UHS UNIVERSAL HEALTH SERVICES, INC.

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UNIVERSAL HEALTH SERVICES, INC.

2008 ANNUAL REPORT

ANNUAL REPORT 2008

Letter to Our Shareholders

UHS had an outstanding year in 2008. In an increasingly difficult environment, profitability improved substantially over 2007. I firmly believe that UHS is well-prepared to weather the current economic downturns, and that we will continue to prosper. Why? Because from its inception nearly 30 years ago, UHS has focused on sound decision-making, generating sustainable growth based on prudent levels of debt.

We have evaluated and acted successfully on good opportunities, and bought UHS stock when it was a compelling investment. Today our seasoned management team is better equipped to operate during an economic downturn than most.

Acute Care, Behavioral Health divisions moving forward

Our Acute Care Division performed well in 2008, with new additions and expansions continuing in line with our disciplined strategy. Selecting faster-growing communities as our core markets has proved to be of long-term benefit to us. Over half of UHS' acute care facilities are located in the most rapidly-developing areas of the country, such as the Las Vegas area, where population increased by almost 30 percent from 2000 to 2006. In South Texas, another area of focus for the company, population has grown about 25 percent over the same period.

Our Behavioral Health Division has been a consistent industry leader in growth and profitability for many years. The industry is highly fragmented and populated by independent providers. Recognizing this profile, we have combined growth through selective acquisition with capacity expansion. UHS' occupancy levels of approximately 75 percent reflect our success in building long-term community referral relationships and physician confidence. We stand to benefit from Congress' adoption of mental health parity legislation which should enhance growth opportunities for this segment of our business.

A well-positioned company

Among publicly traded hospital operators, UHS has one of the most diversified business mix profiles, with earnings generated fairly evenly between its acute care and behavioral health segments. UHS also has one of the most conservative balance sheets in the sector, providing both financial and operational flexibility. While most of the industry runs high leverage ratios, UHS stands out with one of the more favorable profiles. Debt represents only 39 percent of the total capitalization of UHS, versus the industry average of 72 percent, and our debt-to-EBITDA ratio is 1.8 times, compared to the group at 4.6 times.

Wise decisions, successful results

Prudent decision-making is integral to the UHS strategy. The leadership team members who understand and execute UHS' strategy have been with the company for decades. Our goal is not to be the biggest provider of healthcare services, but the best in the communities we serve. We are noted for excellence, which most often results in consistent growth and outstanding financial results.

The George Washington University Hospital in Washington, D.C. is an example of good decision-making. We were chosen to become a partner with the University in 1997 based on our reputation. In 2002 we built a state-of-the-art replacement facility, and today GW Hospital commands a major share of the D.C. market and is highly regarded.

UHS has begun an initiative to lead in specialty care for autism which is a result of the rapidly growing need for such services. Laurel Heights Hospital in Atlanta was among the first to provide advanced autism treatment, and now serves the community with a wide range of care and education. The Behavioral Health Division recently opened a second autism treatment unit at Laurel Heights. In addition, UHS opened Central Florida Behavioral Hospital in Orlando, with 40 beds dedicated to autism. Autism services are expanding in a number of our other facilities across the country.

Healthcare ... an essential industry

We are fortunate to be part of an industry that remains essential to the U.S. economy. The older demographic in our country is growing and along with it, the consumption of healthcare services. In 2007 people aged 65 and older comprised 12 percent of the total population. By 2030, almost 20 percent of Americans – some 72 million people – will be 65 years of age or older. People over age 85 are the fastest-growing segment of our population. By 2030 they will comprise 2.3 percent of our total population, up from 1.8 percent in 2007. The need for healthcare workers is growing, too. We are not scaling back our workforce, indeed we continue to seek highly qualified professionals in many of our facilities.

Our goal for 2009 is to keep our most valuable resource – our people – fully employed, and to provide superior services to our communities. "Teamwork divides the task and multiplies the success." We thank our outstanding team – employees, nurses, and physicians – and the confidence of our shareholders for their contributions to our success.

Alan B. Miller
Chairman of the Board
President and Chief Executive Officer

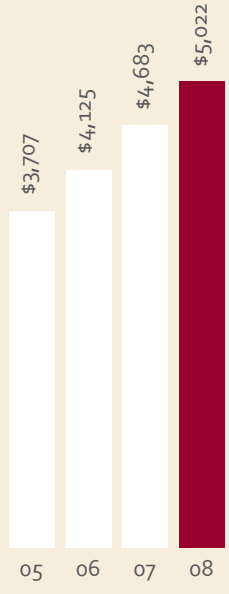
"I am wearing an American Flag lapel pin, and urge you to do the same, in solidarity with our troops in Afghanistan and Iraq."

Universal Health Services, Inc.

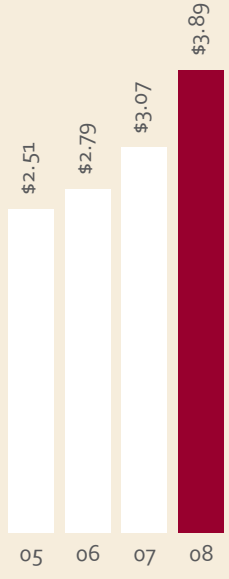
Financial Highlights

Year Ended December 31	2008	2007	Percentage Increase	2006
Net revenues	$5,022,417,000	$4,683,150,000	7%	$4,124,692,000
Adjusted income from continuing operations (1)	$197,334,000	$164,433,000	20%	$156,980,000
Adjusted diluted earnings per share from continuing operations (1)	$3.89	$3.07	27%	$2.79
Patient days	3,268,008	3,156,518	4%	2,925,196
Admissions	393,089	376,411	4%	351,941
Average number of licensed beds	13,110	12,640	4%	11,554

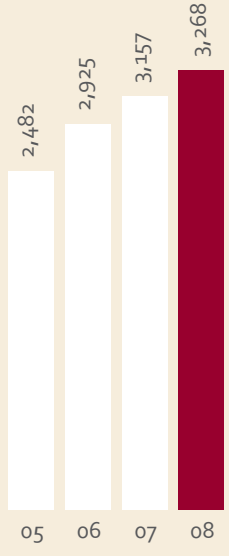
Net revenues
(in millions)



Adjusted diluted earnings per share from continuing operations (1)



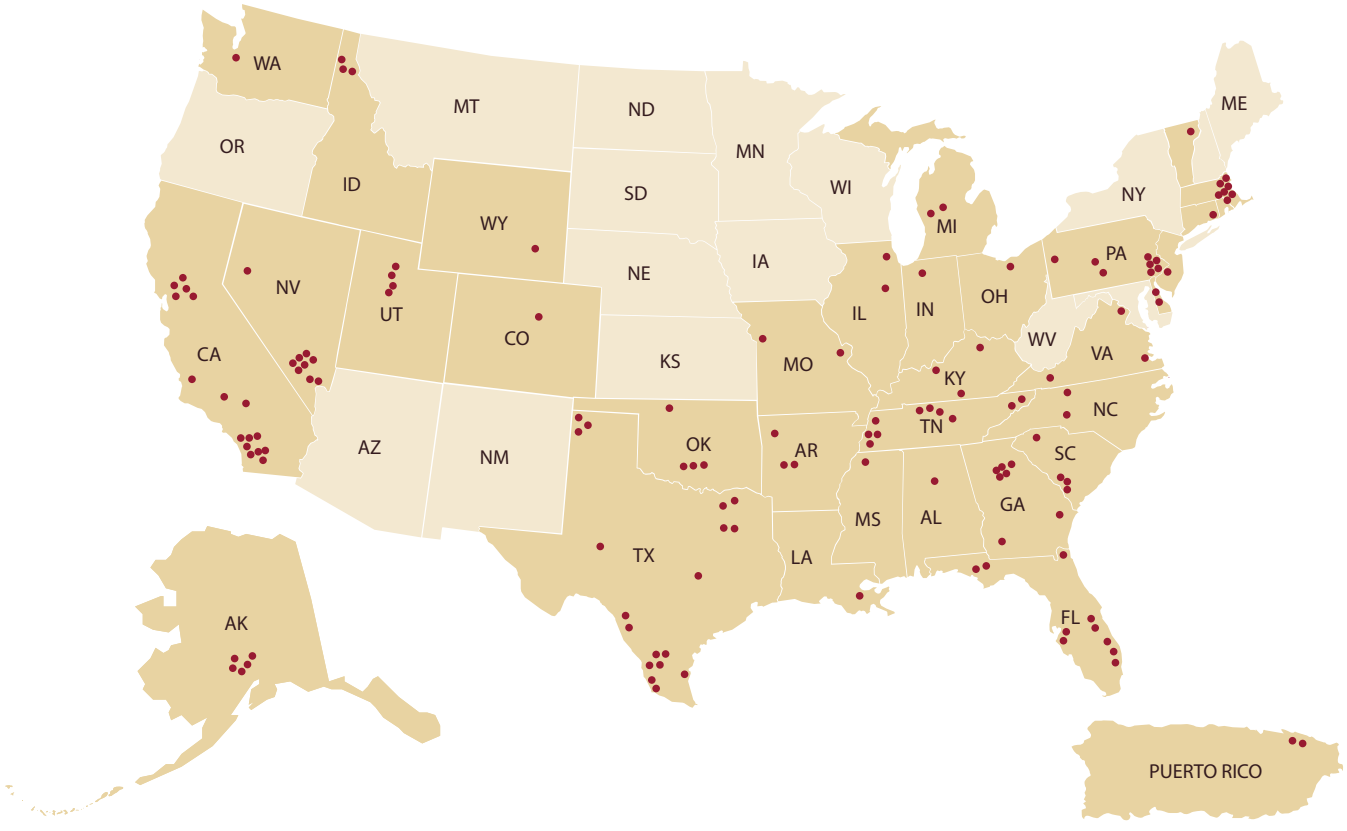
Hospital patient days
(in thousands)



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 contained on pages 81-122 of this report.

(1) Calculation of Adjusted Income from Continuing Operations (in thousands except per share amounts)	2008 Amount	2008 Per Diluted Share	2007 Amount	2007 Per Diluted Share	2006 Amount	2006 Per Diluted Share	2005 Amount	2005 Per Diluted Share
Income from continuing operations	$192,941	$3.80	$170,642	$3.18	$159,200	$2.83	$157,034	$2.66
Other combined adjustments	4,393	0.09	(6,209)	(0.11)	(2,220)	(0.04)	(9,139)	(0.15)
Adjusted income from continuing operations	$197,334	$3.89	$164,433	$3.07	$156,980	$2.79	$147,895	$2.51

For a full state-by-state list of Universal Health Services, Inc. facilities, please visit us at our Web site: **www.uhsinc.com**



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Universal Health Services, Inc. is one of the largest and most respected hospital management companies in the nation. We have focused our efforts primarily on managing acute care hospitals, behavioral health hospitals, and select ambulatory surgery and radiation oncology centers.

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 results.

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.

UHS Acute Care Division:
A unique perspective

For the UHS Acute Care Division, 2008 marked another year of growth attributable to uncommonly accurate vision and carefully crafted strategy.

When it comes to making decisions, we have a disciplined approach to our process. Decisions, whether they involve acquisitions, new programs, new services or expansions, are regarded from a long-term perspective on growth and community needs, rather than immediate short-term gain. Once we make a decision, we stand behind it with continued support.

In the Acute Care Division, a common thread of stability weaves through leadership, where key roles often are filled by long-tenured employees whose talents have been identified and cultivated. The result is leadership characterized by shared values and preservation of the organization's practice of sustained growth.

Yesterday's targeted acquisitions; today's stability

Sustained growth was a key factor in UHS' 1997 acquisition of The George Washington University Hospital, located in the heart of the nation's capital. When GW's leaders recognized that they needed a financial partner to continue to grow, UHS emerged as the health management system of choice. And it was our policy of insightful decision-making and strong support for the field that helped secure buy-in from GW Hospital's leaders.

Indeed, UHS built a brand-new facility for GW Hospital that opened in 2002 with millions of dollars of new equipment, expanded capacity and the same dedication to providing advanced, top-quality care.

Now, GW Hospital's market share has swelled to the number-two position in the Washington, D.C. market, propelled by a 6.6 percent increase in inpatient admissions, a 4.3 percent increase in total surgeries and a 4.7 percent rise in emergency department visits in 2008.

UHS invests in new technology to keep GW Hospital a market leader. In 2008, the hospital became the first in D.C. to acquire a second da Vinci® Surgical System. GW now leads the region in robotic prostate procedures, and leads the country in robotic thoracic procedures.

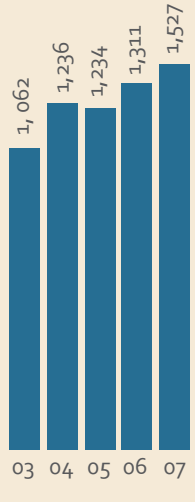
This new technology also has helped spur growth for the hospital's Cancer Center, which has seen a 50 percent increase in patient cases over the past five years.

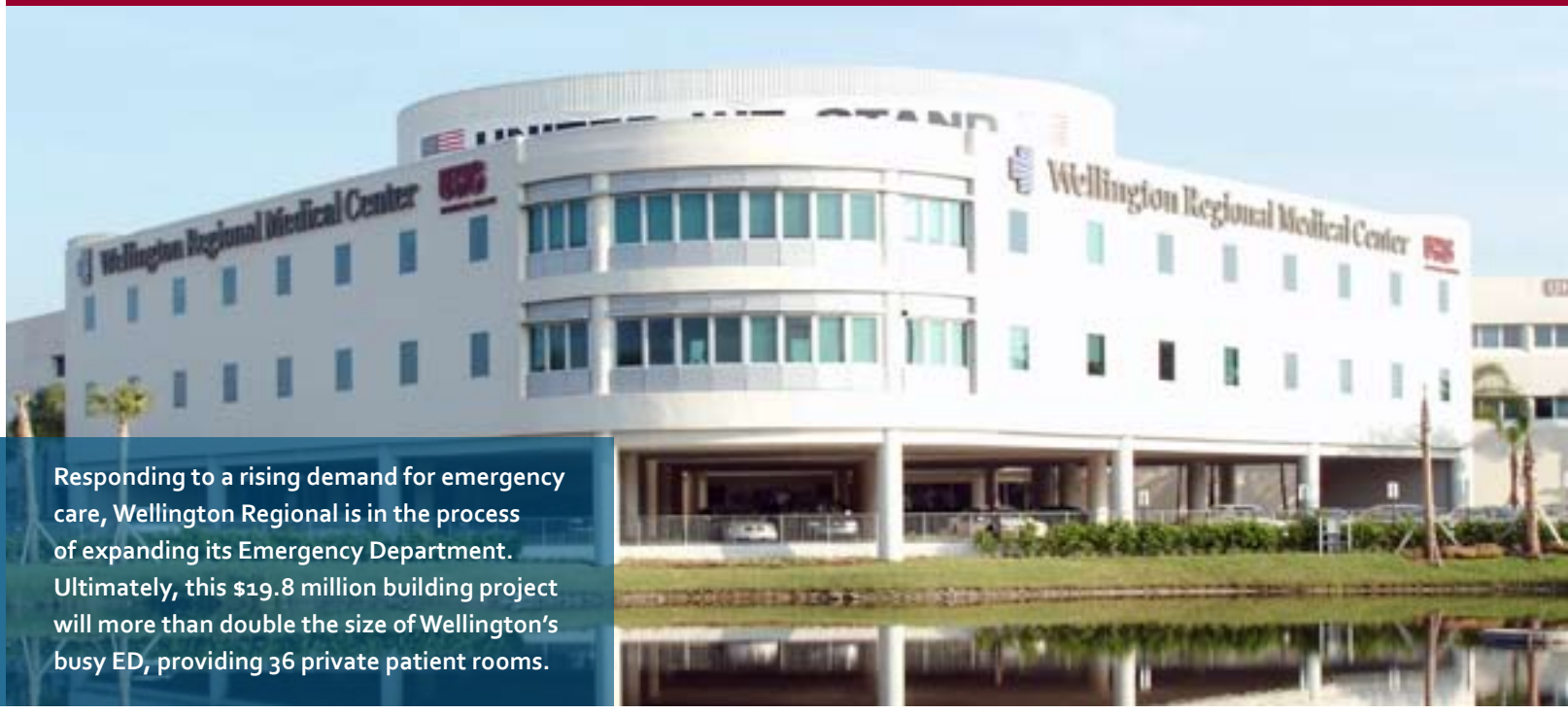
The George Washington University Hospital, a 371-bed tertiary care center, is recognized for innovative, diverse medical services and a wealth of clinical expertise.

With UHS' investment in a second da Vinci Surgical System, GW Hospital leads the region in robotic prostate procedures and leads the country in robotic thoracic procedures.

The Cancer Center at GW Hospital:
A Stable Pattern of Growth

Patient Cases





Responding to a rising demand for emergency care, Wellington Regional is in the process of expanding its Emergency Department. Ultimately, this $19.8 million building project will more than double the size of Wellington's busy ED, providing 36 private patient rooms.

Foresight and follow-through

When UHS built Wellington Regional Medical Center in 1986 in a then-rural area of Palm Beach County, few other hospital management companies would have chosen to enter this market. However, UHS planned with foresight, determining that this community would grow and prosper. Our decision has proven successful.

Today, the Wellington community is thriving, as is the 158-bed hospital, which is providing services available nowhere else in West Palm Beach County. In two areas of expansion, obstetrics (OB) and emergency services, strategic programming decisions have garnered strong loyalty from our well-respected physician groups.

Wellington Regional first began its OB expansion with a Level II neonatal intensive care unit (NICU). A neonatologist group agreed to staff the unit 24/7, and in turn, the hospital made the commitment to build a Level III NICU. Both followed through, and with the recent opening of its advanced NICU, Wellington Regional became the first hospital in the western communities to offer this high-level care.

Investing in emergency department (ED) expansion and innovative programs has helped Wellington Regional cultivate a longstanding relationship with the board-certified emergency physicians who staff the ED. Phase I of the ED expansion, completed in October 2008, includes a spacious new ED with all-new equipment and 16 private patient bays.

Wellington's ER Smart Card program gives ED staff fast access to patients' medical information, helping to prevent medical errors and expedite registration. The Smart Card has met with enthusiastic response from the community, with 5,000 patients currently registered.

Keeping a finger on the pulse of community needs

The beauty of Southern California's Temecula, Murrieta and Lake Elsinore Valleys attracts thousands of new residents every year. UHS serves this community with two acute care facilities: Rancho Springs Medical Center and Inland Valley Medical Center. As with Wellington Regional, Southwest Healthcare System is now seeing the culmination of new programs and expansions that were planned-for several years ago as a result of UHS' vision and foresight.

This community is young and growing. Last year, more than 3,600 babies were born at Southwest Healthcare System. Now, the community's growing families will have the new Women's and Infants' Maternity Center, scheduled to open in 2009 on the Rancho Springs campus.

When Southwest initiated plans to expand its OB program, the decision was made to consolidate women's services in one location. This has allowed the hospitals to consolidate resources, resulting in benefits to patients such as all-private rooms and top-level services. The Center also includes a new NICU – the first and only in Southwest Riverside County.

For years, the dedicated team of doctors and nurses at Rancho Springs Medical Center's Emergency Department has provided high-quality care to upwards of 90 patients each day. Now they look forward to providing expanded services in a bigger, brand-new ED that more than triples the capacity of the previous one, from eight to 27 beds.

And Southwest continues to experience success with its 5-star Bariatric Surgery Center of Excellence program at Inland Valley Medical Center. Southwest was an early provider of bariatric surgery and maintains its position as a leader in this often lifesaving procedure.

Bringing tomorrow into focus

These expansions and new additions aren't the conclusion of the Acute Care Division story. Just as yesterday's decisions have engendered today's growth, we constantly cast a visionary eye toward future opportunities at all of our 25-and-counting facilities. It is, after all, the UHS strategy.

The new Women's and Infants' Maternity Center at Southwest Healthcare System includes 17 private labor and delivery rooms and 24 private postpartum rooms – and the first and only NICU for this growing Southern California community.

UHS Behavioral Health Division:

The right decisions, the right reasons

The UHS Behavioral Health Division continued to see steady growth and excellent financial performance in 2008, thanks to the division's emphasis on sound decision-making based on meeting the needs of the patients it serves. UHS Behavioral Health now has 101 facilities in 32 states from Alaska to Florida, and generated $1.2 billion in revenue in 2008.

The division's success is based on an exceptional group of professionals throughout the division who have long tenure with the company. That leads to a stable company and solid decision-making. Over the years, due to the reputation of UHS, it has been able to hire and retain the best talent in the industry.

For example, six of UHS' eight division vice presidents have been with the company for eight years or more. In addition, the CEOs at its more than 100 hospitals have an average tenure of nine years. Other employees throughout the division share similar lengths of service.

There are reasons why professionals stay at a company for a long time. The UHS Behavioral Health Division maintains a formal "CEO-in-Training" program to help develop rising talent. The division identifies employees who show great potential and places them in an intensive training program, supplying comprehensive reference materials they can use to contribute to the company and advance their careers for years to come.

When UHS makes an acquisition, its people give testimony based on their experiences, and this makes others want to be a part of it. UHS may not always have the highest bid but sellers are aware of its track record, and of how its hospitals are responsive to their communities. This is a key factor in their decision to join UHS.

UHS facilities work to become the preferred provider of behavioral health services in their communities because of quality services and responsiveness to patient needs.

Referral sources and families know they can depend on UHS for services that will make a difference in the lives of the many patients they serve.

Anticipating future needs

The UHS Behavioral Health Division develops programs to meet future needs, such as autism treatment. Statistics from the Centers for Disease Control state that about one out of every 150 children born in the United States today has some form of autism. The company recognized that the increase in autism would lead to an increase in demand for treatment and education programs.

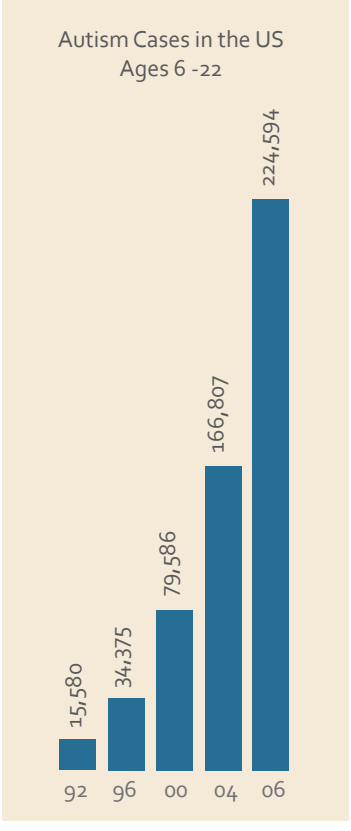
UHS has worked to develop autism programs and to make them available to our facilities. Several of our hospitals have already begun to offer the program. One of the first UHS facilities to provide advanced autism treatment was Laurel Heights Hospital in Atlanta, which recently opened a second unit to double the number of beds in its program from nine to 18. Children with the full spectrum of autism disorders can get the treatment they need there.

