.01

ESC 60 days

Standard Text: The hospital plans the patient's care.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

22. Based on the goals established in the patient's plan of care, staff evaluate the patient's progress.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 22
§482.61(c)(1)(iii) - (B122) - (iii) The specific treatment modalities utilized;
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site for the Psychiatric Hospital deemed service.
During an individual tracer with a IOP, CD patient it was noted that the goals on the treatment plan were not measurable in a manner that would allow evaluation of progress.

Observed in Individual Tracer at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site for the Psychiatric Hospital deemed service.
During Tracer activity the surveyor noted that there were no clinician interventions listed in the Treatment Plan as per the Treatment Planning section of the facility's Plan for the Provision of Care policy CC.001. The patient's Progress Notes also did not record the patient's progress towards the Treatment Plan goals and objectives.

Observed in Individual Tracer at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site for the Psychiatric Hospital deemed service.
Treatment Plan is not measurable and specific for this patient and the Progress Notes do not reflect the patient's progress toward Treatment Plan goals and objectives.

Observed in Individual Tracer at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site for the Psychiatric Hospital deemed service.
The surveyor noted the need to have a specific goal that can be measured on Treatment Plan. Currently the Plan states the patient will report a decrease of delusions and paranoia prior to discharge. It can be difficult to measure "decrease" without a severity or quantifiable value to compare progress to over time.

Chapter:	Provision of Care, Treatment, and Services
Program:	Hospital Accreditation
Standard:	PC.03.05.11 ESC 45 days
Standard Text:	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital evaluates and reevaluates the patient who is restrained or secluded.
Primary Priority Focus Area:	Assessment and Care/Services

Element(s) of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes: A physician, clinical psychologist, or other licensed independent practitioner responsible for the care of the patient evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse or a physician assistant may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3.
Note 1: States may have statute or regulation requirements that are more restrictive than the requirements in this element of performance.
Note 2: The definition of 'physician' is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

Scoring
Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.13(e)(14) - (A-0182) - (14) If the face-to-face evaluation specified in paragraph (e)(12) of this section is conducted by a trained registered nurse or physician assistant, the trained registered nurse or physician assistant must consult the attending physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) as soon as possible after the completion of the 1 hour face-to-face evaluation.
This Standard is NOT MET as evidenced by:
Observed in Record Review at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site for the Psychiatric Hospital deemed service.
A patient who had been ordered into seclusion for potential self harm at 0740 was not evaluated until 0900 by the RN supervisor and at 0910 by the physician.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.01.01.01

ESC 60 days

Standard Text: The hospital maintains complete and accurate medical records for each individual patient.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

19. For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed.

Scoring
Category : C
Score : Partial Compliance

Observation(s):

EP 19
§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.
This Standard is NOT MET as evidenced by:
Observed in Record Review at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site for the Psychiatric Hospital deemed service.
On 05/13/2013 and 05/14/2013 the therapist's notes were not timed.

Observed in Record Review at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site for the Psychiatric Hospital deemed service.
On a progress note titled "Child Program - Weekday" There was neither a date or time for any of the identified activities involving considerable data and multiple signatures.

Chapter:	Care, Treatment, and Services
Program:	Behavioral Health Care Accreditation
Standard:	CTS.02.02.01 ESC 60 days
Standard Text:	The organization collects assessment data on each individual served.
Primary Priority Focus Area:	Assessment and Care/Services

Element(s) of Performance:

1. As relevant to care, treatment, or services, the organization collects the following assessment data about each individual served:
- Environment and living situation(s)
- Leisure and recreation interests
- Religion or spiritual orientation
- Cultural preferences
- Childhood history
- Military service history, if applicable
- Financial issues
- Usual social, peer-group, and environmental setting(s)
- Language preference and language(s) spoken
- Ability to self-care
- Family circumstances, including bereavement
- Current and past trauma
- Community resources accessed by the individual served

Note 1: Relevance to care, treatment, or services may be determined by the individual's presenting needs and the organization's scope of care, treatment, or services.
Note 2: For certain populations, early identification of community resources is important to care, treatment, or services. Such populations include individuals with severe mental illness or disabilities, and children and youth. Community resources for these groups encompass a wide range of services. These services are supportive (such as community mental health, sheltered living, day treatment, or activity programs) as well as commonly accessed by the general public (such as public transportation, banking or retail stores, and so on). For youth or children in foster care or in-home services, resources might include community mental health centers, teen centers, YMCAs, or Jewish community centers. These sources of community services may be used as informational, discharge planning, supportive, or continuing care resources.