Central Florida Behavioral Hospital treats children with the full spectrum of autism disorders, from high-functioning children with Asperger syndrome to children with the most severe forms of the disorder.

High-functioning children with Asperger syndrome may just need help with social functioning, while children with more severe forms of autism need other services, such as alternate forms of communication for those who are nonverbal.

In December 2008, the UHS Behavioral Health Division opened Central Florida Behavioral Hospital in Orlando, with 40 beds dedicated to autism patients. The facility was initially planned to treat children with Asperger syndrome, but it was expanded to serve children who have lower functioning abilities.

Foundations Behavioral Health in Doylestown, Pennsylvania, will soon be adding autism services to its treatment programs. That hospital is completing renovations to its facility and training its staff to treat children with autism in both residential and day programs.



UHS' Lincoln Trail Behavioral Health System in Radcliff, Kentucky, began to work with the U.S. Army's Fort Knox to provide PTSD services for troops returning from Iraq and Afghanistan.

Solid decisions pay off

Sound decision-making often means doing the right things for the right reasons. Sometimes that means taking a path that is different from others in the industry.

One example is the company's response to the need for post traumatic stress disorder (PTSD) services by the U.S. military. UHS' Lincoln Trail Behavioral Health System in Radcliff, Kentucky, began to work with the U.S. Army's Fort Knox to provide PTSD services for troops returning from Iraq and Afghanistan.

Fort Knox came to UHS because they needed an inpatient program to treat PTSD. The hospital had already helped the military develop a PTSD program that was being used at Fort Knox, so the staff developed new inpatient services and trained therapists to treat PTSD patients. To make sure the staff at Lincoln Trail has a thorough understanding of its PTSD patients, nearly everyone who works with those patients participates in a special one-day boot camp orientation at Fort Knox. It gives the staff a feel for what the soldiers have been acclimated to, and it makes everyone appreciate the stress the soldiers experience.

Lincoln Trail's efforts were so successful that PTSD patients today make up about a third of the hospital's patient census and have occupied as many as 38 of the hospital's 116 beds. Meeting the Army's needs for PTSD services continues to bring new opportunities to Lincoln Trail Behavioral Health System.

The facility now provides similar services to members of the 101st Airborne at Fort Campbell, Kentucky, many of whom have completed three or four tours of duty in the Middle East. In addition, Lincoln Trail is now working with the Army to develop treatment services for soldiers who have mTBI, or mild traumatic brain injury. Other hospitals throughout the division are also providing this needed service.

Ready for the future

No matter where they are located, UHS facilities work hard to become the preferred provider of behavioral health services in their communities because of quality services and responsiveness to patient needs. Referral sources and families know they can depend on UHS behavioral facilities for services that will make a difference in the lives of the many patients they serve. Over the past four years, the division has taken the lead in the industry by adding bed capacity in key markets. As a result, UHS facilities are better able to provide needed services and treatment programs to their communities.

For more than 25 years, the UHS Behavioral Health Division has documented a consistent record of growth and superior financial performance under varying economic conditions. Today, thanks to a clear strategic vision, sound decision-making by a stable and committed leadership and an unwavering focus on meeting patient needs, the company is well-positioned to continue its success into the future.

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, 2008

OR

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

For the transition period from to

Commission File No. 1-10765

UNIVERSAL HEALTH SERVICES, INC.

(Exact name of registrant as specified in its charter)

Delaware	**23-2077891**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification Number)**
UNIVERSAL CORPORATE CENTER **367 South Gulph Road** **P.O. Box 61558** **King of Prussia, Pennsylvania** **(Address of principal executive offices)**	**19406-0958** **(Zip Code)**

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

Securities registered pursuant to Section 12(b) of the Act:

Title of each Class	**Name of each exchange on which registered**
Class B Common Stock, $.01 par value	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act:
Class D Common Stock, $.01 par value
(Title of each Class)

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.

Yes ☒ **No** ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act.

Yes ☐ **No** ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.

Yes ☒ **No** ☐

Indicate by check mark 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, 2008 was $2.94 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, officers subject to Section 16(b) of the Securities Exchange Act of 1934, and 10% stockholders 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, 2009, were 3,328,404, 45,780,143, 335,800 and 22,269, respectively.

DOCUMENTS INCORPORATED BY REFERENCE:

Portions of the registrant's definitive proxy statement for our 2009 Annual Meeting of Stockholders, which will be filed with the Securities and Exchange Commission within 120 days after December 31, 2008 (incorporated by reference under Part III).

UNIVERSAL HEALTH SERVICES, INC.
2008 FORM 10-K ANNUAL REPORT

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This Annual Report on Form 10-K is for the year ended December 31, 2008. This Annual Report modifies and supersedes documents filed prior to this Annual Report. Information that we file with the SEC in the future will automatically update and supersede information contained in this Annual Report. In this Annual Report, "we," "us," "our" and the "Company" refer to Universal Health Services, Inc. and its subsidiaries.

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, 2009, we owned and/or operated or had under construction, 26 acute care hospitals (including 1 new facility currently being constructed) and 101 behavioral health centers located in 32 states, Washington, D.C. and Puerto Rico. As part of our ambulatory treatment centers division, we manage and/or own outright or in partnerships with physicians, 9 surgical hospitals and surgery and radiation oncology centers located in 6 states and Puerto Rico.

Net revenues from our acute care hospitals, surgical hospitals, surgery centers and radiation oncology centers accounted for 74%, 74% and 75% of our consolidated net revenues in 2008, 2007 and 2006, respectively. Net revenues from our behavioral health care facilities accounted for 25% of our consolidated net revenues during each of 2008, 2007 and 2006. During each of 2008 and 2007, approximately 1% of our consolidated net revenues were recorded in connection with two construction management contracts pursuant to the terms of which we: (i) built a newly constructed acute care hospital for an unrelated third party that was completed during the first quarter of 2008, and; (ii) are building a newly constructed acute care hospital for an unrelated party that is scheduled to be completed during the fourth quarter of 2009.

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 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.

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.

Available Information

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 and Corporate Governance Guidelines 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 2008. 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.

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. Applications to state health planning agencies to add new services in existing hospitals are currently on file 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 shareholders.

In addition, our aggressive recruiting of top-notch physicians and developing provider networks help to establish our facilities as an important source of quality healthcare in their respective communities.

2008 Acquisition and Divestiture Activities

Acquisitions:

During 2008, we spent $23 million on the acquisition of businesses and real property, including the following:

- the acquisition of a 76-bed behavioral health facility located in Lawrenceville, Georgia, and;
- the acquisition of previously leased real property assets of a behavioral health facility located in Nevada.

Divestitures:

During 2008, we received $82 million from the divestiture of assets and businesses, including the following:

- the sale of the assets and operations of Central Montgomery Medical Center, a 125-bed acute care facility located in Lansdale, Pennsylvania;
- the sale of our ownership interest in a third-party provider of supply chain services, and;
- the sale our ownership interest in an outpatient surgery center and certain other real property assets.

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 typically 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.

	2008	2007	2006	2005	2004
Average Licensed Beds:					
Acute Care Hospitals—U.S. & Puerto Rico (1)	6,101	5,962	5,617	5,707	6,496
Behavioral Health Centers	7,658	7,348	6,607	4,849	4,225
Acute Care Hospitals—France (2)	—	—	—	667	1,588
Average Available Beds (3):					
Acute Care Hospitals—U.S. & Puerto Rico (1)	5,249	5,110	4,783	5,110	5,592
Behavioral Health Centers	7,629	7,315	6,540	4,766	4,145
Acute Care Hospitals-France (2)	—	—	—	662	1,588
Admissions:					
Acute Care Hospitals—U.S. & Puerto Rico (1)	268,207	262,147	246,429	261,402	286,630
Behavioral Health Centers	129,553	119,730	111,490	102,683	94,743
Acute Care Hospitals—France (2)	—	—	—	37,262	94,536
Average Length of Stay (Days):					
Acute Care Hospitals—U.S. & Puerto Rico (1)	4.5	4.5	4.4	4.5	4.7
Behavioral Health Centers	16.1	16.8	16.6	14.1	13.0
Acute Care Hospitals—France (2)	—	—	—	4.6	4.7
Patient Days (4):					
Acute Care Hospitals—U.S. & Puerto Rico (1)	1,200,672	1,172,130	1,095,375	1,179,894	1,342,242
Behavioral Health Centers	2,085,114	2,007,119	1,855,306	1,446,260	1,234,152
Acute Care Hospitals—France (2)	—	—	—	172,084	442,825
Occupancy Rate—Licensed Beds (5):					
Acute Care Hospitals—U.S. & Puerto Rico (1)	54%	54%	53%	57%	56%
Behavioral Health Centers	74%	75%	77%	82%	80%
Acute Care Hospitals—France (2)	—	—	—	71%	76%
Occupancy Rate—Available Beds (5):					
Acute Care Hospitals—U.S. & Puerto Rico (1)	62%	63%	63%	63%	66%
Behavioral Health Centers	75%	75%	78%	83%	81%
Acute Care Hospitals—France (2)	—	—	—	71%	76%

(1) The acute care facilities located in Puerto Rico were divested by us during the first quarter of 2005 and Central Montgomery Medical Center located in Pennsylvania was divested during the fourth quarter of 2008. The statistical information for these facilities is included in the above information through the respective divestiture dates.

(2) The facilities located in France were divested by us during the second quarter of 2005 and the statistical information for these facilities is included in the above information through the divestiture date.

(3) "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

(4) "Patient Days" is the sum of all patients for the number of days that hospital care is provided to each patient.

(5) "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 Operations and Financial Condition—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 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 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 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, attorney generals 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 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.

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. 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 or recommending or arranging for such referrals or orders of services or other items covered by a federal or state health care program.

The anti-kickback statute contains certain exceptions, and the Office of the Inspector General of the Department of Health and Human Services ("OIG") has issued regulations that provide for "safe harbors," from the federal anti-kickback statute for various activities. These activities, which must meet certain requirements, include (but are not limited to) the following: investment interests, space rental, equipment rental, practitioner recruitment, personnel services and management contracts, sale of practice, referral services, warranties, discounts, employees, group purchasing organizations, waiver of beneficiary coinsurance and deductible amounts, managed care arrangements, obstetrical malpractice insurance subsidies, investments in group practices, freestanding surgery centers, donation of technology for electronic health records and referral agreements for specialty services. The fact that conduct or a business arrangement does not fall within a safe harbor or exception does not automatically render the conduct or business arrangement illegal under the anti-kickback statute. However, such conduct and business arrangements may lead to increased scrutiny by government enforcement authorities.

Although we believe that our arrangements with physicians 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 "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 be liable under the False Claims Act, the defendant must pay 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. In addition, a number of states have adopted their own false claims provisions as well as their own whistleblower provisions whereby a private party may file a civil lawsuit on behalf of the state in state court.

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 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 new 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.

Compliance with the electronic data transmission standards became mandatory in October 2003. However, during the following year HHS agreed to allow providers and other electronic billers to continue to submit pre-HIPAA format electronic claims for periods after October 16, 2003, provided they can show good faith efforts to become HIPAA compliant. Since this exception expired, we believe that we have been in compliance with the electronic data transmission standards.

We were required to comply with the privacy requirements of HIPAA by April 14, 2003. We believe that we were in material compliance with the privacy regulations by that date and remain so, 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. We were required to comply with the security regulations by April 20, 2005 and believe that we have been in substantial compliance to date.

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 and Texas, have passed legislation that prohibits 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 vary from state to state, are often vague and have seldom been interpreted by the courts or regulatory agencies. We do not expect this legislation 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 at this time.

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, 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.

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. The government also has expressed its intent to investigate and enforce EMTALA violations actively in the future. We believe that we operate in substantial compliance with EMTALA.

Health Care Industry Investigations: We are subject to claims and suits in the ordinary course of business, including those arising from care and treatment afforded by our hospitals and are party to various government investigations and litigation. Please see *Item 3. Legal Proceedings* included herein for disclosure related to: (i) Investigation of South Texas Health System affiliates; (ii) Litigation and Administrative Appeal of CMS's Attempt to Terminate Medicare Participation of Two Rivers Psychiatric Hospital, and: (iii) Investigation of Virginia Behavioral Health Facilities.

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.

Compliance Program: Our company-wide compliance program has been in place since 1998. Currently, the program's elements include a Code of Conduct, risk area specific policies and procedures, employee education and training, an internal system for reporting concerns, auditing and monitoring programs, and a means for enforcing the program's policies.

Since its initial adoption, the compliance program continues to be expanded and developed to meet the industry's expectations and our needs. Specific written policies, procedures, training and educational materials and programs, as well as auditing and monitoring activities have been prepared and implemented to address the

functional and operational aspects of our business. Specific areas identified through regulatory interpretation and enforcement activities have also been addressed in our program. Claims preparation and submission, including coding, billing, and cost reports, comprise the bulk of these areas. Financial arrangements with physicians and other referral sources, including compliance with anti-kickback and Stark laws and emergency department treatment and transfer requirements are also the focus of policy and training, standardized documentation requirements, and review and audit.

Medical Staff and Employees

Our facilities had approximately 39,500 employees on December 31, 2008, of whom approximately 27,900 were employed full-time. Our hospitals are staffed by licensed physicians who have been admitted to the medical staff of individual hospitals. With a few exceptions, physicians are not employees of our hospitals and in a number of our markets, may have admitting privileges at other hospitals in addition to ours. Approximately 70 physicians are employed either directly by certain of our acute care facilities or affiliated by 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. We employ approximately 170 psychiatrists within our behavioral health division. Each of our hospitals are managed on a day-to-day basis by a managing director employed by us. In addition, a Board of Governors, including members of the hospital's medical staff, governs the medical, professional and ethical practices at each hospital.

Approximately 2,000 of our employees at six of our hospitals are unionized. At Valley Hospital Medical Center, unionized employees belong to the Culinary Workers and Bartenders Union, the International Union of Operating Engineers and the Service Employees International Union ("SEIU"). Nurses and technicians at Desert Springs Hospital are represented by the SEIU. Registered nurses at Auburn Regional Medical Center located in Washington, are represented by the United Staff Nurses Union, the technical employees are represented by the United Food and Commercial Workers, and the service employees are represented by the SEIU. At The George Washington University Hospital, unionized employees are represented by the SEIU or the Hospital Police Association. 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 Pennsylvania Clinical Schools, unionized employees are represented by the AFL-CIO. We believe that our relations with our employees are satisfactory.

Competition

The health care industry is highly competitive. In recent years, competition among healthcare providers for patients has intensified in the United States due to, among other things, regulatory and technological changes, increasing use of managed care payment systems, cost containment pressures and a shift toward outpatient treatment. In all of the geographical areas in which we operate, there are other hospitals that provide services comparable to those offered by our hospitals. In addition, some of our competitors include hospitals that are owned by tax-supported governmental agencies or by nonprofit corporations and may be supported by endowments and charitable contributions and exempt from property, sale and income taxes. Such exemptions and support are not available to us.

In some markets, certain of our competitors may have greater financial resources, be better equipped and offer a broader range of services than us. Certain hospitals that are located in the areas served by our facilities are specialty or large hospitals that provide medical, surgical and behavioral health services, facilities and equipment that are not available at our hospitals. The increase in outpatient treatment and diagnostic facilities, outpatient surgical centers and freestanding ambulatory surgical also increases competition for us.

During the past several years, the operating results of our acute care facilities located in the McAllen/ Edinburg, Texas market have been pressured by continued intense hospital and physician competition as a physician-owned hospital in the market has eroded a portion of our higher margin business, including cardiac

procedures. Additional newly constructed inpatient capacity and expansion of certain services at the physician owned hospital is expected to be completed and opened during the first quarter of 2009 which may further erode our future patient volumes and results of operations. In response to these competitive pressures, we have undertaken significant capital investment in the market, including two newly constructed facilities that were completed and opened during 2006 as follows: (i) Edinburg Children's Hospital, a 120-bed children's facility, and; (ii) South Texas Behavioral Health Center, a 134-bed replacement behavioral health facility. However, we expect that our future patient volumes, net revenues and profitability will continue to be unfavorably impacted as a result of this increased competitor capacity and expansion of services. A continuation of increased provider competition in this market and other markets in which we operate, as well as potential future capacity added by us and others, could result in additional erosion of the patient volumes, net revenues and financial operating results of our facilities.

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, 2008, we held approximately 6.6% 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 $1.6 million during 2008 and $1.4 million during each of 2007 and 2006. Our pre-tax share of income from the Trust was $900,000 during 2008 and $1.5 million during 2007 and is included in net revenues in the accompanying consolidated statements of income for each year. Our pre-tax share of income from the Trust was $2.3 million in 2006, of which $1.4 million is included in net revenues and the remaining $900,000 was recorded as a reduction to our hurricane related expenses and is included in "income/(loss) from discontinued operations, net of income taxes". The carrying value of this investment was $8.9 million and $9.9 million December 31, 2008 and 2007, respectively, and is included in other assets in the accompanying consolidated balance sheets. The market value of this investment was $25.9 million at December 31, 2008 and $27.9 million at December 31, 2007, based on the closing price of the Trust's stock on the respective dates.

Total rent expense under the operating leases on the hospital facilities with the Trust was $16.1 million during each of 2008 and 2007 and $16.0 million during 2006. In addition, certain of our subsidiaries are tenants in several medical office buildings owned by limited liability companies in which the Trust holds non-controlling ownership interests.

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.

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 the appraised fair market value. In addition, during 2006, as part of the overall exchange and substitution transaction relating to Chalmette Medical Center ("Chalmette") which was completed during the third quarter of 2006, as well as the early five year lease renewals on Southwest Healthcare System-Inland Valley Campus ("Inland Valley"), Wellington Regional Medical Center ("Wellington"), McAllen Medical Center and The Bridgeway ("Bridgeway"), the Trust agreed to amend the Master Lease to include a change of control provision. The change of control provision grants us the right, upon one month's notice should a change of control of the Trust occur, to purchase any or all of the four leased hospital properties at their appraised fair market value purchase price.

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

Hospital Name	Type of Facility	Annual Minimum Rent	End of Lease Term	Renewal Term (years)
McAllen Medical Center	Acute Care	$5,485,000	December, 2011	20 (a)
Wellington Regional Medical Center	Acute Care	$3,030,000	December, 2011	20 (b)
Southwest Healthcare System, Inland Valley Campus	Acute Care	$2,648,000	December, 2011	20 (b)
The Bridgeway	Behavioral Health	$ 930,000	December, 2014	10 (c)

(a) We have four 5-year renewal options at existing lease rates (through 2031).
(b) We have two 5-year renewal options at existing lease rates (through 2021) and two 5-year renewal options at fair market value lease rates (2022 through 2031).
(c) We have two 5-year renewal options at fair market value lease rates (2015 through 2024).

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 (71)	Chairman of the Board, President and Chief Executive Officer
Steve G. Filton (51)	Senior Vice President, Chief Financial Officer and Secretary
Debra K. Osteen (53)	Senior Vice President
Michael Marquez (55)	Senior Vice President
Marc D. Miller (38)	Senior Vice President and Director

Mr. Alan B. Miller has been Chairman of the Board, President and Chief Executive Officer since inception. 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. Mr. Miller also serves as a Director of Penn Mutual Life Insurance Company. He is the father of Marc D. Miller, Senior Vice President and Director.

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.

Ms. Osteen is responsible for our Behavioral Health Care facilities and was elected Senior Vice President in 2005 and Vice President in 2000. She has served in various capacities related to our Behavioral Health Care facilities since 1984.

Mr. Marquez was elected Senior Vice President and co-head of our Acute Care Hospitals in 2007 and was elected Vice President in 2004. He has served in various capacities related to our acute care division and most recently served as Vice President of our Western Region Acute Care Hospitals from 2000 to 2007.

Mr. Marc D. Miller was elected Senior Vice President and co-head of our Acute Care Hospitals in 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 Chief Executive Officer, President and Chairman of the Board.

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 revenues is produced by a small number of our facilities, which are concentrated in Texas and Nevada.

We have a majority ownership interest in five acute care hospitals in the Las Vegas, Nevada market. The five hospitals, Valley Hospital Medical Center, Summerlin Hospital Medical Center, Desert Springs Hospital, Spring Valley Medical Center and Centennial Hills Hospital Medical Center (opened in January 2008), on a combined basis, contributed 22% in 2008, 21% in 2007, and 21% in 2006 of our consolidated net revenues. On a combined basis, after deducting an allocation for corporate overhead expense, these facilities generated 20% in 2008, 27% in 2007, and 25% in 2006 of our earnings before income taxes and interest expense.

In addition, South Texas Health System, which includes McAllen Medical Center, McAllen Heart Hospital, South Texas Behavioral Health Center, located in McAllen, Texas, and Edinburg Regional Medical Center and Edinburg Children's Hospital, located in Edinburg, Texas, operate within the same market. On a combined basis, these facilities contributed 7% in 2008, 7% in 2007, and 8% in 2006 of our consolidated net revenues. On a combined basis, after deducting an allocation for corporate overhead expense, these facilities generated 3% in 2008, had a pre-tax loss of 3% in 2007, and generated 1% in 2006 of our earnings before income taxes and interest expense.

The significant portion of our revenues derived from these facilities makes us particularly sensitive to regulatory, economic, environmental and competition changes in Texas and Nevada. 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 health care 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 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, the funding requirements from the federal government's stimulus package, the ongoing military engagements in Iraq and Afghanistan, the War on Terrorism and the relief efforts related to hurricanes and other disasters, may affect the availability of taxpayer funds for Medicare and Medicaid programs. If the rates paid or the scope of services covered by government payors are reduced, there could be a material adverse effect on our business, financial position, results of operations.

We receive a large concentration of our Medicaid revenues from Texas and significant amounts from Nevada, Florida, California, Washington, DC and Illinois. These states, as well as most other states in which we operate, have reported significant budget deficits that, for all except Texas at this time, have resulted in a reduction of Medicaid funding for 2009. We can provide no assurance that reductions to Medicaid revenues, particularly in these states, will not have a material adverse effect on our business, financial condition and results of operations.

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.

An increase in uninsured and underinsured patients in our acute care facilities or the deterioration in the collectibility 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. We estimate our provisions for doubtful accounts based on general factors such as payor 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 that might ultimately affect the collectibility 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 could be harmed.