Scoring
Category : C
Score : Partial Compliance

Observation(s):

EP 1
Observed in Individual Tracer at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site.
During an individual tracer with an Adult PHP patient it was noted that the portion of the assessment that collects information on cultural issues was left blank.

Observed in Individual Tracer at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site.
During an individual tracer with an Adolescent PHP patient it was noted that the portion of the assessment that collects information on cultural issues was left blank.

Chapter: Care, Treatment, and Services

Program: Behavioral Health Care Accreditation

Standard: CTS.03.01.03

ESC 60 days

Standard Text: The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

2. The plan for care, treatment, or services includes the following:
- Goals that are expressed in a manner that captures the individual's words or ideas
- Goals that build on the individual's strengths
- Factors that support the transition to community integration when identified as a need during assessment

Note 1: Barriers that might need to be considered include co-occurring illnesses, cognitive and communicative disorders, developmental disabilities, vision or hearing disabilities, physical disabilities, and social and environmental factors.
Note 2: For opioid treatment programs: For patients receiving interim maintenance treatment, neither an initial treatment plan nor a periodic treatment plan evaluation is required.

Scoring Category : C
Score : Insufficient Compliance

3. The objectives of the plan for care, treatment, or services meet the following criteria:
- They include identified steps to achieve the goal(s) (See also CTS.03.01.01, EP 3)
- They are sufficiently specific to assess the progress of the individual served
- They are expressed in terms that provide indices of progress

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in Individual Tracer at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site. During an individual tracer with an Adult PHP patient it was noted that the goals were not expressed in a manner that captured the individuals words or ideas. It should be noted that they were written in a professional manner.

Observed in Individual Tracer at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site. During an individual tracer with an Adult MH IOP patient it was noted that the goals did not capture the patients words or ideas but were written in much more professional language.

Observed in Individual Tracer at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site. During an individual tracer with an Adult MH PHP patient it was noted that the goals did not capture the patients words or ideas. Rather they were written in much more professional language.

EP 3
Observed in Individual Tracer at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site. During an individual tracer with an Adult PHP patient it was noted that the treatment objectives lacked any identified steps to achieve the goal/objective.

Observed in Individual Tracer at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site. During a 2nd individual tracer with an Adult PHP patient it was noted that the treatment objectives lacked any identified steps to achieve the goal/objective.

Observed in Individual Tracer at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site. During an individual tracer in the Adolescent IOP-MH program it was noted that the treatment objectives lacked identified steps to achieve the goal and were not expressed in terms that provide indices of progress.

Observed in Individual Tracer at UHS of Lakeside, LLC (2911 Brunswick Road, Memphis, TN) site. During an individual tracer in the Adolescent IOP-MH program it was noted that the treatment objectives lacked identified steps to achieve the goal and were not expressed in terms that provide indices of progress.

SUPPLEMENTAL #2

May 29, 2015
2:31 pm

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
West Tennessee Regional Office of Licensure
951 Court Avenue
MEMPHIS, TENNESSEE 38103

BILL HASLAM
GOVERNOR

E. DOUGLAS VARNEY
COMMISSIONER

COMPLIANCE EVENT STATUS REPORT

LICENSEE:	FACILITY:
Licensee ID: 1012	Site ID: 2248
UHS of Lakeside, LLC 2911 Brunswick Road Memphis, TN 38133	Lakeside Behavioral Health System 2911 Brunswick Road Memphis, TN 38133

NOTICE TO LICENSEE: A review has been completed of your recently submitted plan of compliance. The approval status given your plan is indicated below. Read the approval status given below carefully. This approval status form and your plan of compliance should become part of your records.

DATE OF NOTICE / REPORT: 12/12/14
DATE OF ASSOCIATED NOTICE OF NON-COMPLIANCE: 11/12/14
COMPLIANCE EVENT & DATE: Annual Inspection 11/7/14
Site ID:2248 Event ID:2,968

I. REVIEW OF PLAN OF NON-COMPLIANCE COMPLETED BY:

Sandra Randle

Sandy Randle, West Tennessee Licensure

II. APPROVAL STATUS OF PLAN OF NON-COMPLIANCE:

POC Approved
Your plan of compliance has been accepted. You are expected to meet the terms of your plan. Re-inspection may be conducted to verify compliance. With re-inspection, you will incur a $50 re-inspection fee.

EVENT SUMMARY

09450-5-02 Licensure Administration and Procedures	0 deficiencies
09450-5-04-.02 Life Safety: HealthCare Occupancies	5 deficiencies
09450-5-04-.09 Life Safety: Mobile Non-ambulatory	0 deficiencies
09450-5-05-.02 Adequacy of Facility Environment and Ancillary Services (ALL FACILITIES)	5 deficiencies
09450-5-05-.03 Adequacy of Facility Environment & Ancillary Services (RESIDENTIAL)	3 deficiencies
09450-5-05-.04 Adequacy of Facility Environment & Ancillary Services (NON-RESIDENTIAL)	0 deficiencies
09450-5-05-.05 Adequacy of Facility Environment & Ancillary Services (FOOD SERVICE)	2 deficiencies
09450-5-05-.06 Adequacy of Facility Environment & Ancillary Services (TRANSPORTATION)	0 deficiencies
09450-5-05-.07 Adequacy of Facility Environment & Ancillary Services (CHILDREN)	0 deficiencies
09450-5-05-.09 Adequacy of Facility Environment & Ancillary Services (VISION LOSS)	0 deficiencies
09450-5-05-.10 Residential Facilities Serving Hearing Impaired (HEARING LOSS)	0 deficiencies
09450-5-05-.11 Non-Residential Facilities Serving Hearing Impaired (HEARING LOSS)	0 deficiencies
09450-5-06 Program Requirements for All Services and Facilities (DEEMED)	1 deficiency
09450-5-14 Mental Health Outpatient Facilities (DEEMED)	0 deficiencies
09450-5-15 Mental Health Adult Day Treatment Services (DEEMED)	0 deficiencies
09450-5-16 Mental Health Hospital Facilities (DEEMED)	1 deficiency

May 29, 2015
2:31 pm

09450-5-17 Mental Health Adult Residential Treatment Services (DEEMED)	0 deficiencies
09450-5-18 Mental Health Crisis Stabilization Unit Facilities (DEEMED)	0 deficiencies
09450-5-30 Mental Health Intensive Day Treatment Program Children & Adolescents Facilitie	0 deficiencies
09450-5-33 Mental Health Partial Hospitalization Programs (DEEMED)	0 deficiencies
09450-5-37 Mental Health Residential Treatment Facility For Children and Youth (DEEMED)	0 deficiencies
09450-5-43 Alcohol and Drug Non-Residential Rehabilitation Treatment Facilities (DEEMED)	0 deficiencies
09450-5-44 Alcohol and Drug Residential Detoxification Treatment Facilities (DEEMED)	0 deficiencies
09450-5-45 Alcohol and Drug Residential Rehabilitation Treatment Facilities (DEEMED)	0 deficiencies
09450-5-46 Alcohol and Drug Residential Treatment Facilities for Children and Youth (DEEM	0 deficiencies

SUPPLEMENTAL #2

May 29, 2015
2:31 pm

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
West Tennessee Regional Office of Licensure
951 Court Avenue
MEMPHIS, TENNESSEE 38103

BILL HASLAM
GOVERNOR

E. DOUGLAS VARNEY
COMMISSIONER

LICENSURE NOTICE OF NON-COMPLIANCE

TO: UHS of Lakeside, LLC
2911 Brunswick Road
Memphis, TN 38133

DATE OF NOTICE:
November 12, 2014
Page 1 of 6

FACILITY IN NON-COMPLIANCE:
Lakeside Behavioral Health System
2911 Brunswick Road
Memphis, TN 38133

Plan of Compliance due by: 11/26/14

Site ID:
2248

EVENT & DATE RESULTING IN THIS NOTICE:
Annual Inspection
November 7, 2014

NOTICE TO LICENSEE: The facility above has been found to be non-compliant with the rule(s) listed herein. You must provide a plan for complying with each rule cited. Your plan of compliance may be specified in the space provided below or by separate document. If a separate document, your plan should reference each rule by item or rule number, must include the date by which you will be compliant, and an authorizing signature. Your plan must be received by the TDMHSAS regional office listed above by the date indicated herein.