Fluctuations in our operating results quarter to quarter earning 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 if 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 hospitals face competition for patients from other hospitals and health care providers.

The health care industry is highly competitive and competition among hospitals and other health care 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.

During the past several years, the operating results of our acute care facilities located in the McAllen/ Edinburg, Texas market have been pressured by continued intense hospital and physician competition as a physician-owned hospital in the market has eroded a portion of our higher margin business, including cardiac procedures. Additional newly constructed inpatient capacity and expansion of certain services at the physician owned hospital is expected to be completed and opened during the first quarter of 2009 which may further erode our future patient volumes and results of operations. In response to these competitive pressures, we have undertaken significant capital investment in the market, including two newly constructed facilities that were completed and opened during 2006 as follows: (i) Edinburg Children's Hospital, a 120-bed children's facility, and; (ii) South Texas Behavioral Health Center, a 134-bed replacement behavioral health facility. However, we expect that our future patient volumes, net revenues and profitability will continue to be unfavorably impacted as a result of this increased competitor capacity and expansion of services. A continuation of increased provider competition in this market and other markets in which we operate, as well as potential future capacity added by us and others, could result in additional erosion of the patient volumes, net revenues and financial operating results of our facilities.

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 or 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 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.

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 health care professionals. We compete with other health care 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 health care 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 by 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.

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 health care services at our facilities, which could harm our business.

We may be subject to liabilities from claims brought against our facilities and governmental investigations.

We are subject to medical malpractice lawsuits, product liability lawsuits, governmental investigations and other legal actions in the ordinary course of business. Some of these actions may involve large claims, as well as significant defense costs (See *Item 3-Legal Proceedings* for disclosure regarding ongoing governmental investigations). We cannot predict the outcome of these lawsuits or investigations or the effect that findings in such lawsuits or investigations may have on us. 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.

Our growth strategy depends 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 health care 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, attorney generals 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 health care 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.

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.

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 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.

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 health care industry is required to comply with extensive and complex laws and regulations at the federal, state and local government levels relating to, among other things:

- hospital billing practices and prices for services;
- relationships with physicians and other referral sources;
- adequacy of medical care and quality of medical equipment and services;
- ownership of facilities;
- qualifications of medical and support personnel;
- confidentiality, maintenance and security issues associated with health-related information and patient medical records;

- the screening, stabilization and transfer of patients who have emergency medical conditions;
- licensure and accreditation of our facilities;
- operating policies and procedures, and;
- construction or expansion of facilities and services.

Among these laws are the False Claims Act, HIPAA, the federal anti-kickback statute and 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 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.

These laws and regulations are extremely complex and, in many cases, we don't 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, 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. 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 health care programs. The imposition of such penalties could have a material adverse effect on our business, financial condition or results of operations.

We are subject to uncertainties regarding health care reform.

An increasing number of legislative initiatives have been introduced or proposed in recent years that would result in major changes in the health care delivery system on a national or a state level. Among the proposals that have been introduced are price controls on hospitals, insurance market reforms to increase the availability of group health insurance to small businesses, requirements that all businesses offer health insurance coverage to their employees and the creation of government health insurance plans that would cover all citizens and increase payments by beneficiaries. We cannot predict whether any of the above proposals or other proposals will be adopted and, if adopted, no assurances can be given that their implementation will not have a material adverse effect on our business, financial condition or results of operations.

If the number of uninsured patients treated by our subsidiary hospitals increase, our results of operations may be harmed.

In accordance with our internal policies and procedures, as well as 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. If the number of indigent and charity care patients with emergency medical conditions we treat increases significantly, our results of operations may be harmed.

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 health care 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.

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.

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. In addition, we have commitments with unrelated third-parties

to build newly constructed facilities with a specified minimum number of beds and services. 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.

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. A continuation or worsening of economic conditions may result in a continued increase in the unemployment rate which will likely 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 a significant increase in services provided to uninsured patients. These factors could have a material unfavorable impact on our future patient volumes, revenues and operating results.

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, the degree to which we are, or in the future may become, leveraged, our ability to obtain financing could be adversely impacted and could make us more vulnerable to competitive pressures. Our ability to meet existing and future debt obligations, depends upon our future performance and our ability to secure additional financing on satisfactory terms, each of which is subject to financial, business and other factors that are beyond our control. Any failure by us to meet our financial obligations would harm our business.

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.

ITEM 1B. ***Unresolved Staff Comments***

None.

ITEM 2. *Properties*

Executive Offices

We own an office building with approximately 100,000 square feet available for use located on 11 acres of land in King of Prussia, Pennsylvania.

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	47	Owned
Auburn Regional Medical Center	Auburn, Washington	149	Owned
Centennial Hills Hospital Medical Center (1)	Las Vegas, Nevada	165	Owned
Corona Regional Medical Center	Corona, California	240	Owned
Desert Springs Hospital (1)	Las Vegas, Nevada	286	Owned
Doctors' Hospital of Laredo	Laredo, Texas	180	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
Lancaster Community Hospital	Lancaster, California	117	Owned
Manatee Memorial Hospital	Bradenton, Florida	319	Owned
Northern Nevada Medical Center	Sparks, Nevada	100	Owned
Northwest Texas Healthcare System	Amarillo, Texas	404	Owned
The Pavilion at Northwest Texas Healthcare System	Amarillo, Texas	85	Owned
Palmdale Regional Medical Center (10)	Palmdale, California	171	Owned
South Texas Health System (4)			
Edinburg Regional Medical Center	Edinburg, Texas	127	Owned
Edinburg Children's Hospital	Edinburg, Texas	86	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	122	Leased
Rancho Springs Campus	Murrieta, California	96	Owned
Spring Valley Hospital Medical Center (1)	Las Vegas, Nevada	210	Owned
St. Mary's Regional Medical Center	Enid, Oklahoma	245	Owned
Summerlin Hospital Medical Center (1)	Las Vegas, Nevada	281	Owned
Texoma Medical Center	Denison, Texas	174	Owned
TMC Behavioral Health Center	Denison, Texas	60	Owned
Valley Hospital Medical Center (1)	Las Vegas, Nevada	404	Owned
Wellington Regional Medical Center (3)	West Palm Beach, Florida	158	Leased

Behavioral Health Care Facilities

Name of Facility	Location	Number of Beds	Real Property Ownership Interest
Academy at Canyon Creek	Springville, Utah	128	Owned
Alabama Clinical Schools	Birmingham, Alabama	80	Owned
Anchor Hospital	Atlanta, Georgia	102	Owned
Arbour Counseling Services	Rockland, Massachusetts	—	Owned
The Arbour Hospital	Boston, Massachusetts	118	Owned
Arbour Senior Care	Rockland, Massachusetts	—	Owned
Arbour-Fuller Hospital	South Attleboro, Massachusetts	82	Owned
Arbour-HRI Hospital	Brookline, Massachusetts	68	Owned
Ascent Therapeutic Adventure Program	Naples, Idaho	120	Owned
Boulder Creek Academy	Bonners Ferry, Idaho	100	Owned
The Bridgeway (3)	North Little Rock, Arkansas	114	Leased
Bristol Youth Academy	Bristol, Florida	80	Owned
Carmichael NPS	Carmichael, California	—	Leased
The Carolina Center for Behavioral Health	Greer, South Carolina	89	Owned
Cedar Grove Residential Treatment Center	Murfreesboro, Tennessee	34	Owned
Cedar Ridge	Oklahoma City, Oklahoma	36	Owned
Cedar Ridge Residential Treatment Center	Oklahoma City, Oklahoma	80	Owned
Center for Change	Orem, Utah	58	Owned
Central Florida Behavioral Hospital	Orlando, FL	120	Owned
Clarion Psychiatric Center	Clarion, Pennsylvania	74	Owned
Coastal Harbor Treatment Center	Savannah, Georgia	132	Owned
Community Behavioral Health	Memphis, Tennessee	50	Leased
Compass Intervention Center	Memphis, Tennessee	88	Owned
Cottonwood Treatment Center	S. Salt Lake City, Utah	82	Leased
Del Amo Hospital	Torrance, California	166	Owned
Dover Behavioral Health	Dover, Delaware	52	Owned
Elmira NPS	Elmira, California	—	Leased
Fairmount Behavioral Health System	Philadelphia, Pennsylvania	185	Owned
Forest View Hospital	Grand Rapids, Michigan	62	Owned
Foundations Behavioral Health	Doylestown, Pennsylvania	114	Leased
Foundations for Living	Mansfield, Ohio	84	Owned
Glen Oaks Hospital	Greenville, Texas	54	Owned
Good Samaritan Counseling Center	Anchorage, Alaska	—	Owned
Grand Terrace NPS	Grand Terrace, California	—	Owned
Hampton Behavioral Health Center	Westhampton, New Jersey	100	Owned
Hartgrove Hospital	Chicago, Illinois	136	Owned
Hemet NPS	Hemet, California	—	Owned
Hermitage Hall	Nashville, Tennessee	112	Owned
Highlands Behavioral Health System	Highlands Ranch, Colorado	86	Owned
The Hope Program	Fountain, Florida	32	Owned
The Horsham Clinic	Ambler, Pennsylvania	146	Owned
Hospital San Juan Capestrano	Rio Piedras, Puerto Rico	108	Owned
Jacksonville Youth Center	Jacksonville, Florida	—	Owned
Keys of Carolina	Charlotte, North Carolina	60	Owned
Keystone Newport News	Newport News, Virginia	108	Owned
KeyStone Center	Wallingford, Pennsylvania	140	Owned
King George School	Sutton, Vermont	90	Owned

Name of Facility	Location	Number of Beds	Real Property Ownership Interest
La Amistad Behavioral Health Services	Maitland, Florida	80	Owned
Lakeside Behavioral Health System	Memphis, Tennessee	290	Owned
Laurel Heights Hospital	Atlanta, Georgia	122	Owned
Lincoln Trail Behavioral Health System	Radcliff, Kentucky	116	Owned
McDowell Center for Children	Dyersburg, Tennessee	31	Owned
Marion Youth Center	Marion, Virginia	48	Owned
The Meadows Psychiatric Center	Centre Hall, Pennsylvania	101	Owned
Meridell Achievement Center	Austin, Texas	112	Owned
Midwest Center for Youth and Families	Kouts, Indiana	76	Owned
Mountain Youth Academy	Mountain City, Tennessee	60	Owned
Natchez Trace Youth Academy	Waverly, Tennessee	85	Owned
North Star Hospital	Anchorage, Alaska	74	Owned
North Star Bragaw	Anchorage, Alaska	34	Owned
North Star DeBarr Residential Treatment Center	Anchorage, Alaska	60	Owned
North Star Palmer Residential Treatment Center	Palmer, Alaska	29	Owned
Northwest Academy	Bonners Perry, Idaho	120	Owned
Nueces County JJAEP NPS	Corpus Christi, Texas	—	Owned
Oak Plains Academy	Ashland City, Tennessee	90	Owned
Old Vineyard Behavioral Health	Winston-Salem, North Carolina	111	Owned
Parkwood Behavioral Health System	Olive Branch, Mississippi	112	Owned
The Pavilion	Champaign, Illinois	77	Owned
Peachford Behavioral Health System of Atlanta	Atlanta, Georgia	224	Owned
Pembroke Hospital	Pembroke, Massachusetts	115	Owned
Pennsylvania Clinical Schools	Coatesville, Pennsylvania	114	Owned
Provo Canyon School	Provo, Utah	266	Owned
Rancho Cucamonga NPS	Rancho Cucamonga, California	—	Owned
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
Riverside NPS	Riverside, California	—	Owned
River Crest Hospital	San Angelo, Texas	80	Owned
River Oaks Hospital	New Orleans, Louisiana	126	Owned
Rockford Center	Newark, Delaware	92	Owned
Roxbury	Shippensburg, Pennsylvania	84	Owned
St. Louis Behavioral Medicine Institute	St. Louis, Missouri	—	Owned
Spring Mountain Sahara	Las Vegas, Nevada	30	Owned
Spring Mountain Treatment Center	Las Vegas, Nevada	82	Owned
Steele Canyon NPS	El Cajon, California	—	Leased
Stonington Institute	North Stonington, Connecticut	72	Owned
SummitRidge	Lawrenceville, Georgia	76	Owned
Talbott Recovery Campus	Atlanta, Georgia	—	Owned
Timberlawn Mental Health System	Dallas, Texas	144	Owned
Turning Point Care Center	Moultrie, Georgia	59	Owned
Turning Point Youth Center	St. Johns, Michigan	60	Owned
Two Rivers Psychiatric Hospital	Kansas City, Missouri	105	Owned
Upper East TN Juvenile Detention Facility	Johnson City, Tennessee	10	Owned
Vallejo NPS	Vallejo, California	—	Leased
Victorville NPS	Victorville, California	—	Leased
Westwood Lodge Hospital	Westwood, Massachusetts	133	Owned
Wyoming Behavioral Institute	Casper, Wyoming	90	Owned

Surgical Hospitals, Ambulatory Surgery Centers and Radiation Oncology Centers

Name of Facility	Location	Real Property Ownership Interest
Cancer Institute of Nevada (6) (8)	Las Vegas, Nevada	Owned
Cancer Care Institute of Carolina	Aiken, South Carolina	Owned
Cornerstone Regional Hospital (9)	Edinburg, Texas	Leased
OJOS/Eye Surgery Specialists of Puerto Rico (6)	Santurce, Puerto Rico	Leased
Northwest Texas Surgery Center (6)	Amarillo, Texas	Leased
Palms Westside Clinic ASC (9)	Royal Palm Beach, Florida	Leased
Surgery Center at Wellington (7)	West Palm Beach, Florida	Leased
Surgery Center of Midwest City (5)	Midwest City, Oklahoma	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. Centennial Hills Hospital Medical Center, a newly constructed facility, was completed and opened in January, 2008.

(2) We hold an 80% ownership interest in this facility through a general partnership interest in limited partnership. The remaining 20% ownership interest is held by an unaffiliated, third-party.

(3) Real property leased from the Trust.

(4) In October, 2007, the license for Edinburg Regional Medical Center, Edinburg Children's Hospital, McAllen Medical Center, McAllen Heart Hospital and South Texas Behavioral Health Center were consolidated under one license operating as the South Texas Health System.

(5) We own general and limited partnership interests in a limited partnership that owns and operates this center.

(6) We own a majority interest in a LLC that owns and operates this center.

(7) We own minority interests in LLCs that own and operate these centers which are managed by unaffiliated third-parties.

(8) Real property is owned by a limited partnership or LLC that is majority owned by us.

(9) We own non-controlling ownership interests of approximately 50% in the entities that operate these facilities.

(10) New acute-care facility currently under construction and scheduled to be completed and opened by early 2010.

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 $41 million in 2008, $39 million in 2007 and $35 million in 2006.

ITEM 3. *Legal Proceedings*

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

Investigation of South Texas Health System affiliates:

We and our South Texas Health System affiliates, which operate McAllen Medical Center, McAllen Heart Hospital, Edinburg Regional Medical Center and certain other affiliates, were served with a subpoena dated November 21, 2005, issued by the Office of Inspector General of the Department of Health and Human Services

("OIG"). At that time, the Civil Division of the U.S. Attorney's office in Houston, Texas indicated that the subpoena was part of an investigation under the False Claims Act regarding compliance with Medicare and Medicaid rules and regulations pertaining to the employment of physicians and the solicitation of patient referrals from physicians from January 1, 1999 to the date of the subpoena, related to the South Texas Health System. Documents were produced on a rolling basis pursuant to this subpoena and several additional requests, including an additional March 9, 2007 subpoena, beginning in January of 2006. On February 16, 2007, our South Texas Health System affiliates were served with a search warrant in connection with what we were advised was a related criminal Grand Jury investigation concerning the production of documents. At that time, the government obtained various documents and other property related to the facilities. Follow-up Grand Jury subpoenas for documents and witnesses and other requests for information were subsequently served on South Texas Health System facilities and certain employees and former employees.

We have received notification from the U.S. Department of Justice ("DOJ") that, at this time, the DOJ will not be pursuing criminal prosecutive action against Universal Health Services, Inc. or our South Texas Health System affiliates. The DOJ is still investigating whether or not any individuals independently obstructed justice as it relates to the civil subpoena dated November 21, 2005. Our representatives have been advised that the Civil Division of the U.S. Attorney's office in Houston, Texas is continuing its investigation in connection with the civil subpoena dated November 21, 2005 issued by the OIG. Our legal representatives continue to meet with representatives of the Civil Division to discuss the status of this matter. We understand that, based on those discussions and its investigations to date, the government is focused on certain arrangements entered into by the South Texas Health System affiliates which, the government believes, may have violated Medicare and Medicaid rules and regulations pertaining to payments to physicians and the solicitation of patient referrals from physicians and other matters relating to payments to various individuals which may have constituted improper payments. We are cooperating with the investigations and are responding to the matters raised with us. We have been negotiating a possible settlement of this matter with the government. We expect to continue our discussions with the government to attempt to resolve this matter in a manner satisfactory to us and the government. During 2008, we recorded a pre-tax charge of $25 million to establish a reserve in connection with this matter. However, there is no assurance that a settlement can be reached, and, should a settlement be reached, we are unable at this time to determine the ultimate settlement amount. Should we be unable to ultimately reach a settlement, we are unable at this time to determine the extent of the total financial and/or other exposure to us in connection with this matter

Litigation and Administrative Appeal of CMS's Attempt to Terminate Medicare Participation of Two Rivers Psychiatric Hospital:

In late September, 2008, the Centers for Medicare and Medicaid Services ("CMS") issued a decision to terminate the participation in the Medicare program of Two Rivers Psychiatric Hospital ("Two Rivers"), a behavioral health facility operated by one of our affiliates in Kansas City. This decision was issued after state surveyors found Two Rivers to be allegedly out of compliance with the conditions of participation required for the Medicare program. Two Rivers filed an administrative appeal with the U.S. Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, seeking review of that decision. In order to prevent CMS from terminating the facility from the program prior to a hearing in the administrative appeal, Two Rivers filed a complaint in the U.S. District Court for the Western District of Missouri against the Secretary, U.S. Department of Health and Human Services, seeking a temporary restraining order and preliminary injunction against CMS' proceeding with the termination. The Court issued a temporary restraining order in favor of Two Rivers, preventing CMS from terminating Two Rivers from the Medicare program and referring the case to a magistrate judge for a settlement conference prior to a hearing on the preliminary injunction motion. On December 12, 2008, CMS and Two Rivers entered into a settlement agreement under which CMS rescinded its termination action and Two Rivers withdrew the administrative appeal and stipulated to a dismissal of the federal court action. The settlement agreement provides, among other terms, that Two Rivers would retain a monitor for six months to: (a) evaluate Two Rivers' systems for compliance with the Medicare conditions of participation; (b) make recommendations to Two Rivers based on the evaluation; (c) provide

monthly reports to CMS and Two Rivers; and (d) notify CMS if conditions at Two Rivers present a serious threat to patient safety, health or welfare. The settlement agreement also provides that CMS and the Missouri state survey agency will resurvey Two Rivers on or before six and at twelve months after monitoring is initiated. Although Two Rivers is no longer being terminated by CMS from participation in the Medicare program, there is no assurance that during or after the monitoring period a new termination action would not be initiated by CMS should Two Rivers be found to be out of compliance with conditions of participation in Medicare, which could have a material adverse effect on us.

Investigation of Virginia Behavioral Health Facilities:

In late 2007 and again recently, the Office of Inspector General for the Department of Health and Human Services ("OIG") issued subpoenas to two of our facilities, Marion Youth Center and Mountain Youth Academy, seeking documents related to the treatment of Medicaid beneficiaries at the facilities. We believe that the OIG is investigating whether claims for reimbursement submitted by those facilities to the Virginia Medicaid program were supported by adequate documentation of the services provided.

On August 4, 2008, the Office of the Attorney General for the Commonwealth of Virginia issued a subpoena to Keystone Newport News, another of our facilities. We believe the Office of Attorney General is investigating whether Keystone Newport News complied with various Virginia laws and regulations, including documentation requirements.

In response to these subpoenas, we have been producing the requested documents on a rolling basis and we are cooperating with the investigations in all respects. We also have met with representatives of the OIG, the Virginia Attorney General, the United States Attorney for the Western District of Virginia, and the United States Department of Justice Civil Division to discuss a possible resolution of this matter. There is no assurance that we will be able to satisfactorily negotiate a resolution to this issue. At this time we are unable to evaluate the extent of any potential financial and/or other exposure in connection with this matter.

Ethridge v. Universal Health Services et. al:

In June, 2008, we and one of our acute care facilities, Lancaster Community Hospital, were named as defendants in a wage and hour lawsuit in Los Angeles County Superior Court. This is a purported class action lawsuit alleging that the hospital failed to provide sufficient meal and break periods to certain employees. We have denied liability and are defending the case vigorously which has not yet been certified as a class action by the court. Given the early stage of this case and the uncertainty of the nature, legal viability and extent of the claims, we are unable to determine the extent of potential financial exposure at this time. Further, some of the issues in this lawsuit may have been settled by a previous settlement related to a previously filed class action wage and hour suit against the hospital.

The healthcare industry is subject to numerous laws and regulations which include, among other things, matters such as government healthcare participation requirements, various licensure 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. Providers that are found to have violated these laws and regulations may be excluded from participating in government healthcare programs, 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, from time to time, we are subjected to inquiries or actions with respect to

our facilities. 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 above. Even if we were to ultimately prevail, such inquiries and/or actions could have a material adverse effect on us.

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. ***Submission of Matters to a Vote of Security Holders***

No matter was submitted during the fourth quarter of the fiscal year ended December 31, 2008 to a vote of security holders.

PART II

ITEM 5. ***Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***

Our Class B Common Stock is traded on the New York Stock Exchange. Shares of our Class A, Class C and Class D Common Stock are not traded in any public market, but are each convertible into shares of our Class B Common Stock on a share-for-share basis.

The table below sets forth, for the quarters indicated, the high and low reported closing sales prices per share reported on the New York Stock Exchange for our Class B Common Stock for the years ended December 31, 2008 and 2007.

	2008	2007
	High-Low Sales Price	**High-Low Sales Price**
Quarter:		
1st	**$ 54.46-$46.73**	$ 60.19-$55.17
2nd	**$ 65.00-$54.84**	$ 63.00-$56.87
3rd	**$ 65.08-$56.03**	$ 62.30-$48.76
4th	**$ 53.17-$32.44**	$ 53.80-$48.45

Number of shareholders of record as of January 31, 2009, were as follows:

Class A Common	11
Class B Common	344
Class C Common	5
Class D Common	139

Stock Repurchase Programs

During 1999, 2004, 2005, 2006 and 2007, our Board of Directors approved stock repurchase programs authorizing us to purchase up to an aggregate of 21.5 million shares of our outstanding Class B Common Stock on the open market at prevailing market prices or in negotiated transactions off the market. There is no expiration date for our stock repurchase programs. The following schedule provides information related to our stock repurchase programs for each of the three years ended December 31, 2008:

	Additional Shares Authorized For Repurchase	Total number of shares purchased(a)	Average price paid per share for forfeited restricted shares	Total Number of shares purchased as part of publicly announced programs	Average price paid per share for shares purchased as part of publicly announced program	Aggregate purchase price paid (in thousands)	Maximum number of shares that may yet be purchased under the program
Balance as of January 1, 2006							3,603,320
2006	5,000,000	6,536,240	$0.01	6,527,155	$53.68	$350,372	2,076,165
2007	5,000,000	1,462,537	$0.01	1,451,073	$51.06	$ 74,091	5,625,092
2008	—	3,293,568	$0.01	3,268,318	$45.71	$149,404	2,356,774
Total for three year period ended December 31, 2008	10,000,000	11,292,345	$0.01	11,246,546	$51.03	$573,867	

(a.) Includes 9,085, 11,464 and 25,250 restricted shares that were forfeited by former employees pursuant to the terms of our restricted stock purchase plan during 2006, 2007 and 2008, respectively.

During the period of October 1, 2008 through December 31, 2008, we repurchased the following shares:

	Additional Shares Authorized For Repurchase	Total number of shares purchased(a)	Average price paid per share for forfeited restricted shares	Total Number of shares purchased as part of publicly announced programs	Average price paid per share for shares purchased as part of publicly announced program	Aggregate purchase price paid (in thousands)	Maximum number of shares that may yet be purchased under the program
October, 2008	—	—	N/A	—	$ N/A	$ N/A	3,571,098
November, 2008	—	626,665	$0.01	624,165	$39.56	$24,692	2,946,933
December, 2008	—	590,159	N/A	590,159	$34.36	$20,276	2,356,774
Total October through December	—	1,216,824	$0.01	1,214,324	$37.03	$44,968	

(a.) Includes 2,500 restricted shares that were forfeited by former employees pursuant to the terms of our restricted stock purchase plan.

Dividends

During the two years ending December 31, 2008, dividends per share were declared and paid as follows:

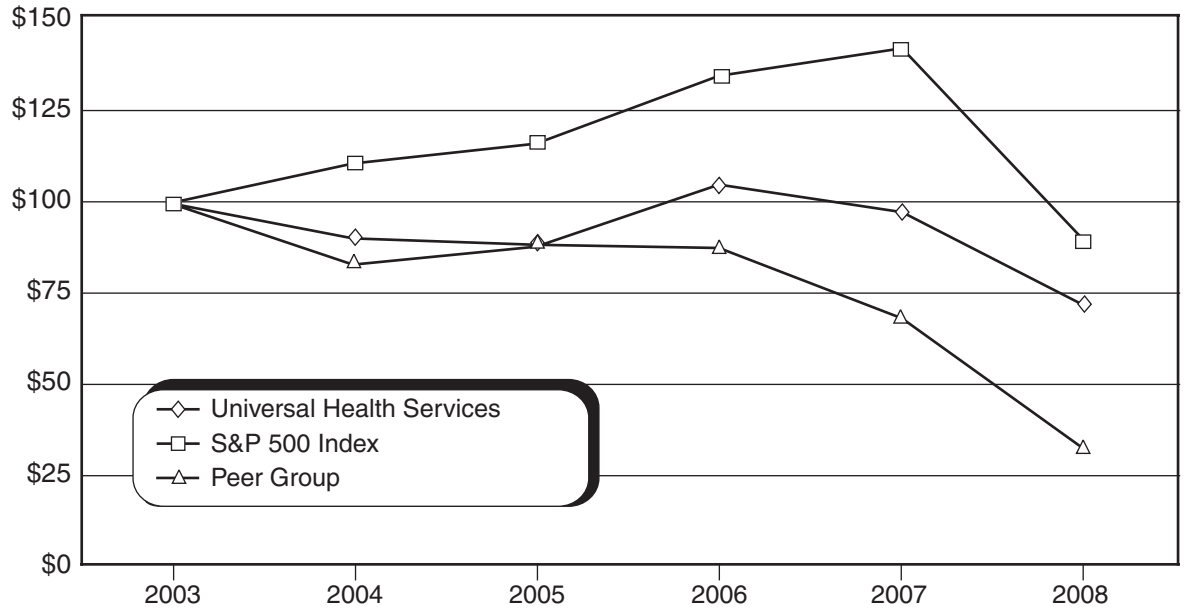
	2008	2007
First quarter	$.08	$.08
Second quarter	$.08	$.08
Third quarter	$.08	$.08
Fourth quarter	$.08	$.08
Total	$.32	$.32

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, 2008. The graph assumes an investment of $100 made in our common stock and each Index as of January 1, 2004 and has been weighted based on market capitalization. Note that our common stock price performance shown below should not be viewed as being indicative of future performance.

Companies in the peer group, which consist of companies in the S&P 400 Health Care Facilities Index (in which we are also included), the S&P 500 Health Care Facilities Index and the S&P 600 Health Care Facilities Index, are as follows: Community Health Systems, Inc., HCA Inc. (included through December, 2005), Health Management Associates, LifePoint Hospitals, Inc., Province Healthcare Company (included through December, 2004 and acquired by LifePoint Hospitals, Inc. during 2005), Tenet Healthcare Corporation and Triad Hospitals, Inc. (included through December, 2006 and acquired by Community Health Systems in 2007).

COMPARISON OF FIVE YEAR CUMULATIVE TOTAL RETURN
(The Company, S&P 500 and Peer Group)



Company Name / Index	2003	2004	2005	2006	2007	2008
Universal Health Services, Inc	$100.00	$ 83.40	$ 88.16	$105.18	$ 97.71	$72.14
S&P 500 Index	$100.00	$110.88	$116.33	$134.70	$142.10	$89.53
Peer Group	$100.00	$ 90.47	$ 88.71	$ 87.96	$ 68.85	$32.98

ITEM 6. *Selected Financial Data*

The following table contains our selected financial data for, or as the end of, each of the five years ended December 31, 2008. 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.*

Selected Financial Data

	Year Ended December 31				
	2008	**2007**	**2006**	**2005**	**2004**
Summary of Operations (in thousands)					
Net revenues	$5,022,417	$4,683,150	$4,124,692	$3,706,618	$3,342,886
Income from continuing operations	$ 192,941	$ 170,642	$ 159,200	$ 157,034	$ 164,158
Net income	$ 199,377	$ 170,387	$ 259,458	$ 240,845	$ 169,492
Net margin	4.0%	3.6%	6.3%	6.5%	5.1%
Return on average equity	13.0%	11.3%	18.9%	19.4%	14.4%
Financial Data (in thousands)					
Cash provided by operating activities	$ 463,100	$ 348,495	$ 169,239	$ 425,426	$ 392,880
Capital expenditures, net (1)	$ 354,537	$ 339,813	$ 341,140	$ 241,412	$ 230,760
Total assets	$3,742,462	$3,608,657	$3,277,042	$2,858,709	$3,022,843
Long-term borrowings	$ 990,661	$1,008,786	$ 821,363	$ 637,654	$ 852,229
Common stockholders' equity	$1,543,850	$1,517,199	$1,402,464	$1,205,098	$1,220,586
Percentage of total debt to total capitalization	39%	40%	37%	35%	42%
Operating Data—Acute Care Hospitals (2)					
Average licensed beds	5,452	5,292	4,947	4,884	4,940
Average available beds	5,145	4,985	4,658	4,559	4,311
Inpatient admissions	263,536	256,681	240,451	236,753	228,454
Average length of patient stay	4.5	4.5	4.4	4.4	4.5
Patient days	1,182,894	1,149,399	1,069,890	1,036,366	1,020,817
Occupancy rate for licensed beds	59%	60%	59%	58%	56%
Occupancy rate for available beds	63%	63%	63%	62%	65%
Operating Data—Behavioral Health Facilities					
Average licensed beds	7,658	7,348	6,607	4,849	4,225
Average available beds	7,629	7,315	6,540	4,766	4,145
Inpatient admissions	129,553	119,730	111,490	102,683	94,743
Average length of patient stay	16.1	16.8	16.6	14.1	13.0
Patient days	2,085,114	2,007,119	1,855,306	1,446,260	1,234,152
Occupancy rate for licensed beds	74%	75%	77%	82%	80%
Occupancy rate for available beds	75%	75%	78%	83%	81%
Per Share Data					
Net income from continuing operations—basic	$ 3.81	$ 3.20	$ 2.92	$ 2.82	$ 2.85
Net income from continuing operations—diluted	$ 3.80	$ 3.18	$ 2.83	$ 2.66	$ 2.67
Net income—basic	$ 3.94	$ 3.19	$ 4.76	$ 4.33	$ 2.94
Net income—diluted	$ 3.93	$ 3.18	$ 4.56	$ 4.00	$ 2.75
Dividends declared	$ 0.32	$ 0.32	$ 0.32	$ 0.32	$ 0.32
Other Information (in thousands)					
Weighted average number of shares outstanding—basic	50,611	53,381	54,557	55,658	57,653
Weighted average number of shares and share equivalents outstanding—diluted	50,776	53,569	57,908	62,647	64,865

(1) Amounts include non-cash capital lease obligations, if any.
(2) Excludes statistical information related to divested facilities and facilities held for sale.

ITEM 7. *Management's Discussion and Analysis of Operations and Financial Condition*

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, 2009, we owned and/or operated or had under construction, 26 acute care hospitals (including 1 new facility currently being constructed) and 101 behavioral health centers located in 32 states, Washington, D.C. and Puerto Rico. As part of our ambulatory treatment centers division, we manage and/or own outright or in partnerships with physicians, 9 surgical hospitals and surgery and radiation oncology centers located in 6 states and Puerto Rico.

Net revenues from our acute care hospitals, surgical hospitals, surgery centers and radiation oncology centers accounted for 74%, 74% and 75% of our consolidated net revenues in 2008, 2007 and 2006, respectively. Net revenues from our behavioral health care facilities accounted for 25% of our consolidated net revenues during each of 2008, 2007 and 2006. During each of 2008 and 2007, approximately 1% of our consolidated net revenues were recorded in connection with two construction management contracts pursuant to the terms of which we: (i) built a newly constructed acute care hospital for an unrelated third party that was completed during the first quarter of 2008, and; (ii) are building a newly constructed acute care hospital for an unrelated party that is scheduled to be completed during the fourth quarter of 2009.

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 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

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.

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 existing laws and government regulations and/or changes in laws and government regulations;
- possible unfavorable changes in the levels and terms of reimbursement for our charges by third party payors or government programs, including Medicare or Medicaid;
- an increase in the number of uninsured and self-pay patients treated at our acute care facilities that unfavorably impacts our ability to satisfactorily and timely collect our self-pay patient accounts;

- our ability to enter into managed care provider agreements on acceptable terms;
- the outcome of known and unknown litigation, government investigations, and liabilities and other claims asserted against us, including the government's ongoing investigations of our South Texas Health Systems affiliates and other matters as disclosed in Item 1. Legal Proceedings;
- the potential unfavorable impact on our business of continued deterioration in national, regional and local economic and business conditions, including a continuation or worsening of unfavorable credit market conditions;
- competition from other healthcare providers, including physician owned facilities in certain markets, including McAllen/Edinburg, Texas, the site of one of our largest acute care facilities;
- 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;
- a significant portion of our revenues is produced by a small number of our facilities;
- 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;
- 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, 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%, 37% and 38% of our net patient revenues during 2008, 2007 and 2006, respectively. Revenues from managed care entities, including health maintenance organizations and managed Medicare and Medicaid programs accounted for 46%, 44% and 41% of our net patient revenues during 2008, 2007 and 2006, respectively.

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 can not 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 2008 or 2007 and favorably impacted our 2006 after-tax operating results by $5 million ($8 million pre-tax). 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, 2008, 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. Our acute care hospitals provided charity care and uninsured discounts, based on charges at established rates, amounting to (amounts include uninsured discounts mentioned above and data related to an acute care facility that is reflected as discontinued operations) $614 million, $562 million and $443 million during 2008, 2007 and 2006, respectively.

At our acute care facilities, Medicaid pending accounts comprise the large majority of our receivables that are pending approval from third-party payors but we also have smaller amounts due from other miscellaneous payors such as county indigent programs in certain states. Approximately 5% or $36 million as of December 31, 2008 and 5% or $31 million as of December 31, 2007 of our accounts receivable, net, were comprised of Medicaid pending accounts.

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 if we are unable to definitively determine if they are currently Medicaid eligible without further evaluation. 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 pending ultimate disposition of the patient's Medicaid eligibility.

Based on historical hindsight information related to Medicaid pending accounts, we estimate that approximately 58% or $21 million of the $36 million Medicaid pending accounts receivable as of December 31, 2008 will subsequently qualify for Medicaid reimbursement. Approximately 58% or $18 million of $31 million total Medicaid pending accounts receivable as of December 31, 2007 subsequently qualified for Medicaid pending reimbursement and were therefore appropriately classified at the patient's registration. Additional charity reserves of $13 million during each of 2008 and 2007 were established to cover the Medicaid Pending patients that failed to qualify for the Medicaid program based on historical conversion rates. Based on general factors as discussed below in *Provision for Doubtful Accounts*, our facilities make estimates at each financial reporting period to reserve for amounts that are deemed to be uncollectible. Such estimated uncollectible amounts related to Medicaid pending, as well as other accounts receivable payor classifications, are considered when the overall individual facility and company-wide reserves are developed.

Below are the Medicaid pending receivable agings as of December 31, 2008 and 2007 (amounts in thousands):

	2008	%	2007	%
Under 60 days	$13,554	37.9	$11,916	38.2
61-120 days	8,309	23.3	7,963	25.6
121-180 days	4,283	12.0	3,450	11.1
Over 180 days	9,585	26.8	7,836	25.1
Total	$35,731	100.0	$31,165	100.0

Provision for Doubtful Accounts: 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 which is the patient's responsibility, primarily co-payments and deductibles. We estimate our provisions for doubtful accounts based on general factors such as payor 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 collectibility 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 is sent at least two statements followed by a series of collection letters. 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. Patients that express an inability to pay are reviewed for write-off as potential charity care. Our accounts receivable are recorded net of established charity care reserves of $83 million as of December 31, 2008 and $81million as of December 31, 2007 (including additional charity care reserves of $13 million established during each of 2008 and 2007, as discussed above in *Revenue recognition*).

Uninsured patients that do not qualify as charity patients are extended an uninsured discount of at least 20% of total charges. During the collection process the hospital establishes a partial reserve in the allowance for doubtful accounts for self-pay balances outstanding for greater than 60 days from the date of discharge. All self-pay accounts at the hospital level are fully reserved if they have been outstanding for greater than 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. Potential charity accounts are fully reserved when it is determined the patient may be unable to pay.

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. At December 31, 2008 and December 31, 2007, accounts receivable are recorded net of allowance for doubtful accounts of $163 million and $121 million, respectively.

Approximately 93% during 2008, 93% during 2007 and 94% during 2006, of our consolidated provision for doubtful accounts, was incurred by our acute care hospitals. Shown below is our payor mix concentrations and related aging of our billed accounts receivable, net of contractual allowances, for our acute care hospitals as of December 31, 2008 and 2007:

As of December 31, 2008: (amounts in thousands)	0-60 days	61-120 days	121-180 days	Over 180 days
Medicare	$ 49,254	$ 3,993	$ 1,091	$ 4,830
Medicaid	29,072	16,049	9,409	22,858
Commercial insurance and other	187,273	53,539	21,600	44,670
Private pay	70,174	38,510	24,921	34,645
Total	$335,773	$112,091	$57,021	$107,003

As of December 31, 2007: (amounts in thousands)	0-60 days	61-120 days	121-180 days	Over 180 days
Medicare	$ 51,426	$ 3,656	$ 1,128	$ 2,937
Medicaid	27,884	16,769	8,174	16,530
Commercial insurance and other	185,540	58,332	23,286	36,381
Private pay	65,244	28,050	20,241	29,381
Total	$330,094	$106,807	$52,829	$85,229

Self-Insured Risks: We provide for self-insured risks, primarily general and professional liability claims and workers' compensation claims, based on estimates of the ultimate costs for both reported claims and claims incurred but not reported. Estimated losses from asserted and incurred but not reported claims are accrued based on our estimates of the ultimate costs of the claims, which includes costs associated with litigating or settling claims, and the relationship of past reported incidents to eventual claims payments. All relevant information, including our own historical experience, the nature and extent of existing asserted claims and reported incidents, is used in estimating the expected amount of claims. We also consider amounts that may be recovered from excess insurance carriers, state guaranty funds and other sources in estimating our ultimate net liability for such risk. 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.

For the years of 1998 through 2001, most of our subsidiaries were covered under commercial insurance policies with PHICO, a Pennsylvania based insurance company that was placed into liquidation in February, 2002. As a result, although PHICO continued to be liable for claims on our behalf that were related to 1998 through 2001, we began paying the claims upon PHICO's liquidation. Since that time, although we preserved our right to receive reimbursement from the PHICO estate, we were not previously able to assess the probability of collection or reasonably quantify our share of the liquidation proceeds. In January, 2009, a court order from the Commonwealth Court of Pennsylvania was executed in connection with the partial liquidation of the PHICO estate. As a result, during the fourth quarter of 2008, based upon our share of the undisputed and resolved claims made against the PHICO estate as of a specified date and as approved by the liquidator to the court, we recorded a $10 million reduction to our professional and general liability self-insured claims expense. These liquidation proceeds were received during the first quarter of 2009.

During the second quarter of 2007, based upon the results of a reserve analysis, we recorded an $18 million (pre-minority interest) reduction to our prior year reserves for professional and general liability self-insured

claims. This favorable change in our estimated future claims payments was partially due to the favorable impact of medical malpractice tort reform experienced in several states in which we operate as well as a decrease in obstetrical-related claims due to a company-wide patient safety initiative in this high-risk specialty. Adjustments to our prior year reserves for professional and general liability self-insured claims did not have a material impact on our financial statements during 2006.

Based upon the results of workers' compensation reserves analyses, we recorded reductions to our prior year reserves for workers' compensation claims amounting to $4 million during 2008 (recorded during the fourth quarter) and $5 million during 2007 ($2 million recorded during the second quarter of 2007 and $3 million recorded during the fourth quarter of 2007). Adjustments to our prior year reserves for workers' compensation claims did not have a material impact on our financial statements during 2006.

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, it is reasonably likely that our future financial results may include material adjustments to prior period reserves.

Below is a schedule showing the changes in our general and professional liability and workers' compensation reserves during the three years ended December 31, 2008 (amount in thousands):

	General and Professional Liability	Workers' Compensation	Total
Balance at January 1, 2006 (a)	$216,459	$ 45,329	$261,788
Plus: accrued insurance expense, net of commercial premiums paid	59,752	16,704	76,456
Less: Payments made in settlement of self-insured claims	(31,591)	(13,265)	(44,856)
Plus: Liabilities assumed at acquisition	176	668	844
Balance at January 1, 2007 (a)	244,796	49,436	294,232
Plus: accrued insurance expense, net of commercial premiums paid	49,177	14,954	64,131
Less: Payments made in settlement of self-insured claims	(37,960)	(15,648)	(53,608)
Balance at January 1, 2008 (a)	256,013	48,742	304,755
Plus: accrued insurance expense, net of commercial premiums paid (b)	56,904	16,509	73,413
Less: Payments made in settlement of self-insured claims	(41,807)	(16,754)	(58,561)
Balance at December 31, 2008 (a)	$271,110	$ 48,497	$319,607

(a) Net of expected recoveries from various state guaranty funds in connection with a commercial general and professional insurance company's (PHICO) liquidation in 2002 (see *Professional and General Liability Claims and Property Insurance*).

(b) Excludes the impact of the $10 million recovery from the liquidation of the PHICO estate, as discussed above.

In addition, we also maintain self-insured employee benefits programs for employee healthcare and dental claims. The ultimate costs related to these programs 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.

Long-Lived Assets: We review our long-lived assets, including amortizable 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: Goodwill is 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, 2008 which indicated no impairment of goodwill. 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.

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 carryforwards.

We operate in multiple jurisdictions with varying tax laws. We are subject to audits by any of these taxing authorities. During 2008, the estimated liabilities for uncertain tax positions (including accrued interest and penalties) were increased in the amount of approximately $2 million due to tax positions taken in the current and prior years. Also during 2008, 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. During 2007, the estimated liabilities for uncertain tax positions (including accrued interest and penalties) were reduced due to the lapse of the statue of limitations and the conclusions of income tax audits of varying taxing authorities resulting in a net income tax benefit of approximately $2 million. Our tax returns have been examined by the Internal Revenue Service (IRS) through the year ended December 31, 2002. The IRS has recently commenced an audit for the tax year ended December 31, 2006. We believe that adequate accruals have been provided for federal, foreign and state taxes.

Accounting for Uncertainty in Income Taxes: Effective January 1, 2007, we adopted the provisions of FASB issued Interpretation No. 48 ("FIN 48"), Accounting for Uncertainty in Income Taxes. As a result of the implementation of FIN 48, we recognized a $12 million decrease in the liability for unrecognized tax benefits. This decrease in the liability resulted in an increase to the January 1, 2007 balance of retained earnings of approximately $12 million. As of January 1, 2007, after the implementation of FIN 48, our unrecognized tax benefits were approximately $6 million. The amount at implementation that would favorably affect the effective tax rate and provision for income taxes was approximately $4 million, approximately $3 million of which was recorded during 2007. The balance at December 31, 2008 and 2007, if subsequently recognized, that would favorably affect the effective tax rate and provision for income taxes is approximately $2 million and $1 million, respectively.

Recent Accounting Pronouncements: For a summary of recent accounting pronouncements, please see *Note 13 to the Consolidated Financial Statements* as included in this Report on Form 10-K for the year ended December 31, 2008.