PLEASE RETAIN A COPY OF YOUR PLAN OF COMPLIANCE UPON SUBMISSION
IT WILL NOT BE RETURNED TO YOU BY THIS OFFICE

YOUR PLAN OF COMPLIANCE MUST BE RETURNED NO LATER THAN: November 26, 2014

Item | Rule Number | Rule Description & Findings | event ID:2,968

0940-5-4 Life Safety Licensure Rules

Item	Rule Description & Findings	
	0940-5-4-.02 HEALTH CARE OCCUPANCIES	
	0940-5-4-.02(2) Criteria. For the purpose of life safety facilities required to meet Health Care Occupancies must comply with the applicable standards of the Life Safety Code of the National Fire Protection Association, 1985 Edition, Health Care Occupancies, Chapter 12 (new) or Chapter 13 (existing) or equivalent standards hereafter adopted by the Office of the State Fire Marshal.	critical
1	**The escutcheon cup was missing from the sprinkler heads located in the storage room next to the Director's office in the East building, in consult room #1 of in the Cresthaven building, and in kitchen area of the Gero building.** Licensee's Planned Date of Completion: 11 / 17 / 14 Licensee's Plan of Compliance (use a separate page if more space is needed): The escutcheon cups for the sprinkler heads were replaced by the East director's office, Cresthaven consult room #1 and Geriatric kitchen area. This will be monitored for compliance daily by department heads and during monthly safety inspections	2,754
	0940-5-4-.02(2) Criteria. For the purpose of life safety facilities required to meet Health Care Occupancies must comply with the applicable standards of the Life Safety Code of the National Fire Protection Association, 1985 Edition, Health Care Occupancies, Chapter 12 (new) or Chapter 13 (existing) or equivalent standards hereafter adopted by the Office of the State Fire Marshal.	critical
2	**There was no updated maintenance tag indicating that the annual maintenance was conducted for one of the fire extinguishers in the nursing station of the Gero building.** **Clean towels were stacked in front of the fire extinguisher in West in the kitchen paper goods storage room, blocking access to the fire extinguisher.** Licensee's Planned Date of Completion: 11 / 19 / 14	3,735

Phone: (901)543-7442 Fax: (901)543-7008

Item	Rule Number	Rule Description & Findings	
		0940-5-4 Life Safety Licensure Rules	
		Licensee's Plan of Compliance (use a separate page if more space is needed): An annual inspection for all fire extinguishers, including the one noted in the Geriatric nursing station, was completed on 11/20/14. All extinguishers have an updated maintenance tag. The towels were removed from in front of the fire extinguisher, and staff has been educated on the importance of maintaining free/open access to emergency equipment. This will be monitored for compliance daily by the department head and during monthly safety inspections	
		0940-5-4-.02(2) Criteria. For the purpose of life safety facilities required to meet Health Care Occupancies must comply with the applicable standards of the Life Safety Code of the National Fire Protection Association, 1985 Edition, Health Care Occupancies, Chapter 12 (new) or Chapter 13 (existing) or equivalent standards hereafter adopted by the Office of the State Fire Marshal.	"critical"
3		**Portable electric space heaters were observed in West in the Nurse's Station on the Gero overflow unit and under a desk in the Pharmacy.** Licensee's Planned Date of Completion: 11 / 14 / 14 Licensee's Plan of Compliance (use a separate page if more space is needed): The portable electric space heaters were removed from the West nurse's station of the geriatric overflow hallway and from the pharmacy. In the newsletter, staff has been instructed to not bring any heaters into the environment. This will be monitored for compliance daily by department heads and during monthly safety inspections.	3,736
		0940-5-4-.02(2) Criteria. For the purpose of life safety facilities required to meet Health Care Occupancies must comply with the applicable standards of the Life Safety Code of the National Fire Protection Association, 1985 Edition, Health Care Occupancies, Chapter 12 (new) or Chapter 13 (existing) or equivalent standards hereafter adopted by the Office of the State Fire Marshal.	"critical"
4		**Items were stored within 18 inches of sprinkler heads and too close to the ceiling in West the cafeteria storage closet, kitchen, paper goods storage, and in the safety search room.** Licensee's Planned Date of Completion: 11 / 14 / 14 Licensee's Plan of Compliance (use a separate page if more space is needed): The products that were stored within 18" of the ceiling in the West cafeteria storage closet, kitchen paper goods storage and the safety search room have been removed. Staff has been educated to not store items within 18" of the sprinkler head. This will be monitored for compliance daily by department heads and during monthly safety inspections.	3,737
		0940-5-4-.02(2) Criteria. For the purpose of life safety facilities required to meet Health Care Occupancies must comply with the applicable standards of the Life Safety Code of the National Fire Protection Association, 1985 Edition, Health Care Occupancies, Chapter 12 (new) or Chapter 13 (existing) or equivalent standards hereafter adopted by the Office of the State Fire Marshal.	"critical"
5		**A bolt type latch was installed on the inside portion of the door of the room used to search incoming patients on the assessment unit of West. (NOTE: J.H. McNatt, fire marshal for this facility was consulted on this issue and he verified that a lock of this type in this situation shall not be used.)** Licensee's Planned Date of Completion: 11 / 14 / 14 Licensee's Plan of Compliance (use a separate page if more space is needed): The bolt type latch installed on the inside portion of the door of the search room has been removed. The facility will not use this type latch in the future	3,738