Results of Operations

The following table summarizes our results of operations, and is used in the discussion below, for the years ended December 31, 2008, 2007 and 2006 (dollar amounts in thousands):

	Year Ended December 31,					
	2008		2007		2006	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Net revenues	$5,022,417	100.0%	$4,683,150	100.0%	$4,124,692	100.0%
Operating charges:						
Salaries, wages & benefits	2,133,181	42.5%	2,004,995	42.8%	1,765,162	42.8%
Other operating expenses	1,044,278	20.8%	982,614	21.0%	921,836	22.3%
Supplies expense	694,477	13.8%	666,320	14.2%	547,915	13.3%
Provision for doubtful accounts	476,745	9.5%	410,543	8.8%	343,383	8.3%
Depreciation & amortization	193,635	3.9%	180,557	3.9%	161,097	3.9%
Lease & rental expense	69,882	1.4%	67,867	1.4%	63,574	1.5%
	4,612,198	91.8%	4,312,896	92.1%	3,802,967	92.2%
Income before interest expense, hurricane insurance recoveries in excess of expenses, minority interests & income taxes	410,219	8.2%	370,254	7.9%	321,725	7.8%
Interest expense, net	53,207	1.1%	51,626	1.1%	32,558	0.8%
Hurricane insurance recoveries in excess of expenses	—	—	—	—	(770)	0.0%
Minority interests in earnings of consolidated entities	40,693	0.8%	43,361	0.9%	37,519	0.9%
Income before income taxes	316,319	6.3%	275,267	5.9%	252,418	6.1%
Provision for income taxes	123,378	2.5%	104,625	2.3%	93,218	2.2%
Income from continuing operations	192,941	3.8%	170,642	3.6%	159,200	3.9%
Income/(loss) from discontinued operations, net of income taxes	6,436	0.2%	(255)	0.0%	100,258	2.4%
Net income	$ 199,377	4.0%	$ 170,387	3.6%	$ 259,458	6.3%

Year Ended December 31, 2008 as compared to the Year Ended December 31, 2007: Net revenues increased 7% or $339 million to $5.02 billion during 2008 as compared to $4.68 billion during 2007. The increase was attributable to:

- a $250 million or 6% 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");
- $114 million of other combined increases in revenues including revenues generated at Centennial Hills Hospital Medical Center ("Centennial Hills Hospital") which opened during the first quarter of 2008 and behavioral health care facilities opened or acquired during 2008 and 2007, and;
- $25 million of other combined net decreases in revenues resulting primarily from decreased revenue earned during 2008 in connection with construction management contracts pursuant to the terms of which we are building/have built newly constructed acute care hospitals for an unrelated third party.

Income before income taxes increased $41 million to $316 million during 2008 as compared to $275 million during 2007 due to the following:

- an increase of $54 million at our acute care facilities as discussed below in *Acute Care Hospital Services* exclusive of the $25 million unfavorable pre-tax provision for settlement recorded during

2008 in connection with the investigation of our South Texas Health System affiliates, as discussed in *Item 3. Legal Proceedings*, and exclusive of the $14 million favorable pre-tax effect recorded during 2007 from the reduction to our prior year reserves for professional and general liability claims, as discussed above in *Self-Insured Risks*;

- an increase of $26 million at our behavioral health care facilities as discussed below in *Behavioral Health Services* exclusive of the $2 million favorable pre-tax effect recorded during 2007 from the reduction to our prior year reserves for professional and general liability self-insured claims, as discussed above in *Self-Insured Risks*;
- a decrease of $25 million resulting from the provision for settlement recorded during 2008 to establish a reserve in connection with the government's investigation of our South Texas Health System affiliates, as discussed in *Item 3. Legal Proceedings*;
- an increase of $10 million resulting from the reduction to our professional and general liability expense recorded during 2008 in connection with the expected receipt of liquidation proceeds from the PHICO estate, as discussed above in *Self-Insured Risks*;
- a decrease of $16 million (after minority interest) resulting from favorable pre-tax effect recorded during 2007 from the reduction to our prior year reserves for professional and general liability self-insured claims, as discussed below, and;
- a decrease of $8 million from other combined net unfavorable changes.

Net income increased $29 million to $199 million during 2008 as compared to $170 million during 2007 due to the following:

- the $41 million increase in income before income taxes, as discussed above, and;
- an unfavorable change of $19 million in the provision for income taxes resulting primarily from the tax provision on the $41 million increase in income before income taxes. Contributing to the increase in the income tax provision was an increase in the effective state income tax rate during 2008, as compared to 2007, and;
- an increase of $7 million due primarily to the after-tax gain realized during 2008 on the sale of a 125-bed acute care hospital located in Pennsylvania.

Year Ended December 31, 2007 as compared to the Year Ended December 31, 2006: Net revenues increased 14% or $558 million to $4.68 billion in 2007 as compared to $4.12 billion during 2006. The increase was attributable to:

- a $314 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");
- $174 million of other combined increases in revenues resulting from the acute care facility and behavioral health care facilities acquired during 2007 and 2006, and;
- $70 million of other combined net increases in revenues resulting primarily from the revenues earned during 2007 in connection with a construction management contract pursuant to the terms of which we built a newly constructed acute care hospital for an unrelated third party.

Income before income taxes increased $23 million to $275 million during 2007 as compared to $252 million during 2006 due to the following:

- an increase of $10 million at our acute care facilities as discussed below in *Acute Care Hospital Services* exclusive of the $14 million favorable pre-tax effect resulting from the reduction recorded during 2007 to our prior year reserves for professional and general liability claims, as discussed above in *Self-Insured Risks*;

- an increase of $16 million at our behavioral health care facilities as discussed below in *Behavioral Health Services* exclusive of the $2 million favorable pre-tax effect resulting from the reduction recorded during 2007 to our prior year reserves for professional and general liability self-insured claims, as discussed above in *Self-Insured Risks*;
- an increase of $16 million (after minority interest) resulting from the reduction recorded during 2007 to our prior year reserves for professional and general liability self-insured claims, as discussed above in *Self-Insured Risks*, and;
- a decrease of $19 million due to an increase in interest expense.

Net income decreased $89 million to $170 million during 2007 as compared to $259 million during 2006 due to the following:

- the $23 million increase in income before income taxes, as discussed above;
- an after-tax decrease of $101 million resulting from the hurricane insurance recoveries, in excess of expenses, recording during 2006 ($168 million before minority interest and income taxes);
- a net unfavorable change of $11 million in the provision for income taxes resulting primarily from the tax provision on the $23 million increase in income before income taxes. Contributing to the increase in the income tax provision was an increase in the effective state income tax rate during 2007 as compared to 2006.

Effective July 1, 2006, the pharmacy services for our acute care facilities were brought in-house from an outsourced vendor. As a result of this change, during the period of January through June of 2007, we experienced an increase to supplies expense of approximately $56 million, an increase to salaries, wages and benefits expense of approximately $22 million and a decrease to other operating expense of approximately $82 million. The transition of our pharmacy services favorably impacted our pre-tax income by approximately $4 million during 2007. As a percentage of our consolidated net revenues for the year ended December 31, 2007, as shown above, the transition of the pharmacy services increased supplies expense by 120 basis points, increased salaries, wages and benefits expense by 40 basis points and decreased other operating expenses by 170 basis points.

Acute Care Hospital Services

Year Ended December 31, 2008 as compared to the Year Ended December 31, 2007:

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, 2008 and 2007 (dollar amounts in thousands):

Acute Care Hospitals—Same Facility Basis	Year Ended December 31, 2008		Year Ended December 31, 2007	
	Amount	% of Revenues	Amount	% of Revenues
Net revenues	$3,582,575	100.0%	$3,419,108	100.0%
Operating charges:				
Salaries, wages and benefits	1,370,424	38.3%	1,334,937	39.0%
Other operating expenses	664,469	18.5%	645,463	18.9%
Supplies expense	598,643	16.7%	589,613	17.2%
Provision for doubtful accounts	429,997	12.0%	381,718	11.2%
Depreciation and amortization	145,812	4.1%	146,924	4.3%
Lease and rental expense	47,524	1.3%	47,066	1.4%
	3,256,869	90.9%	3,145,721	92.0%
Income before interest expense, minority interests and income taxes	325,706	9.1%	273,387	8.0%
Interest expense, net	4,361	0.1%	3,757	0.1%
Minority interests in earnings of consolidated entities	41,332	1.2%	40,005	1.2%
Income before income taxes	$ 280,013	7.8%	$ 229,625	6.7%

On a same facility basis during 2008, as compared to 2007, net revenues at our acute care hospitals increased $163 million or 5%. Income before income taxes increased $50 million or 22% to $280 million or 7.8% of net revenues during 2008 as compared to $230 million or 6.7% of net revenues during 2007.

Inpatient admissions to these facilities increased 0.1% during 2008, as compared to 2007, while patient days increased 0.8%. The average length of patient stay at these facilities was 4.5 days in each of the years 2008 and 2007. The occupancy rate, based on the average available beds at these facilities, was 64% during 2008 and 63% during 2007. Our same facility inpatient volumes were negatively impacted during 2008, as compared to 2007, by the: (i) opening of the previously disclosed, newly constructed capacity at the physician-owned competitor hospital in McAllen, Texas, and; (ii) the opening of our newly constructed Centennial Hills Hospital. Since Centennial Hills Hospital is a newly opened facility, it is not included in our same facility basis results during 2008. However, we believe a portion of the patient volume at Centennial Hills Hospital during 2008 would have been treated at our previously existing hospitals in the Las Vegas, Nevada market which are included in our same facility basis results.

Our same facility net revenues were favorably impacted by an increase in prices charged to private payors including health maintenance organizations and preferred provider organizations. On a same facility basis, net revenue per adjusted admission (adjusted for outpatient activity) at these facilities increased 4.8% during 2008, as compared to 2007, and net revenue per adjusted patient day increased 4.1% during 2008, as compared to 2007.

We continue to experience an increase in uninsured patients throughout our portfolio of acute care hospitals which in part, has resulted from an increase in the number of patients who are employed but do not have health insurance. 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. Our acute care hospitals provided charity care and uninsured discounts, based on charges at established rates, amounting to (includes data for an acute care facility reflected as discontinued operations) $614 million during 2008 and $562 million during 2007. An increase in the level of uninsured patients to our facilities and the resulting adverse

trends in the provision for doubtful accounts and charity care provided, could have a material unfavorable impact on our future operating results.

The following table summarizes the results of operations for all our acute care operations during 2008 and 2007. Included in these results, in addition to the same facility results shown above, are: (i) the 2008 financial results for Centennial Hills Hospital located in Las Vegas, Nevada which was opened during the first quarter of 2008; (ii) the unfavorable impact resulting from the $25 million provision for settlement recorded during 2008 to establish a reserve in connection with the government's investigation of our South Texas Health System affiliates, as discussed in *Item 3. Legal Proceedings*, and; (ii) the favorable effect recorded during 2007 from the reduction to our prior year reserves for professional and general liability self-insured claims, as mentioned above in *Self-Insured Risks* (amounts in thousands):

All Acute Care Hospitals	Year Ended December 31, 2008		Year Ended December 31, 2007	
	Amount	% of Revenues	Amount	% of Revenues
Net revenues	$3,669,504	100.0%	$3,410,368	100.0%
Operating charges:				
Salaries, wages and benefits	1,413,963	38.5%	1,336,970	39.2%
Other operating expenses	707,758	19.3%	634,142	18.6%
Supplies expense	613,944	16.7%	589,911	17.3%
Provision for doubtful accounts	443,289	12.1%	381,718	11.2%
Depreciation and amortization	153,744	4.2%	146,924	4.3%
Lease and rental expense	49,383	1.3%	47,368	1.4%
	3,382,081	92.2%	3,137,033	92.0%
Income before interest expense, minority interests and income taxes	287,423	7.8%	273,335	8.0%
Interest expense, net	4,361	0.1%	3,757	0.1%
Minority interests in earnings of consolidated entities	38,827	1.0%	40,239	1.2%
Income before income taxes	$ 244,235	6.7%	$ 229,339	6.7%

During 2008, as compared to 2007, net revenues at our acute care hospitals increased 8% or $259 million to $3.67 billion. The increase in net revenues was attributable to:

- a $163 million increase at same facility revenues, as discussed above;
- $93 million of revenues generated at Centennial Hills Hospital, and;
- a net increase of $3 million resulting from other combined revenue changes.

Income before income taxes increased $15 million to $244 million or 6.7% of net revenues during 2008 as compared to $229 million or 6.7% of net revenues during 2007. The increase in income before income taxes at our acute care facilities resulted from:

- a $50 million increase at our acute care facilities on a same facility basis, as discussed above;
- a decrease of $25 million resulting from the provision for settlement recorded during 2008 to establish a reserve in connection with the government's investigation of our South Texas Health System affiliates, as discussed in *Item 3. Legal Proceedings*;
- a decrease of $14 million (after minority interest) resulting from the favorable pre-tax effect recorded during 2007 to our prior year reserves for professional and general liability self-insured claims attributable to our acute care facilities, as discussed above in *Self-Insured Risks,* and;
- $4 million of other combined net increases.

Year Ended December 31, 2007 as compared to the Year Ended December 31, 2006:

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, 2007 and 2006 (dollar amounts in thousands):

Acute Care Hospitals—Same Facility Basis	Year Ended December 31, 2007 Amount	Year Ended December 31, 2007 % of Revenues	Year Ended December 31, 2006 Amount	Year Ended December 31, 2006 % of Revenues
Net revenues	$3,261,872	100.0%	$3,023,917	100.0%
Operating charges:				
Salaries, wages and benefits	1,261,043	38.6%	1,160,446	38.4%
Other operating expenses	615,109	18.9%	653,968	21.6%
Supplies expense	566,474	17.4%	478,270	15.8%
Provision for doubtful accounts	364,254	11.2%	322,292	10.7%
Depreciation and amortization	142,238	4.4%	131,616	4.4%
Lease and rental expense	44,498	1.4%	42,742	1.4%
	2,993,616	91.8%	2,789,334	92.2%
Income before interest expense, hurricane insurance recoveries in excess of expenses, minority interests and income taxes	268,256	8.2%	234,583	7.8%
Interest expense, net	3,458	0.1%	1,619	0.1%
Minority interests in earnings of consolidated entities	40,005	1.2%	34,316	1.1%
Income before income taxes	$ 224,793	6.9%	$ 198,648	6.6%

On a same facility basis during 2007, as compared to 2006, net revenues at our acute care hospitals increased $238 million or 8%. Income before income taxes increased $26 million or 13% to $225 million or 6.9% of net revenues during 2007 as compared to $199 million or 6.6% of net revenues during 2006.

Inpatient admissions to these facilities increased 2.6% during 2007, as compared to 2006, while patient days increased 2.4%. The average length of patient stay at these facilities was 4.4 days in each of the years 2007 and 2006. The occupancy rate, based on the average available beds at these facilities, was 63% during each of 2007 and 2006.

Our same facility net revenues were favorably impacted by an increase in prices charged to private payors including health maintenance organizations and preferred provider organizations. On a same facility basis, net revenue per adjusted admission (adjusted for outpatient activity) at these facilities increased 3.1% during 2007, as compared to 2006, and net revenue per adjusted patient day increased 3.3% during 2007, as compared to 2006.

The pharmacy services for our acute care facilities were brought in-house from an outsourced vendor effective July 1, 2006. As a result of this change, during the period of January through June of 2007, our acute care facilities experienced an increase to supplies expense of approximately $56 million, an increase to salaries, wages and benefits expense of approximately $22 million and a decrease to other operating expenses of approximately $82 million. The transition of our pharmacy services favorably impacted the pre-tax income of our acute care facilities by approximately $4 million during 2007. As a percentage of our 2007 same facility acute care net revenues, as shown above, the transition of the pharmacy services increased supplies expense by 170 basis points, increased salaries, wages and benefits expense by 70 basis points and decreased other operating expenses by 250 basis points. Since this transition occurred on July 1st of 2006, the same facility acute care financial statements for the six month periods of July 1st through December 31st of 2007 and 2006 were comparably stated.

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. Our acute care hospitals provided charity care and uninsured discounts, based on charges at established rates, amounting to (includes data for an acute care facility reflected as discontinued operations) $562 million during 2007 and $443 million during 2006.

The following table summarizes the results of operations for all our acute care operations during 2007 and 2006. Included in these results, in addition to the same facility results shown above, are: (i) the financial results for the Texoma Healthcare System that was acquired on January 1, 2007; (ii) the prior period effect of a favorable adjustment recorded during 2007 to reduce our reserves for professional and general liability self-insured claims (as discussed above); (iii) the net hurricane related expenses and insurance recoveries; (iv) the prior year portion of recording or reserving of Medicaid supplemental payments and cost reports settlements, and; (v) the write-down of the carrying-value of an investment in a joint-venture (dollar amounts in thousands).

	Year Ended December 31, 2007		Year Ended December 31, 2006	
All Acute Care Hospitals	**Amount**	**% of Revenues**	**Amount**	**% of Revenues**
Net revenues	$3,410,368	100.0%	$3,039,775	100.0%
Operating charges:				
Salaries, wages and benefits	1,336,970	39.2%	1,160,446	38.2%
Other operating expenses	634,142	18.6%	663,996	21.8%
Supplies expense	589,912	17.3%	478,270	15.7%
Provision for doubtful accounts	381,718	11.2%	322,292	10.6%
Depreciation and amortization	146,924	4.3%	131,616	4.3%
Lease and rental expense	47,368	1.4%	42,781	1.4%
	3,137,034	92.0%	2,799,401	92.1%
Income before interest expense, hurricane insurance recoveries in excess of expenses, minority interests and income taxes	273,334	8.0%	240,374	7.9%
Interest expense, net	3,757	0.1%	1,619	0.1%
Hurricane recoveries in excess of expenses	—	—	(770)	0.0%
Minority interests in earnings of consolidated entities	40,239	1.2%	34,316	1.1%
Income before income taxes	$ 229,338	6.7%	$ 205,209	6.8%

During 2007, as compared to 2006, net revenues at our acute care hospitals increased 12% or $371 million to $3.41 billion. The increase in net revenues was attributable to:

- a $238 million increase at same facility revenues, as discussed above;
- $157 million of revenues generated during 2007 by the Texoma Healthcare System, and;
- a $24 million net decrease in revenues resulting from the recording of various retroactive portions of supplemental Medicaid reimbursements (occurred during 2006) or related reserves (occurred during 2007) and settlement of prior year Medicare cost reports (occurred during 2006).

Income before income taxes increased $24 million to $229 million or 6.7% of net revenues during 2007 as compared to $205 million or 6.8% of net revenues during 2006. The increase in income before income taxes at our acute care facilities resulted from:

- a $26 million increase at our acute care facilities on a same facility basis, as discussed above;
- an increase of $14 million (after minority interest) representing the portion of the reduction recorded during 2007 to our prior year reserves for professional and general liability self-insured claims attributable to our acute care facilities, as discussed above in *Self-Insured Risks*;

- a $24 million net decrease resulting from the unfavorable changes resulting from the recording of various retroactive portions of supplemental Medicaid reimbursements (occurred during 2006) or related reserves (occurred during 2007) and settlement of prior year Medicare cost reports (occurred during 2006);
- a $3 million decrease due to the write-down of the carrying-value of an investment in a joint-venture during 2007,
- a $10 million increase due to 2006 including a $10 million provision recorded in connection with a wage and hour lawsuit in California, and;
- $1 million of other combined favorable changes including the pre-tax income generated during 2007 by the Texoma Healthcare System and the pre-opening losses sustained at our newly constructed Centennial Hills Hospital Medical Center that was completed and opened during the first quarter of 2008.

Behavioral Health Care Services

Year Ended December 31, 2008 as compared to the Year Ended December 31, 2007:

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, 2008 and 2007 (dollar amounts in thousands):

Behavioral Health Care Facilities—Same Facility Basis	Year Ended December 31, 2008 Amount	Year Ended December 31, 2008 % of Revenues	Year Ended December 31, 2007 Amount	Year Ended December 31, 2007 % of Revenues
Net revenues	$1,225,948	100.0%	$1,139,634	100.0%
Operating charges:				
Salaries, wages and benefits	603,227	49.2%	565,901	49.7%
Other operating expenses	227,113	18.5%	213,224	18.7%
Supplies expense	70,926	5.8%	66,973	5.9%
Provision for doubtful accounts	32,014	2.6%	27,955	2.5%
Depreciation and amortization	28,610	2.3%	27,650	2.4%
Lease and rental expense	16,218	1.3%	16,204	1.4%
	978,108	79.8%	917,907	80.6%
Income before interest expense, minority interests and income taxes	247,840	20.2%	221,727	19.4%
Interest expense, net	277	0.0%	335	0.0%
Minority interests in earnings of consolidated entities	—	—	361	0.0%
Income before income taxes	$ 247,563	20.2%	$ 221,031	19.4%

On a same facility basis during 2008, as compared to 2007, net revenues at our behavioral health care facilities increased 8% or $86 million to $1.23 billion during 2008 as compared to $1.14 billion during 2007. Income before income taxes increased $27 million or 12% to $248 million or 20.2% of net revenues during 2008 as compared to $221 million or 19.4% of net revenues during 2007.

Inpatient admissions at these facilities increased 6.4% during 2008, as compared to 2007 while patient days increased 3.2%. The average length of patient stay at these facilities was 16.0 days during 2008 and 16.5 days during 2007. The occupancy rate, based on the average available beds at these facilities, was 75% during each of 2008 and 2007.

On a same facility basis, net revenue per adjusted admission at these facilities increased 1.4% during 2008, as compared to 2007, and net revenue per adjusted patient day increased 4.5% during 2008, as compared to 2007.

The following table summarizes the results of operations for all our behavioral health care facilities for 2008 and 2007, including newly acquired or recently opened facilities (amounts in thousands):

All Behavioral Health Care Facilities	Year Ended December 31, 2008 Amount	Year Ended December 31, 2008 % of Revenues	Year Ended December 31, 2007 Amount	Year Ended December 31, 2007 % of Revenues
Net revenues	$1,251,116	100.0%	$1,146,078	100.0%
Operating charges:				
Salaries, wages and benefits	619,484	49.5%	572,279	49.9%
Other operating expenses	234,908	18.8%	215,365	18.8%
Supplies expense	72,768	5.8%	67,514	5.9%
Provision for doubtful accounts	32,688	2.6%	27,907	2.4%
Depreciation and amortization	29,796	2.4%	27,807	2.4%
Lease and rental expense	16,654	1.3%	16,531	1.4%
	1,006,298	80.4%	927,403	80.9%
Income before interest expense, minority interests and income taxes	244,818	19.6%	218,675	19.1%
Interest expense, net	293	0.1%	411	0.0%
Minority interests in losses of consolidated entities	—	—	(1,627)	(0.1%)
Income before income taxes	$ 244,525	19.5%	$ 219,891	19.2%

During 2008, as compared to 2007, net revenues at our behavioral health care facilities (including newly acquired and recently opened facilities), increased 9% or $105 million to $1.25 billion during 2008 as compared to $1.15 billion during 2007. The increase in net revenues was attributable to:

- a $86 million increase in same facility revenues, as discussed above, and;
- $19 million of revenues generated at facilities recently acquired or opened.