Item	Rule Number / Rule Description & Findings	
	0940-5-4 Life Safety Licensure Rules	
	0940-5-5 Adequacy of Facility Environment and Ancillary Services	
	0940-5-5-.02 GENERAL ENVIRONMENTAL REQUIREMENTS FOR ALL FACILITIES.	
	0940-5-5-.02(1) The facility must be maintained in a safe manner and a continuing effort made to eliminate potential hazards.	
6	**Open partially used milk containers intended for individual use had been returned to the refrigerators on the Gero overflow unit in West in the group room and in the nurse's station.** Licensee's Planned Date of Completion: 11 / 14 / 14 Licensee's Plan of Compliance (use a separate page if more space is needed): The partially used milk containers were removed from the Gero overflow unit group room and nurse's station. Staff has been educated to not put open containers back in the refrigerator. This will be monitored for compliance daily by the department head and during monthly safety inspections.	2,552
	0940-5-5-.02(2) The facility must be maintained in a sanitary and clean condition, free from all accumulation of dirt and rubbish, well-ventilated, and free from foul, stale or musty odors.	
7	**The floors in the safety search room and the vitals room off the secondary waiting area in West were dirty and covered with debris.** **The floor of the Group Room in TRP was covered with dirt and trash.** Licensee's Planned Date of Completion: 11 / 14 / 14 Licensee's Plan of Compliance (use a separate page if more space is needed): The floors have been cleaned and debris removed in the safety search room and vitals room off of the secondary waiting area. The floor of the group room in TRP has also been cleaned. These areas will be monitored for cleanliness daily by the housekeeping manager and monthly during the facility safety inspections.	2,553
	0940-5-5-.02(2) The facility must be maintained in a sanitary and clean condition, free from all accumulation of dirt and rubbish, well-ventilated, and free from foul, stale or musty odors.	
8	**The inside portion of the refrigerator and freezer sections of the unit in the group room in the overflow Gero unit in West contained spilled food and juice, dry creamer, and paper. Juice had spilled on a tray on a shelf in the refrigerator in the receptionist area in West. Liquid had also spilled on the shelf in the freezer in the Group Room in TRP.** Licensee's Planned Date of Completion: 11 / 14 / 14 Licensee's Plan of Compliance (use a separate page if more space is needed): The refrigerators/freezers in the Gero overflow unit group room, receptionist area of West and group room in TRP have all been cleaned. Going forward, this equipment will be cleaned daily by dietary when they drop off juice/milk in the various locations. This will be monitored for compliance daily by department heads and monthly during the facility safety inspections.	4,584
	0940-5-5-.02(2) The facility must be maintained in a sanitary and clean condition, free from all accumulation of dirt and rubbish, well-ventilated, and free from foul, stale or musty odors.	
9	**A wet mop was sitting in an empty bucket in the janitor's closet across from the nurse's station in TRP rather than being properly hung to ensure proper drying.**	

Item	Rule Number / Rule Description & Findings	
	0940-5-5 Adequacy of Facility Environment and Ancillary Services	
	Licensee's Planned Date of Completion: 11 / 14 / 14 Licensee's Plan of Compliance (use a separate page if more space is needed): The mop has been properly stored, and staff has been educated on the proper procedure. This is being monitored for compliance daily by the housekeeping manager and monthly during the safety inspections.	4,585
10	0940-5-5-.02(2) The facility must be maintained in a sanitary and clean condition, free from all accumulation of dirt and rubbish, well-ventilated, and free from foul, stale or musty odors. **The area under the grab bar in the shower in one of the handicap accessible bathrooms on the men's unit in West was covered with what appeared to be mold. In addition a significant amount of dirt/debris was on the floor of the same shower.** Licensee's Planned Date of Completion: 11 / 14 / 14 Licensee's Plan of Compliance (use a separate page if more space is needed): The area under the grab bar in the handicap accessible bathroom in west has been cleaned. The floor has also been cleaned. The housekeeping manager is monitoring for compliance daily and monthly during the safety inspections.	4,586
11	0940-5-5-.03 ENVIRONMENTAL REQUIREMENTS FOR RESIDENTIAL FACILITIES. The governing body must ensure that each client is provided with the following: 0940-5-5-.03(1)(c) Clean linens consisting of both a top and bottom sheet, which are clean, in good repair, and are changed as often as needed, but at least weekly; **In the adolescent building, there were several beds that were not equipped with the top sheet. In some of these cases, there were two bedspreads and the bottom sheet.** Licensee's Planned Date of Completion: 11 / 14 / 14 Licensee's Plan of Compliance (use a separate page if more space is needed): All the beds have been equipped with a fitted sheet, top sheet and blanket. Housekeeping has been educated to make sure each bed is equipped with the proper linen daily. The manager is monitoring for compliance on a daily basis and monthly during the safety inspections.	2,572
12	The governing body must ensure that each client is provided with the following: 0940-5-5-.03(1)(d) Bedding, such as blankets, which are clean, in good repair, and appropriate to the weather; **At the time of this inspection, there was a stain that appeared to be blood on one of the bedspreads in the line of sight bedroom in the Gero building.** Licensee's Planned Date of Completion: 11 / 14 / 14 Licensee's Plan of Compliance (use a separate page if more space is needed): The bedspread was replaced, and staff was educated to immediately replace any stained linen. This is being monitored for compliance daily by the managers and monthly during the safety inspections.	2,573

0940-5-5 Adequacy of Facility Environment and Ancillary Services

0940-5-5-.03(7) An outdoor area must be provided which is neat, free of potential hazards, and is appropriate to meeting the needs of the clients.