Income before income taxes increased $25 million or 11% to $245 million or 19.5% of net revenues during 2008, as compared to $220 million or 19.2% of net revenues during 2007. The increase in income before income taxes at our behavioral health facilities was attributable to:

- a $27 million increase at our behavioral health facilities on a same facility basis, as discussed above;
- a decrease of $2 million resulting from the favorable pre-tax effect recorded during 2007 from the reduction to our prior year reserves for professional and general liability self-insured claims attributable to our behavioral health care facilities, as discussed above in *Self-Insured Risks,* and;
- a $4 million decrease resulting primarily from the aggregate net loss, net of aggregate income, incurred at facilities acquired or opened during 2008 and 2007.

Year Ended December 31, 2007 as compared to the Year Ended December 31, 2006:

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, 2007 and 2006 (dollar amounts in thousands):

	Year Ended December 31, 2007		Year Ended December 31, 2006	
Behavioral Health Care Facilities—Same Facility Basis	**Amount**	**% of Revenues**	**Amount**	**% of Revenues**
Net revenues	$1,105,011	100.0%	$1,028,776	100.0%
Operating charges:				
Salaries, wages and benefits	546,567	49.5%	513,325	49.9%
Other operating expenses	206,013	18.6%	192,559	18.7%
Supplies expense	64,025	5.8%	60,819	5.9%
Provision for doubtful accounts	27,372	2.5%	20,507	2.0%
Depreciation and amortization	25,189	2.3%	22,126	2.2%
Lease and rental expense	16,166	1.5%	16,218	1.6%
	885,332	80.1%	825,554	80.2%
Income before interest expense, minority interests and income taxes	219,679	19.9%	203,222	19.8%
Interest expense, net	232	0.0%	274	0.0%
Minority interests in earnings (losses) of consolidated entities	(1,627)	(0.1%)	(949)	(0.0%)
Income before income taxes	$ 221,074	20.0%	$ 203,897	19.8%

On a same facility basis during 2007, as compared to 2006, net revenues at our behavioral health care facilities increased 7% or $76 million to $1.11 billion during 2007 as compared to $1.03 billion during 2006. Income before income taxes increased $17 million or 8% to $221 million or 20.0% of net revenues during 2007 as compared to $204 million or 19.8% of net revenues during 2006.

Inpatient admissions and patient days at these facilities each increased 4.3% during 2007, as compared to 2006. The average length of patient stay at these facilities was 16.7 days during each of 2007 and 2006. The occupancy rate, based on the average available beds at these facilities, was 77% and 78% during 2007 and 2006.

On a same facility basis, net revenue per adjusted admission at these facilities increased 3.2% during 2007, as compared to 2006, and net revenue per adjusted patient day increased 3.1% during 2007, as compared to 2006. The increase in net revenues at our behavioral health care facilities during 2007, as compared to 2006, partially resulted from a scheduled increase in the Medicare prospective payment system rates.

The following table summarizes the results of operations for all our behavioral health care facilities for 2007 and 2006, including newly acquired facilities (amounts in thousands):

All Behavioral Health Care Facilities	Year Ended December 31, 2007 Amount	% of Revenues	Year Ended December 31, 2006 Amount	% of Revenues
Net revenues	$1,146,078	100.0%	$1,028,967	100.0%
Operating charges:				
Salaries, wages and benefits	572,279	49.9%	513,979	49.9%
Other operating expenses	215,365	18.8%	193,397	18.8%
Supplies expense	67,514	5.9%	61,027	5.9%
Provision for doubtful accounts	27,907	2.4%	20,507	2.0%
Depreciation and amortization	27,807	2.4%	22,154	2.2%
Lease and rental expense	16,531	1.4%	16,240	1.6%
	927,403	80.9%	827,304	80.4%
Income before interest expense, minority interests and income taxes	218,675	19.1%	201,663	19.6%
Interest expense, net	411	0.0%	274	0.0%
Minority interests in earnings (losses) of consolidated entities	(1,627)	(0.1%)	(949)	(0.1%)
Income before income taxes	$ 219,891	19.2%	$ 202,338	19.7%

During 2007, as compared to 2006, net revenues at our behavioral health care facilities (including newly acquired facilities), increased 11% or $117 million to $1.15 billion during 2007 as compared to $1.03 billion during 2006. The increase in net revenues was attributable to:

- a $76 million increase in same facility revenues, as discussed above, and;
- $41 million of revenues generated at facilities acquired and/or opened during 2007 and 2006.

Income before income taxes increased $18 million or 9% to $220 million or 19.2% of net revenues during 2007, as compared to $202 million or 19.7% of net revenues during 2006. The increase in income before income taxes at our behavioral health facilities was attributable to:

- a $17 million increase at our behavioral health facilities owned for more than a year, as discussed above;
- a $2 million increase representing the portion of the reduction recorded during 2007 to our prior year reserves for professional and general liability self-insured claims attributable to our behavioral health care facilities, as discussed above in *Self-Insured Risks,* and;
- a $1 million decrease resulting from the aggregate net loss (net of aggregate income) generated at facilities acquired and/or opened during 2007 and 2006.

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 and we continue to experience an increase in uninsured and self-pay patients which unfavorably impacts the collectibility of our patient accounts thereby increasing our provision for doubtful accounts and charity care provided.

The significant portion of our revenues derived from these facilities makes us particularly sensitive to regulatory, economic, environmental and competition changes in Texas and Nevada. 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.

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.

	Percentage of Net Patient Revenues		
Acute Care and Behavioral Health Care Facilities Combined	**2008**	**2007**	**2006**
Third Party Payors:			
Medicare	24%	24%	25%
Medicaid	12%	13%	13%
Managed Care (HMO and PPOs)	46%	44%	41%
Other Sources	18%	19%	21%
Total	100%	100%	100%

	Percentage of Net Patient Revenues		
Acute Care Facilities	**2008**	**2007**	**2006**
Third Party Payors:			
Medicare	27%	27%	29%
Medicaid	9%	9%	10%
Managed Care (HMO and PPOs)	47%	46%	41%
Other Sources	17%	18%	20%
Total	100%	100%	100%

	Percentage of Net Patient Revenues		
Behavioral Health Care Facilities	**2008**	**2007**	**2006**
Third Party Payors:			
Medicare	16%	15%	15%
Medicaid	22%	26%	25%
Managed Care (HMO and PPOs)	42%	41%	43%
Other Sources	20%	18%	17%
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 diagnosis related group ("DRG"). Every 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 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 DRG assignment also affects the predetermined capital rate paid with each DRG. The 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 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.

DRG rates are adjusted by an update factor each federal fiscal year, which begins on October 1. The index used to adjust the 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 DRG payments have been lower than the projected increase in the cost of goods and services purchased by hospitals. For federal fiscal years 2008, 2007 and 2006, the update factors were 3.3%, 3.4% and 3.7%, respectively. For 2009, the update factor is 3.6%. Hospitals are allowed to receive the full basket update if they provide the Centers for Medicare and Medicaid Services ("CMS") with specific data relating to the quality of services provided. We have complied fully with this requirement and intend to comply fully in future periods.

In August 2006, CMS finalized new provisions for the hospital IPPS for the upcoming federal fiscal year, which included a significant change in the manner in which it determines the underlying relative weights used to calculate the DRG payment amount. For federal fiscal year 2007, CMS began to phase-in the use of hospital costs rather than hospital charges for the DRG relative weight determination. This change is to phase-in ratably over three years with full phase-in to be completed in federal fiscal year 2009.

On August 1, 2007, CMS issued a final rule revising Medicare payment and policy under the hospital IPPS for federal fiscal year 2008. These changes, which were first proposed in April 2007, will restructure the inpatient DRGs to account more fully for the severity of patient illness. Specifically, the final rule creates 745 new severity-adjusted DRGs to replace the current 538 DRGs. As a result, payments are expected to increase for hospitals serving more severely ill patients and decrease for those serving patients who are less severely ill. The new severity-adjusted DRGs were phased in over two years starting October 1, 2007 and will be fully phased during the federal fiscal year ending September 30, 2009. The new severity adjusted DRGs have resulted in an approximate 2 percent increase in to our inpatient Medicare DRG reimbursement as compared to the prior DRG system.

The August, 2007 final rule also includes important provisions to ensure that Medicare no longer pays for the additional costs of certain preventable conditions (including certain infections) acquired in the hospital. The reporting of hospital acquired conditions, also referred to as Present on Admission (POA) codes, became effective on October 1, 2007. Further, CMS implemented Medicare DRG payment reductions for certain

preventable conditions beginning on October 1, 2008. We do not expect this payment change for preventable conditions to have a material impact on our results of operations. In addition, the rule expanded the list of publicly reported quality measures that hospitals would need to report in calendar year 2008 in order to qualify for the full market basket update in federal fiscal year 2009 and reduces Medicare's payment when a hospital replaces a device that is supplied to the hospital at no or reduced cost.

In September, 2007, the "TMA, Abstinence Education, and QI Programs Extension Act of 2007" legislation took effect and will scale back cuts in hospital reimbursement that CMS was set to impose under the final rule for the Inpatient Prospective Payment System ("IPPS") for federal fiscal year 2008. CMS planned on reducing the standardized amount by 1.2% in 2008 and 1.8% in 2009 to account for expected changes in coding practices by hospitals in response to the CMS implementation of the new Medicare-Severity Diagnosis Related Group system for inpatient hospitals. The new law cuts these reductions by 0.6% in 2008 and 0.9% in 2009. In federal fiscal years 2010 to 2012, the new law also requires CMS to make an adjustment to the Medicare standardized amount in these years to reflect the removal of actual aggregate payment increases or decreases for documentation and coding adjustments that occurred during federal fiscal years 2008 and 2009 as compared to the initial CMS estimates of the MS-DRG coding and documentation change impact of 0.6% and 0.9%, respectively. We are unable to predict the impact of this CMS adjustment on the revenues and operating results of our acute care hospitals.

In July, 2008, CMS published the final IPPS 2009 payment rule which provides for a 3.6% market basket increase to the base Medicare DRG blended rate. When statutorily mandated budget neutrality factors and annual geographic wage index updates are considered, we estimate our overall increase from the final rule in federal fiscal year 2009 will approximate 3.7% to 4.2%.

Outpatient services were traditionally paid at the lower of customary charges or on a reasonable cost basis. The Balanced Budget Act of 1997 established the outpatient prospective payment system for outpatient hospital services provided on or after August 1, 2000 ("OPPS"). Under the OPPS, CMS pays for hospital outpatient services on a rate-per-service basis that varies according to the ambulatory payment classification ("APC") group to which the service is assigned. The OPPS rate is an unadjusted national payment amount that includes the Medicare payment and the beneficiary co-payment. Special payments under the OPPS may be made for certain new technology items and services through transitional pass-through payments and special reimbursement rates.

On November 1, 2007, CMS released a final rule with comment period updating the hospital OPPS. The rule is effective for those services furnished in calendar year 2008, by general acute care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities and long-term acute care hospitals. CMS estimates that hospitals will receive an overall average increase of 3.8 percent in Medicare payments for outpatient services in 2008, after accounting for the annual market basket update and other factors that typically affect the level of payments. Changes in the final rule including providing larger payment bundles for certain OPPS services which will, in CMS's estimation, provide hospitals with more flexibility in managing their resources. The rule also updates the payment rates for the revised ambulatory surgical center payment system, beginning in 2008.

We operate inpatient rehabilitation hospital units that treat Medicare patients with specific medical conditions which are excluded from the Medicare IPPS DRG payment methodology. Inpatient rehabilitation facilities ("IRFs") must meet a certain volume threshold each year for the number patients with these specific medical conditions, often referred to as the "75 Percent Rule." The Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA") included a favorable permanent decrease of the IRF "75 Percent Rule" qualifying threshold to 60% from the current threshold of 65%. Medicare payment for IRF patients is based on a prospective case rate based on a CMS determined Case-Mix Group classification and is updated annually by CMS. The MMSEA includes provisions that provide IRF's with a zero percent increase in Medicare rates for federal fiscal year 2009.

Psychiatric hospitals have also traditionally been excluded from the IPPS. However, on January 1, 2005, CMS implemented a new PPS ("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. The new system was phased-in over a three-year period and was fully implemented for our behavioral health facilities by June 30, 2008. Also, CMS has included a stop-loss provision to ensure that hospitals avoid significant losses during the transition. In May 2006, CMS published its annual increase to the federal component of the Psych PPS per diem rate. This increase includes the effects of market basket updates resulting in a 4.5% increase in total payments for Rate Year 2007, covering the period of July 1, 2006 to June 30, 2007. The market basket was increased by 3.2% for the period of July 1, 2007 through June 30, 2008. In addition, according to the May, 2008 CMS notice, the market basked increase is 3.2% for the period of July 1, 2008 through June 30, 2009.

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 a large concentration of our Medicaid revenues from Texas and significant amounts from Nevada, Florida, California, Washington, DC and Illinois. These states, as well as most other states in which we operate, have reported significant budget deficits that, for all except Texas at this time, have resulted in the reduction of Medicaid funding for 2009. We can provide no assurance that reductions to Medicaid revenues, particularly in the above-mentioned states, will not have a material adverse effect on our future results of operations. Furthermore, many states are currently working to effectuate further significant reductions in the level of Medicaid funding due to significant state budget deficits also projected for 2010, which could adversely affect future levels of Medicaid reimbursement received by our hospitals. Conversely, on February 17, 2009, the American Recovery and Reinvestment Act of 2009 was signed into law and contained various Medicaid provisions that will impact our hospitals including the following: (i) temporary increases to Medicaid funding through enhanced federal matching assistance percentages ("FMAPs") for a 27 month period retroactive to October 1, 2008 through December 31, 2010 with all states receiving a FMAP increase of 6.2% and also receiving a bonus FMAP increase contingent on the increased level of a state's unemployment rate; (ii) a temporary increase of 2.5% in the federal Medicaid disproportionate share hospital allotment for both federal fiscal years 2009 and 2010, and; (iii) states will be required to maintain effort on Medicaid eligibility consistent with requirements prior to passage of this law. Due to the indirect nature of the enhanced Medicaid federal funding contained within the American Recovery and Reinvestment Act of 2009, we are unable to determine the impact of these Medicaid changes on our future results of operations.

In February, 2005, a Texas Medicaid State Plan Amendment went into effect for Potter County that expands the supplemental inpatient reimbursement methodology for the state's Medicaid program. This state plan amendment was approved retroactively to March, 2004. In connection with this program, we earned revenues of $21 million during 2008, $21 million during 2007 and $22 million during 2006. At this time, the local hospital district in Potter County continues to fund the program's inter-governmental transfers ("IGTs"). The failure of the hospital district to make future IGTs at a level consistent with 2008 levels will reduce revenues in connection with this program to approximately $8 million during 2009. If during 2009 the hospital district makes IGTs consistent with 2008, we believe we would be entitled to revenues of approximately $18 million during 2009.

In July, 2006, CMS retroactively approved to June 11, 2005, an amendment to the Texas Medicaid State Plan which permits the state of Texas to make supplemental payments to certain hospitals located in Hidalgo, Maverick and Webb counties. Our four acute care hospital facilities located in these counties are eligible to receive these

supplemental Medicaid payments. This program was subject to final state rule making procedures and the local governmental agencies providing the necessary funds on an ongoing basis through inter-governmental transfers to the state of Texas. In connection with this program, we earned revenues of $9 million during 2008, $11 million during 2007 (before $9 million reduction recorded during 2007 to establish a reserve for the 2006 and 2005 supplemental payments, as discussed below) and $13 million during 2006. At this time, we believe we will be entitled to revenues of approximately $9 million during 2009 in connection with this program.

As part of the CMS routine retroactive review of a new Texas Medicaid state plan amendment ("SPA") that pertains to the Medicaid supplemental payment programs for Hidalgo and Webb counties, CMS previously indicated that certain IGTs related to this retroactive SPA approval may have been ineligible for federal matching dollars which were used to fund the programs. In the anticipation of a possible CMS retroactive IGT ineligibility determination, we recorded a charge of $9 million during 2007 to establish a reserve for potential CMS action related to these Medicaid supplemental payments applicable to state fiscal years 2005 and 2006. In April, 2008, we received notification that the $9 million of retroactive Medicaid supplemental payment were deemed ineligible for federal matching dollars. These funds will be recouped by the Texas Health and Human Services Commission ("THHSC") as an offset to future IGTs during state fiscal year 2009.

In October, 2007, we were notified by the THHSC that CMS deferred approximately 25% of the federal financial participation ("FFP") on Medicaid supplemental payments made to private hospitals during the second calendar quarter of 2007 pursuant to two SPAs approved by CMS in July and September of 2006. This deferral applies to our acute care hospitals that operate in Hildalgo, Maverick and Webb counties. In April, 2008, we received notification from THHSC that a settlement agreement has been reached with CMS and that both CMS and THHSC intend to remove the supplemental payment deferral status. THHSC has resumed its distribution of supplemental payments in August, 2008 at levels consistent with pre-deferral amounts. We estimate that our hospitals in these counties will be entitled to supplemental payment reimbursements of approximately $7 million annually.

In September 2005, legislation in Texas went into effect that ensures that some form of Medicaid managed care will exist in every Texas county. In addition, the Texas STAR+PLUS program, which provides an integrated acute and long-term care Medicaid managed care delivery system to elderly and disabled Medicaid beneficiaries in the Harris County service area will be expanded to seven additional service areas. Such actions could have a material unfavorable impact on the reimbursement our Texas hospitals receive.

We operate two freestanding psychiatric hospitals in the Dallas, Texas region that operated under the Lone Star Select II prospective per diem payment program. We were notified by the Commission that this per diem payment program terminated on August 31, 2006. These affected facilities were paid on a TEFRA cost based payment system for September and October of 2006. Effective November 1, 2006, the Commission's payment for these hospitals is based on a prospective per diem rate based on a prior year cost report.

As directed by Texas Senate Bill 10, the HHSC is currently drafting a Medicaid Reform Waiver ("Waiver") proposal that would create a newly established Healthcare Opportunity Pool that requires CMS's approval prior to implementation. The overall Waiver program design will be budget neutral on a statewide basis but individual hospitals, including those owned and operated by us, could be either favorably or adversely impacted. Although, at this time, we are unable to estimate the impact of the Waiver program on our future operating results, we can give no assurance that this Waiver program will not have a material adverse effect on our future results of operations. HHSC has yet to receive CMS's approval for this waiver and it's uncertain as to when, or if, this Waiver program will be implemented by HHSC.

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.

Tricare: In April, 2008, the Department of Defense ("DoD") issued a proposed rule that would change the payment methodology for outpatient services that, if enacted, could significantly decrease payment for these services. In December, 2008, the DoD issued a final rule that basically adopted the current Medicare payment Outpatient Prospective Payment System for services provided to Tricare outpatients with a limited phase-in for certain emergency and clinic services. Based upon our estimates, payments to us for these services could be reduced by as much as $4 million in 2009 and by $6 million annually in 2010 and thereafter. The effective date of this final rule is projected to be May, 2009.

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.

As mentioned above, the American Recovery and Reinvestment Act of 2009 was signed into law in February, 2009. This law contains a federal health care provision that provides a 65% subsidy for COBRA continuation premiums for up to nine months for workers who have been involuntarily terminated, including their families. We are unable to determine the impact of this provision on our future results of operations.

Other Sources: Our hospitals provide services to individuals that do not have any form of health care coverage. Such patients are evaluated, at the time of service or shortly thereafter, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other state assistance programs, as well as our local hospital's 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. In addition, effective January 1, 2006, we implemented a formal uninsured discount policy for our acute care hospitals which had the effect of lowering both our provision for doubtful accounts and net revenues during 2006 and 2007 but did not materially impact net income in either year.

State Medicaid Disproportionate Share Hospital Payments: Hospitals that have an unusually large number of low-income patients (i.e., those with a Medicaid utilization rate of at least one standard deviation above the mean Medicaid utilization, or having a low income patient utilization rate exceeding 25%) are eligible to receive a disproportionate share hospital ("DSH") adjustment. Congress established a national limit on DSH adjustments. Although this legislation and the resulting state broad-based provider taxes have affected the payments we receive under the Medicaid program, to date the net impact has not been materially adverse.

Upon meeting certain conditions and serving a disproportionately high share of Texas' and South Carolina's low income patients, five of our facilities located in Texas and one facility located in South Carolina received additional reimbursement from each state's DSH fund. The Texas and South Carolina programs have been renewed for each state's 2009 fiscal years (covering the period of September 1, 2008 through August 31, 2009 for Texas and October 1, 2008 through September 30, 2009 for South Carolina). Included in our financial results was an aggregate of $42 million during 2008, $41 million during 2007 and $43 million during 2006. Failure to renew these DSH programs beyond their scheduled termination dates, failure of our hospitals that currently receive DSH payments to qualify for future DSH funds under these programs, or reductions in reimbursements, could have a material adverse effect on our future results of operations.

In February 2003, the Office of the Inspector General of the Department of Health and Human Services published a report indicating that Texas Medicaid may have overpaid Texas hospitals for DSH payments. To date, no actions to follow up on this report have had any material impact on our Texas hospitals.

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 ongoing military engagement in Iraq, the War on Terrorism, economic recovery stimulus packages, responses to natural disasters, such as Hurricane Katrina, the continuing 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 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 from our surgical hospitals, ambulatory surgery centers and radiation oncology centers were $29 million during 2008 and $34 million in each of 2007 and 2006. In connection with construction management contracts pursuant to the terms of which we are building/have built newly constructed acute care hospitals for an unrelated third party, we earned revenues of $64 million during 2008, $83 million during 2007 and $13 million during 2006. Combined income before income taxes earned in connection with the revenues mentioned above was $11 million during 2008, $9 million during 2007 and $5 million during 2006.

Interest expense was $53 million during 2008, $52 million during 2007 and $33 million during 2006. In June, 2008, we issued an additional $150 million of senior notes (the "Notes") which formed a single series with the original Notes issued in June, 2006 (see *Note 4—Long Term Debt*). Other than their date of issuance and initial price to the public, the terms of the Notes issued in June, 2008 are identical to, and trade interchangeably with, the Notes which were originally issued in June, 2006. The proceeds from this issuance were used to repay outstanding borrowings pursuant to our revolving credit agreement and accounts receivable securitization program. During 2008, as compared to the 2007, the combined average outstanding borrowings on the above-mentioned debt instruments increased $84 million. The increase in the combined average outstanding borrowings were offset by a decrease in the combined average annual interest rate of 0.9% during 2008 as compared to 2007. The $19 million increase in interest expense during 2007, as compared to 2006, was due primarily to a $345 million increase in our average outstanding borrowings under our revolving credit and demand notes and accounts receivable securitization program. For additional disclosure, see Note 4 to the Consolidated Financial Statements—*Long Term Debt.*

Below is a schedule of our interest expense during 2008, 2007 and 2006 (amounts in thousands):

	2008	2007	2006
Revolving credit & demand notes	$12,597	$23,396	$ 5,825
$200 million, 6.75% Senior Notes due 2011	13,510	13,510	13,500
7.125% Senior Notes due 2016 (a.)	24,012	17,899	8,956
Accounts receivable securitization program	4,653	2,879	—
Convertible debentures, 5.00%	—	—	7,791
Other combined, including interest rate swap expense, net	7,198	4,232	1,667
Capitalized interest on major construction projects	(7,899)	(9,230)	(3,403)
Interest income	(864)	(1,060)	(1,778)
Interest expense, net	$53,207	$51,626	$32,558

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

The effective tax rate was 39.0% during 2008, 38.0% during 2007 and 36.9% during 2006. The increase in our effective tax rate during 2008 as compared to 2007 and 2007 as compared to 2006 resulted primarily from increases in the effective state income tax rate.

Discontinued Operations

During 2008, we sold a 125-bed acute care hospital located in Pennsylvania and commenced divestiture considerations for the real property of our four acute care facilities located in Louisiana that were severely damaged and closed during 2005 as a result of damage sustained from Hurricane Katrina. The operating results and gain on divestiture for the facility located in Pennsylvania, as well as the hurricane insurance recoveries in excess of expenses recorded during 2006 in connection with our facilities located in Louisiana, are reflected as "Income/(loss) from discontinued operations, net of income taxes" in the Consolidated Statements of Income for each period presented.

The following table shows the results of operations of these facilities, on a combined basis, for all facilities reflected as discontinued operations (amounts in thousands):

	Year Ended December 31,		
	2008	2007	2006
Net revenues	$58,467	$67,887	$ 66,823
(Loss)/income before hurricane recoveries in excess of expenses, minority interests, gain on divestitures and income taxes	$ (2,996)	$ (398)	$ 1,371
Hurricane insurance recoveries in excess of expenses	—	—	167,229
Minority interests in earnings of consolidated entities	—	(13)	(8,762)
Gain on divestiture	13,413	—	—
Income/(loss) from discontinued operations, before income taxes	10,417	(411)	159,838
Income tax (expense)/benefit	(3,981)	156	(59,580)
Income/(loss) from discontinued operations, net of income taxes	$ 6,436	$ (255)	$100,258

Professional and General Liability Claims and Property Insurance

Effective January 1, 2008, most of our subsidiaries became self-insured for malpractice exposure up to $10 million per occurrence, as compared to $20 million per occurrence in the prior year. We purchased several excess policies through commercial insurance carriers which provide for coverage in excess of $10 million up to $195 million per occurrence and in the aggregate. However, we are liable for 10% of the claims paid pursuant to the commercially insured coverage in excess of $10 million up to $60 million per occurrence and in the aggregate.

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. 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 claims asserted against us will not have a material adverse effect on our future results of operations.

As of December 31, 2008, the total accrual for our professional and general liability claims was $272 million ($271 million net of expected recoveries from state guaranty funds) of which $42 million is included in other current liabilities. As of December 31, 2007, the total accrual for our professional and general liability claims was $258 million ($256 million net of expected recoveries from state guaranty funds), of which $32 million is included in other current liabilities. As a result of a commercial insurer's liquidation in 2002, we became liable for unpaid claims related to our facilities, some of which remain outstanding as of December 31, 2008. The reserve for the estimated future claims payments for these outstanding liabilities is included in the accrual for our professional and general liability claims as of December 31, 2008.

For the years of 1998 through 2001, most of our subsidiaries were covered under commercial insurance policies with PHICO, a Pennsylvania based insurance company that was placed into liquidation in February, 2002. As a result, although PHICO continued to be liable for claims on our behalf that were related to 1998 through 2001, we began paying the claims upon PHICO's liquidation. Since that time, although we preserved our right to receive reimbursement from the PHICO estate, we were not previously able to assess the probability of collection or reasonably quantify our share of the liquidation proceeds. In January, 2009, a court order from the Commonwealth Court of Pennsylvania was executed in connection with the partial liquidation of the PHICO estate. As a result, during the fourth quarter of 2008, based upon our share of the undisputed and resolved claims made against the PHICO estate as of a specified date and as approved by the liquidator to the court, we recorded a $10 million reduction to our professional and general liability self-insured claims expense. Since we received these liquidation proceeds during the first quarter of 2009, the $10 million reimbursement from the PHICO estate is included in accounts receivable, net, as of December 31, 2008. We are also entitled to receive reimbursement from state guaranty funds for certain claims paid by us. Included in other assets was $1 million as of December 31, 2008 and $2 million as of December 31, 2007 related to estimated expected recoveries from various state guaranty funds in connection with payment of these claims.

Effective April 1, 2008, we have commercial property insurance policies covering catastrophic losses resulting from windstorm damage up to a $1 billion policy limit per occurrence. Losses resulting from non-named windstorms are subject to a $250,000 deductible. Losses resulting from named windstorms are subject to a 5% deductible based upon the declared 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, except for facilities in Alaska, California and the New Madrid (which includes certain counties located in Arkansas, Illinois, Kentucky, Mississippi, Missouri and Tennessee) and Pacific Northwest Seismic Zones which are subject to a $100 million limitation. The earthquake limit in Puerto Rico is $25 million. Earthquake losses are

subject to a $250,000 deductible for our facilities located in all states except California, Alaska, Washington and Puerto Rico where earthquake losses are subject to a 5% deductible based upon the declared value of the property. Flood losses have a $250,000 deductible except in FEMA designated flood zones A and V (which are located in certain sections of Florida, Oklahoma and Texas) in which case the losses are subject to a $500,000 deductible. Due to an increase in property losses experienced nationwide in recent years, the cost of commercial property insurance has increased. As a result, catastrophic coverage for earthquake and flood has been limited to annual aggregate losses (as opposed to per occurrence losses). Given these insurance market conditions, there can be no assurance that a continuation of these unfavorable trends, or a sharp increase in uninsured property losses sustained by us, will not have a material adverse effect on our future results of operations.

Effects of Inflation and Seasonality

Seasonality—Our 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—Although inflation has not had a material impact on our results of operations over the last three years, the healthcare industry is very labor intensive and salaries and benefits are subject to inflationary pressures as are rising supply costs which tend to escalate as vendors pass on the rising costs through price increases. 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. Although we cannot predict our ability to continue to cover future cost increases, we believe that through adherence to cost containment policies, labor management and reasonable price increases, the effects of inflation on future operating margins should be manageable. However, our ability to pass on these 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. In addition, as a result of increasing regulatory and competitive pressures and a continuing industry wide shift of patients into managed care plans, our ability to maintain margins through price increases to non-Medicare patients is limited.

Liquidity

Year ended December 31, 2008 as compared to December 31, 2007:

Net cash provided by operating activities

Net cash provided by operating activities was $463 million during 2008 as compared to $348 million during 2007. The net increase of $115 million, or 33%, was primarily attributable to the following:

- a favorable net change of $49 million due to an increase in net income plus or minus the adjustments to reconcile net income to net cash provided by operating activities (depreciation and amortization, gains on sales of businesses and assets and provision for settlements);
- a favorable change of $35 million in accounts receivable;
- an unfavorable change of $22 million in other receivables consisting of: (i) a $12 million unfavorable change in receivables recorded in connection with two construction management contracts pursuant to the terms of which we are building/built newly constructed acute care hospitals for an unrelated third party, and; (ii) a $10 million unfavorable change resulting from the receivable recorded during the fourth quarter of 2008 in connection with the proceeds received in 2009 from the liquidation of the PHICO estate, as discussed above;
- a favorable change of $30 million in other working capital accounts due primarily to the timing of accrued payroll and accounts payable disbursements;

- a favorable change of $26 million in other assets and deferred charges which included the receipt during 2008 of a previously outstanding $9 million deposit held by our pharmacy supply distributor and a $5 million reduction in the long-term receivables related to the construction management contracts mentioned above, and;
- $3 million of other combined net unfavorable changes.

Days sales outstanding ("DSO"): Our DSO are calculated by dividing our annual net revenue by the number of days in the year. The result is divided into the accounts receivable balance at the end of the year to obtain the DSO. Without adjustment, our DSO were 46 days in 2008, 48 days in 2007 and 52 days in 2006. After adjusting our respective year-end accounts receivable balances for the items mentioned below, our adjusted DSO were 44 days in 2008, 48 days in 2007 and 47 days in 2006. Our adjusted DSO were calculated by reducing our respective year-end accounts receivable balances for the following: (i) the PHICO liquidation and construction management receivables as of December 31, 2008; (ii) the construction management receivables as of December 31, 2007, and; (iii) the construction management receivables and the $45 million of combined receivables related to the Texas upper payment limit and disproportionate share hospital receivables, which were paid to us during 2007, as of December 31, 2006.

Net cash used in investing activities

Net cash used in investing activities was $297 million during 2008 as compared to $450 million during 2007.

2008:

The $297 million of net cash used in investing activities during 2008 consisted of $355 million spent on capital expenditures, $82 million received from the sale of assets and businesses, $23 million spent on the acquisition of assets and businesses and $1 million of other combined net uses of cash.

2008 Capital Expenditures:

During 2008, we spent $355 million to finance capital expenditures, including the following:

- construction costs related to the newly constructed Centennial Hills Hospital, a 165-bed acute care hospital in Las Vegas, Nevada which was completed and opened during the first quarter of 2008;
- construction costs related to the newly constructed Palmdale Regional Medical Center, a 171-bed acute care hospital in Palmdale, California that is scheduled to be completed and opened in 2010;
- construction costs related to a major expansion of the emergency, imaging and women's services at our Southwest Healthcare System hospitals located in Riverside County, California;
- construction costs related to a newly constructed 220-bed replacement acute care hospital in Denison, Texas that is scheduled to be completed and opened in 2010;
- construction costs related to various other projects at certain of our acute care facilities including an emergency room and imaging expansion at Wellington Regional Medical Center located in Florida and expansion of the operating rooms at Valley Hospital Medical Center in Nevada;
- construction costs related to multiple projects in process to add capacity to our busiest behavioral health facilities, and;
- capital expenditures for equipment, renovations and new projects at various existing facilities.

2008 Divestiture of Assets and Businesses:

During 2008, we received $82 million from the divestiture of assets and businesses, including the following:

- the sale of the assets and operations of Central Montgomery Medical Center, a 125-bed acute care facility located in Lansdale, Pennsylvania;

- the sale of our ownership interest in a third-party provider of supply chain services, and;
- the sale of certain real property assets.

2008 Acquisitions of Assets and Businesses:

During 2008, we spent $23 million on the acquisition of businesses and real property, including the following:

- the acquisition of a 76-bed behavioral health care facility located in Lawrenceville, Georgia, and;
- the acquisition of previously leased real property assets of a behavioral health facility located in Nevada;

Also during 2008, we spent a combined $2 million to purchase/repurchase minority ownership interests in two outpatient surgery centers. We also received $2 million of net settlement proceeds related to a prior year acquisition.

2007:

The $450 million of net cash used in investing activities during 2007 consisted of $340 million spent on capital expenditures, $102 million spent on the acquisition of businesses and real property, $15 million spent to purchase minority ownership interests in majority owned businesses and $7 million received for the sale of vacant property.

2007 Capital Expenditures:

During 2007, we spent $340 million to finance capital expenditures, including the following:

- construction costs related to Centennial Hills Hospital;
- construction costs related to major renovation at our Manatee Memorial Hospital in Bradenton, Florida which was completed and opened during the second quarter of 2007;
- construction costs related to a newly constructed Palmdale Regional Medical Center;
- construction costs related to the expansions at Southwest Healthcare System, Wellington Regional Medical Center and Valley Hospital Medical Center;
- construction costs related to multiple projects in process to add capacity to our busiest behavioral health facilities, and;
- capital expenditures for equipment, renovations and new projects at various existing facilities.

2007 Acquisitions of Businesses:

During 2007, we spent $102 million on the acquisition of businesses and real property, including the following:

- the acquisition of certain assets of Texoma Healthcare System located in Texas, including a 153-bed acute care hospital, a 60-bed behavioral health hospital, a 21-bed freestanding rehabilitation hospital and TexomaCare, a 34-physician group practice structured as a 501A corporation;
- the acquisition of previously leased real property assets of a behavioral health facility located in Ohio;
- the acquisition of a 52-bed behavioral health facility located in Delaware;
- the acquisition of a 102-bed behavioral health facility located in Pennsylvania, and;
- the acquisition of a 78-bed behavioral health facility located in Utah.

Also during 2007, we spent $15 million to acquire the remaining 10% minority ownership interest in a limited liability company ("LLC") that owns Methodist Hospital and Lakeland Medical Pavilion located in Louisiana that were severely damaged and closed as a result of Hurricane Katrina. In addition, we received $7 million of combined cash proceeds in connection with the sale of vacant property located in Texas and Kentucky.

Net cash provided by/used in financing activities

Net cash used in financing activities was $177 million during 2008 as compared to $102 million of net cash provided by financing activities during 2007.

2008:

The $177 million of net cash used in financing activities consisted of the following:

- generated $150 million of net proceeds (net of financing costs) from the issuance of additional senior notes which have a 7.25% coupon rate and are scheduled to mature on June 30, 2016;
- spent $167 million for debt repayments consisting primarily of repayments pursuant to our accounts receivable securitization program, revolving credit facility and short-term, on-demand credit facility;
- spent $149 million to repurchase 3.27 million shares of our Class B Common Stock;
- spent $16 million to pay an $.08 per share quarterly dividend;
- received $2 million of capital contributions from minority members of joint-ventures, and;
- generated $2 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

2007:

The $102 million of net cash provided by financing activities consisted of the following:

- generated $183 million of proceeds generated from borrowings pursuant to our accounts receivable securitization program;
- spent $9 million for debt repayments, including net debt repayments pursuant to our revolving credit facility;
- spent $74 million to repurchase 1.45 million shares of our Class B Common Stock;
- spent $17 million to pay an $.08 per share quarterly dividend;
- received $17 million of capital contributions from minority members consisting primarily of capital contributions received from a third-party for their share of costs related to Centennial Hills, and;
- generated $2 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, 2007 as compared to December 31, 2006:

Net cash provided by operating activities

Net cash provided by operating activities was $348 million during 2007 as compared to $169 million during 2006. The $179 million net increase was primarily attributable to the following:

- a favorable net change of $23 million due primarily to: (i) a favorable $45 million change due to an increase in net income plus or minus the adjustments to reconcile net income to net cash provided by

operating activities (depreciation and amortization, accretion of discount on convertible debentures, gains on sales of assets and businesses, hurricane insurance recoveries and hurricane related expenses), and; (ii) an unfavorable $21 million change in accrued insurance expense, net of commercial premiums paid, resulting primarily from the previously mentioned $18 million reduction to our prior year reserves for professional and general liability self-insured claims recorded during 2007;

- a favorable change of $74 million in accounts receivable, which includes: (i) the favorable change resulting from the collection during 2007 of $45 million of Texas upper payment limit and disproportionate share hospital receivables outstanding as of December 31, 2006; (ii) a favorable change of $18 million resulting from the collection during 2007 of Medicaid supplemental payment program escrow accounts for our Texas hospitals that were funded during 2006, and; (iii) $11 million of other combined favorable changes;
- a favorable change of $121 million in accrued and deferred income taxes resulting from: (i) the $84 million of income tax payments made during 2006 that related to 2005 federal income taxes that were deferred pursuant to an Internal Revenue Service granted postponement of income tax payments to companies that owned Hurricane Katrina-affected businesses in the most severely damaged parishes of Louisiana; (ii) the income tax provision of approximately $6 million recorded during 2007 on the $18 million reduction to our accrual for general and professional liability claims ($16 million after minority interest), and; (iii) $31 million of other combined favorable changes;
- an unfavorable change of $45 million in other working capital accounts due primarily to the timing of certain accrued payroll and accounts payable disbursements;
- a favorable change of $8 million in receivables recorded in connection with two construction management contracts pursuant to the terms of which we built/are building newly constructed acute care hospitals for an unrelated third party, and;
- $2 million of other combined net unfavorable changes.

Hurricane insurance proceeds received: During 2006, we reached an agreement with our insurance carrier to settle all claims related to damage sustained at our facilities located in Louisiana as a result of Hurricane Katrina. Including amounts collected from our other insurance carriers in 2005 and 2006, we received total insurance proceeds of $264 million ($189 million received during 2006 and $75 million received during 2005). We allocated the total insurance proceeds received to "investing activities" and "operating activities" on our consolidated statements of cash flows based upon the percentage of our total insurance claim that related to recovery of property losses and the recovery of all other losses. Of the $189 million of hurricane insurance proceeds received during 2006, $44 million is included in net cash provided by operating activities and the remaining $145 million is included in net cash provided by investing activities.

Income taxes: As a result of Hurricane Katrina, the Internal Revenue Service ("IRS") granted a postponement of payment relief to companies that owned Hurricane Katrina-affected businesses in the most severely damaged parishes of Louisiana. Since four of our facilities were severely damaged and closed as a result of Hurricane Katrina (and remain closed), we qualified for the income tax postponement until the third quarter of 2006. During 2006, we paid $263 million of income taxes, $84 million of which related to 2005 federal income taxes that were previously deferred pursuant to the above mentioned IRS postponement. As of December 31, 2006, no income tax payments remained deferred pursuant to the IRS postponement.

Net cash used in investing activities

Net cash used in investing activities was $450 million during 2007 as compared to $278 million during 2006. The factors contributing to the $450 million of net cash used in investing activities during 2007 are detailed above.

2006:

The $278 million of net cash used in investing activities during 2006 consisted of $341 million spent on capital expenditures and $82 million spent on the acquisition of businesses, less the $145 million of hurricane insurance proceeds received as a result of damage sustained from Hurricane Katrina, as discussed above:

2006 Capital Expenditures:

During 2006, we spent $341 million to finance capital expenditures, including the following:

- construction costs related to Centennial Hills Hospital;
- construction costs related to major renovation at our Manatee Memorial Hospital;
- construction costs related to the newly constructed Palmdale Regional Medical Center;
- construction costs related to the newly constructed 120-bed children's facility in Edinburg, Texas which was completed and opened during 2006;
- construction costs related to the newly constructed 134-bed replacement behavioral health facility in McAllen, Texas which was completed and opened during 2006;
- construction costs related to the newly constructed 104-bed acute care hospital in Eagle Pass, Texas which was completed and opened during 2006;
- construction costs related to multiple projects in process to add capacity to our busiest behavioral health facilities, and;
- capital expenditures for equipment, renovations and new projects at various existing facilities.

2006 Acquisitions of Businesses:

During 2006, we spent $82 million on the acquisition of businesses, including the following:

- the assets of two closed behavioral health care facilities located in Florida and Georgia which were/are being renovated and reopened/scheduled to be reopened either during 2008 (Florida) or during 2009 (Georgia);
- acquisition of a 128-bed behavioral health facility in Utah;
- acquisition of the assets of an 86-bed behavioral health facility in Colorado which was renovated and opened in 2007;
- acquisition of a medical office building in Nevada, and;
- acquisition of a 77-bed behavioral health care facility located in Kentucky.

Net cash provided by/used in financing activities

Net cash provided by financing activities was $102 million during 2007 as compared to $116 million during 2006. The factors contributing to the $102 million of net cash provided by financing activities during 2007 are detailed above.

2006:

The $116 million of net cash provided by financing activities consisted of the following:

- generated $249 million of net proceeds (net of underwriting discount) from the issuance of $250 million of senior notes which have a 7.125% coupon rate and will mature on June 30, 2016;
- generated $245 million of net proceeds from additional borrowings pursuant to our revolving credit facility and our short term, on-demand credit facility;

- spent $35 million for repayments of debt consisting primarily of $31 million spent on the redemption of a portion of our outstanding convertible debentures that were due in 2020 prior to our exercise of our call option in June of 2006;
- spent $350 million to repurchase approximately 6.5 million shares of our Class B Common Stock;
- spent $17 million to pay quarterly cash dividends of $.08 per share;
- received $17 million of capital contributions from a third-party minority member for their share of costs related to Centennial Hills, and;
- generated $7 million of net cash from other financing activities.

2009 Expected Capital Expenditures:

During 2009, we expect to spend approximately $350 million to $400 million on capital expenditures, including approximately $220 million related to expenditures for capital equipment, renovations, new projects at existing hospitals and completion of major construction projects in progress at December 31, 2008. 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

We have an $800 million, unsecured non-amortizing revolving credit agreement, as amended, ("Credit Agreement") which is scheduled to expire on July 28, 2011. In April, 2007, the Credit Agreement was amended to increase commitments from $650 million to $800 million. The Credit Agreement includes a $100 million sub-limit for letters of credit. The interest rate on the borrowings is determined, at our option, as either: (i) the one, two, three or six month London Inter-Bank Offer Rate ("LIBOR") plus a spread of 0.33% to 0.575%; (ii) the higher of the Agent's prime rate or the federal funds rate plus 0.50%, or; (iii) a competitive bid rate. A facility fee ranging from 0.07% to 0.175% is required on the total commitment. The applicable margins over LIBOR and the facility fee are based upon our credit ratings from Standard & Poor's Ratings Services and Moody's Investors Service, Inc. At December 31, 2008, the applicable margin over the LIBOR rate was 0.50% and the facility fee was 0.125%. There are no compensating balance requirements. As of December 31, 2008, we had $303 million of borrowings outstanding under our revolving credit agreement and $434 million of available borrowing capacity, net of $63 million of outstanding letters of credit. Outstanding borrowings pursuant to a short-term, on-demand credit facility which can be refinanced through available borrowings under the terms of our Credit Agreement are classified as long-term on our balance sheet. There were no borrowings outstanding under the short-term on-demand credit facility at December 31, 2008.

In August, 2007, we entered into a $200 million accounts receivable securitization program ("Securitization") with a group of conduit lenders and liquidity banks. The patient-related accounts receivable ("Receivables") for substantially all of our acute care hospitals serve as collateral for the outstanding borrowings. The interest rate on the borrowings is based on the commercial paper rate plus a spread of .35%. The initial term of this Securitization was 364 days and the term can be extended for incremental 364 day periods upon mutual agreement of the parties. The facility was extended for a second 364-day term in August, 2008. The Securitization has a term-out feature that can be exercised by us if the banks do not extend the Securitization which would extend the maturity date to August, 2010. Under the terms of the term-out provision, the borrowing rate would be the same as our Credit Agreement rate. Outstanding borrowings which can be refinanced through available borrowings under the terms of our Credit Agreement are classified as long-term on our balance sheet. We have accounted for this Securitization as borrowings under SFAS No. 140, "Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities". 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 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. As of December 31, 2008, we had $70 million of borrowings outstanding pursuant to this program and $130 million of available borrowing capacity.