13 **The smoking area in the courtyard of TRP had a significant number of discarded cigarette butts on the ground despite the fact there were at least 3 smoker's pots provided.**

The outside smoking patio provided for West on the female side was covered with a significant accumulation of cigarette ashes.

Licensee's Planned Date of Completion: 11 / 14 / 14 2,592

Licensee's Plan of Compliance (use a separate page if more space is needed):

The cigarette butts in the smoking area in the courtyard of TRP have been cleaned up. The patients have been reminded to use the receptacles provided, and this area is being monitored for compliance on a daily basis by the managers and monthly during the safety inspections.

0940-5-5-.05 REQUIREMENTS FOR FACILITIES PROVIDING FOOD SERVICES AND NUTRITION. (All residential facilities required to meet this chapter of rules must comply with the requirements of this rule. Any non-residential facility required to meet this chapter of rules which provides food and nutrition on a regular basis to its clients must comply with the requirements of this rule.)

0940-5-5-.05(10) Foods requiring cold storage must be maintained at a temperature of forty-five (45) degrees Fahrenheit or below.

14 **There was no thermometer in the refrigerator located in the comfort room of the adolescent building.**

Licensee's Planned Date of Completion: 11 / 14 / 14 2,608

Licensee's Plan of Compliance (use a separate page if more space is needed):

A thermometer has been installed in the refrigerator of the adolescent comfort room. This will be monitored for compliance daily and monthly during the safety inspections.

0940-5-5-.05(11) Foods requiring frozen storage must be maintained at a temperature of ten (10) degrees Fahrenheit or below.

15 **The thermometer in the freezer section of the unit in the receptionist area in West registered 12 degrees Fahrenheit.**

Licensee's Planned Date of Completion: 11 / 14 / 14 2,609

Licensee's Plan of Compliance (use a separate page if more space is needed):

A new thermometer was installed in this freezer, and the freezer setting was verified. The freezer is reading below 0 degrees Fahrenheit when the door is closed for several minutes. This unit is being monitored for compliance daily by staff and monthly during safety inspections.

0940-5-6 Program Requirements for All Facilities

0940-5-6-.01 GOVERNANCE REQUIREMENTS FOR ALL FACILITIES.

0940-5-6-.01(1) The governing body must ensure that the facility complies with all applicable federal, state, and local laws, ordinances, rules, and regulations.

Item	Rule Number	Rule Description & Findings	
		0940-5-6 Program Requirements for All Facilities	
16		**There was no documentation in the personnel records for [redacted] and [redacted] indicating a check of the TN DOH Abuse Registry was conducted.** Licensee's Planned Date of Completion: 11 / 24 / 14 Licensee's Plan of Compliance (use a separate page if more space is needed): The TN DOH Abuse Registry checks were conducted for [redacted] and [redacted] in addition to all employees that live outside of Tennessee. There were no matches of current employees to the Abuse Registry.	2.656
		0940-5-16 Mental Health Hospital Facilities	
	0940-5-16-.06	HOSPITAL MEDICATION STORAGE	
	0940-5-16-.06(1)	All medications and other medical preparations intended for internal or external human use must be stored in medicine cabinets or drug rooms. Such cabinets or drug rooms must be kept securely locked when not in use and the key must be in the possession of the supervising nurse or other authorized person.	critical
17		**Two unknown brown pills were on the floor in the Security Department in West.** Licensee's Planned Date of Completion: 11 / 19 / 14 Licensee's Plan of Compliance (use a separate page if more space is needed): The pills were taken to the pharmacy and determined to be Advil. Security staff was educated on the importance of not allowing any items, including pills, to fall on the floor. This will be monitored for compliance daily by the manager and monthly during safety inspections.	134

Please contact me if you have questions.

Sandra Randle
Sandy Randle
West Tennessee Surveyor

SIGNATURE OF LICENSEE OR AUTHORIZED AGENT

11/25/14
DATE OF SIGNATURE

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax:615/532-9940

May 19, 2015

Anna Joy Golden
UHS of Lakeside d/b/a Lakeside Behavioral Health System
2911 Brunswick Road
Memphis, TN 38133

RE: Certificate of Need Application CN1505-019
Lakeside Behavioral Health System

Dear Ms. Golden:

This will acknowledge our May 14, 2015 receipt of your application for a Certificate of Need for the construction of a 48 bed geriatric psychiatric building located at 2911 Brunswick Road, Memphis (Shelby County), TN 38133.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 9:00 am, Tuesday May 26, 2015. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

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1. **Section A, Applicant Profile Item 5**

   The applicant notes there will not be a management/operating entity. Please clarify the reason management fees are designated in the Historical Data Chart.

2. **Section A, Applicant Profile Item 6**

   The Trust Deed Release is noted. However, please clarify the relationship between the applicant and J.P. Morgan and how the provided documentation confirms ownership.

3. **Section B. I. Project Description**

   Please clarify if the applicant's geriatric unit accepts patients 55+ or 65+.

4. **Section B. II. A. Need**

   The square footage and cost per square footage chart is noted. However, please revise the chart to include the Proposed Final Cost/SF section and resubmit.

Please indicate the existing average patient room size and the proposed patient room size of the 48 bed newly constructed building.

If approved, please clarify how the existing building and the overflow space on the West Adult unit will be used.

Please complete the chart below breaking out the bed accommodation mix for the proposed project.

Service Area Patient Accommodation Mix-Most Recent JAR Period

Lakeside Behavioral Health System	**Total Licensed Beds**	**Total Private Beds**	**Total Semi-Private Beds**	**Total**
Overall-Current				
After completion of Proposed Project				
Geriatric Current				
Geriatric after completion of Proposed Project				

5. **Section B. III. A. Plot Plan**

   The plot plan is noted. Please revise the plot plan to include parking areas and access point from Brunswick Road.

6. **Section B. IV. Floor Plan**

   The floor plan is noted. However, please provide a larger more legible copy for review.

7. **Section C. (Need) 1. Specific Criteria (Construction, Renovation, Expansion, and Replacement of Healthcare Institutions) Item 3**

   The applicant has provided suicide rates per 100,000 pop. in Tennessee. Please provide suicide rates per 100,000 population for the latest reporting period for each Tennessee County in the service area . The data is found on the Tennessee Suicide Prevention Network (TSPN) Web-site located at http://tspn.org/wp-content/uploads/2004-13-NUMBERS-ALL.pdf
   .

8. **Section C. (Need) 3. Service Area County Level Map**

   Please list in the narrative on page 25 the following that represents the applicant's service area: 21 Tennessee Counties, 22 Mississippi Counties and the 10 Arkansas Counties.

The County level map designating the applicant's declared service area is noted. However, please provide distinctive highlighting/ markings to readily differentiate the service area counties from the other non- service area counties and resubmit.

9. **Section C, Need, Item 4.A.**

Your response to this item is noted. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the following table and include data for each county in your proposed service area.

Variable	County 1	County 2	County 3	Service Area	Tennessee
Current Year (CY), Age 65+					
Projected Year (PY), Age 65+					
Age 65+, % Change					
Age 65+, % Total (PY)					
CY, Total Population					
PY, Total Population					
Total Pop. % Change					
TennCare Enrollees					
TennCare Enrollees as a % of Total Population					
Median Age					
Median Household Income					
Population % Below Poverty Level					

10. **Section C, Need, Item 4.B.**

The applicant states Lakeside is an enrollment location for the Affordable Care Act. Please provide the inpatient mental health benefits available under the Affordable Care Act.

11. **Section C, Need, Item 6**

Please provide the following utilization for Lakeside by services as indicated in the following table:

Bed Type	2012	2013	2014	% Change 12-14	Year One	Year Two
Hospital						
Beds						
Admissions						
Average Daily Census (ADC)						
Average Length of Stay (ALOS)						
%Occupancy						
Children and Adolescent (0-17)						
Beds						
Admissions						
ADC						
ALOS						
%Occupancy						
Adult (18-65)						
Beds						
Admissions						
ADC						
ALOS						
%Occupancy						
Geriatric (65+)						
Beds						
Admissions						
ADC						
ALOS						
%Occupancy						

12. Section C. (Economic Feasibility) Item 4

Please clarify why there are no management fees in the Projected Data Chart.

Please clarify what the Projected Data Chart represents (this is confusing).

The Projected Days of 730 in Year One and 2,190 in Year Two on the Projected Data Chart do not match the patient days of 4,142 in 2016 and 6,205 in 2017 in the chart on page 42. Please clarify.

Please provide a Projected Data Chart for the proposed project and for the hospital as a whole with both clearly labeled.

There are calculation errors in the net operating revenue columns for Year One and Two. Please revise and resubmit.

Please complete the following for D.9 Other Expenses in the Projected Data chart.

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year____	Year___
1.	$_____	$_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
Total Other Expenses	$_____	$_____

13. Section C. (Economic Feasibility) Item 5

Table sixteen identifying the project's average gross charge, average deduction from operating revenue and average net charge is noted. The amounts do not match up with the Projected Data Chart. Please clarify and resubmit if needed.

14. Section C. (Economic Feasibility) Item 9.

The percent of Gross Revenue for TennCare and Medicare do not match the Projected Data Chart. Please clarify and resubmit the table if needed to match the Projected Data Chart for the proposed project.

The proposed project appears to be a geriatric unit consisting mostly of 65+ patients; please explain why the applicant expects TennCare/Medicaid gross revenue to be more than Medicare in Year One?

15. Section C. (Economic Feasibility) Item 10

Since the proposed project will be funded by United Health Services, Inc., please provide a copy of the parent company's audited financial statements for the most recently completed period for which the balance sheet and income statements are available.

16. Section C. Orderly Development, Item 7.d

Please provide a copy of the latest Joint Commission Accreditation survey.

Please indicate the date of the last survey by the Tennessee Department of Mental Health and Substance Abuse Services. If needed, please provide a copy of survey and acceptance of the corrective action plan, if applicable.

17. Section C. Orderly Development Item 8 and 9

Items 8 and 9 are applicable. Please provide a response.

18. Project Completion forecast Chart

The Project Completion Forecast Chart is noted. However, please enter the Agency projected Initial Decision Date on top of the page and resubmit.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is July 17, 2015. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ∋ 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Phillip Earhart
HSD Examiner

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax:615/532-9940

May 28, 2015

Anna Joy Golden
UHS of Lakeside d/b/a Lakeside Behavioral Health System
2911 Brunswick Road
Memphis, TN 38133

RE: Certificate of Need Application CN1505-019
Lakeside Behavioral Health System

Dear Ms. Golden:

This will acknowledge our May 22, 2015 receipt of supplemental information to your application for a Certificate of Need for the construction of a 48 bed geriatric psychiatric building located at 2911 Brunswick Road, Memphis (Shelby County), TN 38133.

Several items were found which need additional clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 3:00 pm, Friday May 29, 2015. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

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1. **Section C, Need, Item 4.A.**

   Your response to this item using 2017 as the projected year is noted. However, please use 2019 as the projected year. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the following table and include data for each county in your proposed service area.

Variable	County 1	County 2	County 3	Service Area	Tennessee
Current Year (2015), Age 65+					
Projected Year (2019), Age 65+					
Age 65+, % Change					
Age 65+, % Total (2015)					
CY, Total Population					
PY, Total Population					
Total Pop. % Change					
TennCare Enrollees					
TennCare Enrollees as a % of Total Population					
Median Age					
Median Household Income					
Population % Below Poverty Level					

2. **Section C, Need, Item 6**

   The average annual occupancy for the Geriatric program for 2012-2104 is incorrect in Table Eight on page 35 of the original application. Please revise and submit a replacement page.

   The Hospital Projections portion of table eight on page 35 is misleading. The average annual occupancy of 91.7% and 93.9% actually represents the occupancy in Year One and Year Two for the entire 261 bed hospital, not on admission growth. Please replace the Hospital Projection portion of table eight with the projection for the 48 geriatric beds mentioned in the LOI and include in the replacement page for page 35.

3. **Section C. (Economic Feasibility) Item 4**

   The geriatric Projected Data Chart for the volume growth is noted. However, please provide a Projected Data Chart representing the 48 geriatric psychiatric beds that is mentioned in the letter of intent. Please revise any other portions of the application that represents the revised Projected Data Chart for 48 geriatric beds and submit replacement pages.

4. **Section C. (Economic Feasibility) Item 5**

   Please provide the project's average gross charge, average deduction from operating revenue and average net charge for the projected data chart representing the 48 bed geriatric beds. Please revise table sixteen and resubmit.

5. **Section C. (Economic Feasibility) Item 9.**

   Please revise the Year One Gross Revenue and percentages for TennCare and Medicare representing the 48 geriatric beds that is subject to the proposed project.

6. Section C. Orderly Development, Item 7.d

The summary for the 9/11/2013 Joint Commission Survey and the Tennessee Department of Mental Health and Substance Abuse Services survey dated 11/14/2014 are noted. However, as previously requested please provide a copy of the actual survey with patient identifying information blackened.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is July 17, 2015. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ɔ 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Phillip Earhart
HSD Examiner