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

During 2001, we issued $200 million of senior notes which have a 6.75% coupon rate and which mature on November 15, 2011. The interest on the senior notes is paid semiannually in arrears on May 15 and November 15 of each year. The senior notes can be redeemed in whole at any time and in part from time to time.

The average amounts outstanding during 2008, 2007 and 2006 under the revolving credit, demand notes and accounts receivable securitization program were $431 million, $435 million and $90 million, respectively, with corresponding effective interest rates of 3.9%, 6.0% and 6.4% including commitment and facility fees. The maximum amounts outstanding at any month-end were $566 million in 2008, $531 million in 2007 and $352 million in 2006. The effective interest rate on our revolving credit, demand notes and accounts receivable securitization program, including the respective interest expense/income on designated interest rate swaps, was 4.4% in 2008, 5.9% in 2007 and 6.4% in 2006.

On June 23, 2006, we exercised our right to redeem our convertible debentures due in 2020 (the "Debentures") at a price of $543.41 per $1,000 principal amount of Debenture. The aggregate issue price of the Debentures was $250 million or $587 million aggregate principal amount at maturity. The Debentures were issued at a price of $425.90 per $1,000 principal amount of Debenture. The Debentures' yield to maturity was 5% per annum, .426% of which was cash interest. The Debentures were convertible at the option of the holders into 11.2048 shares of our common stock per $1,000 of Debentures. We had the right to redeem the Debentures any time on or after June 23, 2006 at a price equal to the issue price of the Debentures plus accrued original issue discount and accrued cash interest to the date of redemption. During the second quarter of 2006, approximately 10% of the Debentures were redeemed or repurchased. We spent an aggregate of approximately $31 million to either redeem Debentures at a price of $543.41 per $1,000 principal amount of Debenture or repurchase Debentures on the open market. In late June of 2006, approximately 90% of the holders converted their Debentures into 5.9 million shares of our Class B Common Stock. In connection with this conversion, we reclassified approximately $288 million of long-term debt to capital in excess of par.

Our total debt as a percentage of total capitalization was 39% at December 31, 2008 and 40% at December 31, 2007.

Our revolving credit agreement includes a material adverse change clause that must be represented at each draw. The facility also requires compliance with maximum debt to capitalization and minimum fixed charge coverage ratios. We are in compliance with all required covenants as of December 31, 2008. We also believe that we would remain in compliance if the full amount of our commitment was borrowed.

The fair value of our long-term debt at December 31, 2008 and 2007 was approximately $924 million and $1.05 billion, respectively.

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. There can be no assurance that such additional funds will be available in the preferred amounts or from the preferred sources.

Contractual Obligations and Off-Balance Sheet Arrangements

As of December 31, 2008, we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds. Our outstanding letters of credit and surety bonds as of December 31, 2008 totaled $79 million consisting of: (i) $63 million related to our self-insurance programs; (ii) $14 million related pending appeals of legal judgments, and; (iii) $2 million of other debt guarantees related to public utilities and entities in which we own a minority interest.

Obligations under operating leases for real property, real property master leases and equipment amount to $145 million as of December 31, 2008. The real property master leases are leases for buildings on or near hospital property for which we guarantee a certain level of rental income. We sublease space in these buildings and any amounts received from these subleases are offset against the expense. In addition, we lease four hospital facilities from the Trust with terms expiring in 2011 and 2014. These leases contain up to four 5-year renewal options.

The following represents the scheduled maturities of our contractual obligations as of December 31, 2008:

	Payments Due by Period (dollars in thousands)				
Contractual Obligation	**Total**	**Less than 1 year**	**2-3 years**	**4-5 years**	**After 5 years**
Long-term debt obligations (a)	$ 999,369	$ 8,708	$579,338	$ 2,028	$409,295
Estimated future interest payments on debt outstanding as of December 31, 2008 (b)	284,880	58,150	97,920	57,200	71,610
Construction commitments (c)	179,945	158,099	21,846	—	—
Purchase and other obligations (d)	136,843	32,027	46,572	46,894	11,350
Operating leases (e)	145,356	40,258	62,452	28,726	13,920
Estimated future defined benefit pension plan and other retirement plan payments (f)	233,958	7,393	9,747	10,853	205,965
Total contractual cash obligations	$1,980,351	$304,635	$817,875	$145,701	$712,140

(a) Includes capital lease obligations.

(b) Assumes that all debt outstanding as of December 31, 2008, including borrowings under our revolving credit agreement and accounts receivable securitization program remain outstanding until the final maturity of the debt agreements at the same interest rates which were in effect as of December 31, 2008. We have the right to repay borrowings, upon short notice and without penalty, pursuant to the terms of the revolving credit agreement, demand note and accounts receivable securitization program.

(c) Estimated cost to complete construction of: (i) a new 171-bed acute care facility located in Palmdale, California, and; (ii) a new 220-bed replacement acute care facility in Denison, Texas. We are required to build the facility in Palmdale, California pursuant to an agreement with a third-party. As of December 31, 2008, we have spent $137 million in connection with the construction of this facility which we expect to be completed and opened in 2010. In connection with our January, 2007 acquisition of certain assets of Texoma Healthcare System, we are committed to build a 220-bed replacement acute care facility in Denison, Texas within three years of the closing date. As of December 31, 2008, we have spent $27 million in connection with construction of this replacement facility. In addition to the projects mentioned above, we had various other projects under construction as of December 31, 2008 with estimated additional cost to complete and equip of approximately $220 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 amounts contractually committed to a third-party.

(d) Consists of: (i) a $125 million related to a long-term contract with a third-party to provide certain data processing services and laboratory information system and order management technology for our acute care facilities; (ii) a $10 million liability for physician commitments recorded in connection with the adoption of FASB issued Interpretation No. 45-3, “Application of FASB Interpretation No. 45 to Minimum Revenue

Guarantees Granted to a Business or Its Owners" ("FIN 45-3"), and; (iii) a $2 million commitment payable over a four-year period in connection with the William & Mary Funding. See Note 1 to the Consolidated Financial Statements for additional disclosure related to FIN 45-3.

(e) Reflects our future minimum operating lease payment obligations related to our operating lease agreements outstanding as of December 31, 2008 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 $218 million of estimated future payments related to our non-contributory, defined benefit pension plan (estimated through 2086), as disclosed in Note 10 to the Consolidated Financial Statements, and $16 million of estimated future payments related to another retirement plan liability. Included in our other non-current liabilities as of December 31, 2008 was a $38 million liability recorded in connection with the non-contributory, defined benefit pension plan and an $11 million liability recorded in connection with the other retirement plan.

As of December 31, 2008, the total accrual for our professional and general liability claims was $272 million ($271 million net of expected recoveries from state guaranty funds) of which $42 million is included in other current liabilities and $230 million is included in other non-current liabilities. We exclude the $272 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 amounts. Please see *Professional and General Liability Claims and Property Insurance* above for additional disclosure related to our professional and general liability claims and reserves.

ITEM 7A. ***Quantitative and Qualitative Disclosures about Market Risk***

Our interest expense is sensitive to changes in the general level of interest rates. To mitigate the impact of fluctuations in domestic interest rates, a portion of our debt is fixed rate accomplished by either borrowing on a long-term basis at fixed rates or by, from time to time, entering into interest rate swap transactions. From time to time, we may enter into interest rate swap agreements that require us to pay fixed and receive floating interest rates or to pay floating and receive fixed interest rates over the life of the agreements. We may also, from time to time, enter into treasury locks ("T-Locks") to protect from a rise in the yield of the underlying treasury security for a forecasted bond issuance.

During the fourth quarter of 2007, we entered into two interest rate swaps whereby we pay a fixed rate on a total notional principal amount of $150 million and receive 3-month LIBOR. Each of the two interest rate swaps has a notional principal amount of $75 million. The fixed rate payable on the first interest rate swap is 4.7625% and matures on October 5, 2012. The fixed rate payable on the second interest rate swap is 4.865% and the maturity date is October, 17, 2011. The notional amount of the second interest rate swap reduces to $50 million on October 18, 2010.

As of December 31, 2006, we had no U.S. dollar denominated interest rate swaps. During the second quarter of 2006, in connection with the issuance of the $250 million of senior notes ("Notes") which have a 7.125% coupon rate and mature on June 30, 2016, we entered into T-Locks, with an aggregate notional amount of $250 million, to lock in the 10-year treasury rate underlying the bond issuance. These T-Locks, which were designated as cash flow hedges, were unwound during the second quarter of 2006 resulting in a $3 million cash payment to us which has been recorded in accumulated other comprehensive income (net of income taxes) and is being amortized over the life of the 10-year Notes.

The table below presents information about our long-term financial instruments that are sensitive to changes in interest rates as of December 31, 2008. For debt obligations, the table presents principal cash flows and related weighted-average interest rates by contractual maturity dates. The fair value of long-term debt was determined based on market prices quoted at December 31, 2008, for the same or similar debt issues.

Maturity Date, Fiscal Year Ending December 31 (Dollars in thousands)	2009	2010	2011	2012	2013	Thereafter	Total
Long-term debt:							
Fixed rate:							
Debt	$2,295	$ 2,080	$202,814	$ 985	$1,043	$403,995	$613,212
Average interest rates	7.0%	7.0%	7.0%	7.1%	7.1%	7.1%	7.1%
Variable rate:							
Debt	$6,413	$ 994	$373,450	$ —	$ —	$ 5,300	$386,157
Average interest rates	3.6%	5.8%	2.8%	—	—	2.1%	2.8%
Interest rate swaps:							
Notional amount	—	$25,000	$ 50,000	$75,000	—	—	$150,000
Average interest rates	—	4.9%	4.9%	4.8%	—	—	4.8%

As calculated based upon our variable rate debt outstanding as of December 31, 2008 that is subject to interest rate fluctuations, each 1% change in interest rates would impact our pre-tax income by approximately $2 million.

ITEM 8. ***Financial Statements and Supplementary Data***

Our Consolidated Balance Sheets, Consolidated Statements of Income, Consolidated Statements of Common Stockholders' Equity, and Consolidated Statements of Cash Flows, together with the reports of PricewaterhouseCoopers LLP and KPMG LLP, independent registered public accounting firms, 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, 2008, 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 significant changes in our internal control over financial reporting or in other factors during the fourth quarter of 2008 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,* 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.

Based on its assessment, management has concluded that we maintained effective internal control over financial reporting as of December 31, 2008, based on criteria in *Internal Control—Integrated Framework,* issued by the COSO. The effectiveness of the Company's internal control over financial reporting as of December 31, 2008 has been audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm as stated in their report which appears herein.

ITEM 9B ***Other Information***

None.

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, 2008. See also "Executive Officers of the Registrant" appearing in Item I 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, 2008.

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" in our Proxy Statement, to be filed with the Securities and Exchange Commission within 120 days after December 31, 2008.

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, 2008.

ITEM 14. ***Principal Accounting Fees and Services.***

There is hereby incorporated by reference the information to appear under the caption "Relationship with Independent Auditor" in our Proxy Statement, to be filed with the Securities and Exchange Commission within 120 days after December 31, 2008.

PART IV

ITEM 15. ***Exhibits, 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 6¾% Notes due 2011, previously filed as Exhibit 4.1 to Registrant's Current Report on Form 8-K dated November 13, 2001, is incorporated herein by reference.

4.4 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.

4.5 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.

4.6 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.

4.7 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.

4.8 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.

10.1* Employment Agreement, dated as of December 27, 2007, 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 December 27, 2007, 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 3, 2008, 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* 2002 Executive Incentive Plan, previously filed as Exhibit 10.17 to Registrant's Annual Report on Form 10-K for the year ended December 31, 2002, is incorporated herein by reference.

10.8 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.

10.9 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.

10.10 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.

10.11* Deferred Compensation Plan for Universal Health Services Board of Directors and Amendment thereto, previously filed as Exhibit 10.22 to Registrant's Annual Report on Form 10-K for the year ended December 31, 2002, is incorporated herein by reference.

10.12 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.

10.13 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.

10.14* Amended and Restated 1992 Stock Option Plan, previously filed as Exhibit 10.33 to Registrant's Annual Report on Form 10-K for the year ended December 31, 2000, is incorporated herein by reference.

10.15 Credit Agreement dated as of March 4, 2005, by and among Universal Health Services, Inc., JPMorgan Chase Bank, N.A., as Administrative Agent, Bank of America, N.A., as Syndication Agent and ABN Amro Bank N.V., Sun Trust Bank and Wachovia Bank, National Association, as Co-Documentation Agents, previously filed as Exhibit 10.1 to the Registrant's Current Report on Form 8-K, dated March 8, 2005, is incorporated herein by reference.

10.16* 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.

10.17* Second Amended and Restated 2001 Employees' Restricted Stock Purchase Plan, previously filed as Exhibit 99.2 to the Company's Current Report on Form 8-K dated May 22, 2008, is incorporated herein by reference.

10.18* 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.

10.19* Amended and Restated Universal Health Services, Inc. 2005 Stock Incentive Plan, previously filed as Exhibit 99.1 to the Company's Current Report on Form 8-K dated May 22, 2008, is incorporated herein by reference.

10.20* 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.

10.21* 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.

10.22* Restricted Stock Purchase Agreement by and between Universal Health Services, Inc. and Alan B. Miller, Chairman of the Board, President and Chief Executive Officer of the Company, previously filed as Exhibit 10.1 to Registrant's Quarterly Report on Form 10-Q for the quarter ended March 31, 2005, is incorporated herein by reference.

10.23 Sale and Purchase Agreement of the Médi-Partenaires Group, dated April 21, 2005, among UHS International, Inc., Santé et Loisirs, CMS Staff, SF Staff, MP staff and Financiere Opale, previously filed as Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated April 28, 2005, is incorporated herein by reference.

10.24 Ownership Interest Purchase Agreement, dated as of October 3, 2005, among Harbinger Private Equity Fund I, L.L.C., Keystone Group Kids, Inc., Michael Lindley, Marty Weber, Ameris Healthcare Investments, LLC, Rainer Twiford, Al Smith, Mike White, Rodney Cawood, Buddy Turner, Jeff Cross, Gail Debiec, Brad Gardner, Brad Williams, Don Wert, Rob Minor, Mike McCulla, Jim Shaheen, Rob Gaeta, and Universal Health Services, Inc., previously filed as Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated October 11, 2005, is incorporated herein by reference.

10.25* Universal Health Services, Inc., Executive Incentive Plan, previously filed as Exhibit 10.2 to Registrant's Current Report on Form 8-K, dated April 1, 2005, is incorporated herein by reference.

10.26 Amendment No. 1 to the Credit Agreement by and among Universal Health Services, Inc., JPMorgan Chase Bank, N.A., as Administrative Agent, Bank of America, N.A., as Syndication Agent and ABN Amro Bank N.V., Sun Trust Bank and Wachovia Bank, National Association, as Co-Documentation Agents, dated June 28, 2006, previously filed as Exhibit 10.1 to the Registrant's Current Report on Form 8-K, dated August 1, 2006, is incorporated herein by reference.

10.27* Description of Contribution Agreement relating to Mr. Alan Miller, previously filed as Exhibit 10.1 to the Registrant's Current Report on Form 8-K, dated July 26, 2006, is incorporated herein by reference.

10.28* Universal Health Services, Inc. Restricted Stock Purchase Agreement dated as of March 15, 2006, 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 March 21, 2006, is incorporated herein by reference.

10.29 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.

10.30 Amendment No. 2 to the Credit Agreement, dated as of April 13, 2007 by and among the Company, JP Morgan Chase Bank, N.A., as Administrative Agent, Bank of America, N.A., as Syndication Agent and ABN Amro Bank, N.V., Sun Trust Bank and Wachovia Bank, National Association, as Co-Documentation Agents and other lenders named therein, previously filed as Exhibit 10.1 to the Registrant's Current Report on Form 8-K dated April 13, 2007, is incorporated herein by reference.

10.31 Credit and Security Agreement, dated as of August 31, 2007, previously filed as Exhibit 10.1 to the Registrant's Current Report on Form 8-K dated September 6, 2007, is incorporated herein by reference.

10.32 Form of Receivables Sale Agreement, dated as of August 31, 2007, previously filed as Exhibit 10.2 to the Registrant's Current Report on Form 8-K dated September 6, 2007, is incorporated herein by reference.

10.33 Form of Performance Undertaking, dated as of August 31, 2007, previously filed as Exhibit 10.3 to the Registrant's Current Report on Form 8-K dated September 6, 2007 is incorporated herein by reference.

10.34 Underwriting Agreement by and among Banc of America Securities LLC, as representative of the underwriters named in Schedule II, and Universal Health Services, Inc., dated May 29, 2008, previously filed as Exhibit 1.1 to the Company's Current Report on Form 8-K dated May 30, 2008, 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.

23.2 Consent of Independent Registered Public Accounting Firm-KPMG 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.

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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.

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, President and Chief Executive Officer

February 26, 2009

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, President and Chief Executive Officer (Principal Executive Officer)	February 26, 2009
/s/ ANTHONY PANTALEONI **Anthony Pantaleoni**	Director	February 26, 2009
/s/ ROBERT H. HOTZ **Robert H. Hotz**	Director	February 26, 2009
/s/ JOHN H. HERRELL **John H. Herrell**	Director	February 26, 2009
/s/ JOHN F. WILLIAMS, JR., M.D. **John F. Williams, Jr., M.D.**	Director	February 26, 2009
/s/ LEATRICE DUCAT **Leatrice Ducat**	Director	February 26, 2009
/s/ RICK SANTORUM **Rick Santorum**	Director	February 26, 2009
/s/ MARC D. MILLER **Marc D. Miller**	Director and Senior Vice President	February 26, 2009
/s/ STEVE FILTON **Steve Filton**	Senior Vice President, Chief Financial Officer and Secretary (Principal Financial and Accounting Officer)	February 26, 2009

UNIVERSAL HEALTH SERVICES, INC.

INDEX TO FINANCIAL STATEMENTS
AND FINANCIAL STATEMENT SCHEDULE

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Shareholders of
Universal Health Services, Inc.:

In our opinion, the 2008 and 2007 consolidated financial statements listed in the accompanying index present fairly, in all material respects, the financial position of Universal Health Services, Inc. at December 31, 2008 and 2007, and the results of their operations and their cash flows for the years ended December 31, 2008 and 2007 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, 2008, based on criteria established in *Internal Control—Integrated Framework* 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 under 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.

As discussed in Note 6 to the consolidated financial statements, the Company changed the manner in which it accounts for uncertain tax positions in fiscal 2007.

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.

/s/ PricewaterhouseCoopers LLP

Philadelphia, Pennsylvania
February 26, 2009

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders of
Universal Health Services, Inc.:

We have audited the 2006 consolidated financial statements of Universal Health Services, Inc. and subsidiaries as listed in the accompanying index. In connection with our audit of the 2006 consolidated financial statements, we also have audited the 2006 financial statement schedule listed in the accompanying index. These consolidated financial statements and financial statement schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements and financial statement schedule based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the results of operations and cash flows of Universal Health Services, Inc. and subsidiaries for the year ended December 31, 2006, in conformity with U.S. generally accepted accounting principles. Also in our opinion, the related financial statement schedule referred to above, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

As discussed in note 1 to the consolidated financial statements, the Company adopted Statement of Financial Accounting Standards No. 123(R), *Share-Based Payment*, and related interpretations on January 1, 2006.

/s/ KPMG LLP

Philadelphia, Pennsylvania
February 28, 2007

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2008	**2007**	**2006**
	(in thousands, except per share data)		
Net revenues	**$5,022,417**	$4,683,150	$4,124,692
Operating charges:			
Salaries, wages and benefits	**2,133,181**	2,004,995	1,765,162
Other operating expenses	**1,044,278**	982,614	921,836
Supplies expense	**694,477**	666,320	547,915
Provision for doubtful accounts	**476,745**	410,543	343,383
Depreciation and amortization	**193,635**	180,557	161,097
Lease and rental expense	**69,882**	67,867	63,574
	4,612,198	4,312,896	3,802,967
Income before interest expense, minority interests, hurricane insurance recoveries in excess of expenses and income taxes	**410,219**	370,254	321,725
Interest expense, net	**53,207**	51,626	32,558
Minority interests in earnings of consolidated entities	**40,693**	43,361	37,519
Hurricane insurance recoveries in excess of expenses	**—**	—	(770)
Income before income taxes	**316,319**	275,267	252,418
Provision for income taxes	**123,378**	104,625	93,218
Income from continuing operations	**192,941**	170,642	159,200
Income (loss) from discontinued operations, net of income tax (expense) benefit of ($4.0 million) during 2008, $156 during 2007 and ($59.6 million) during 2006	**6,436**	(255)	100,258
Net income	**$ 199,377**	$ 170,387	$ 259,458
Basic earnings (loss) per share:			
From continuing operations	**$ 3.81**	$ 3.20	$ 2.92
From discontinued operations	**0.13**	(0.01)	1.84
Total basic earnings per share	**$ 3.94**	$ 3.19	$ 4.76
Diluted earnings per share:			
From continuing operations	**$ 3.80**	$ 3.18	$ 2.83
From discontinued operations	**0.13**	—	1.73
Total diluted earnings per share	**$ 3.93**	$ 3.18	$ 4.56
Weighted average number of common shares—basic	**50,611**	53,381	54,557
Add: Shares for conversion of convertible debentures	**—**	—	3,117
Other share equivalents	**165**	188	234
Weighted average number of common shares and equivalents—diluted	**50,776**	53,569	57,908

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

	December 31,	
	2008	**2007**
	(Dollar amounts in thousands)	
Assets		
Current assets:		
Cash and cash equivalents	**$ 5,460**	$ 16,354
Accounts receivable, net	**625,437**	627,186
Supplies	**76,043**	72,399
Deferred income taxes	**34,522**	23,153
Other current assets	**26,375**	35,755
Assets of facilities held for sale	**21,580**	—
Total current assets	**789,417**	774,847
Property and Equipment		
Land	**214,531**	221,983
Buildings and improvements	**1,799,427**	1,585,985
Equipment	**917,408**	853,763
Property under capital lease	**40,880**	38,584
	2,972,246	2,700,315
Accumulated depreciation	**(1,255,682)**	(1,112,415)
	1,716,564	1,587,900
Construction-in-progress	**383,728**	346,016
	2,100,292	1,933,916
Other assets:		
Goodwill	**732,937**	750,395
Deferred charges	**10,428**	8,257
Other	**109,388**	141,242
	852,753	899,894
	$ 3,742,462	$ 3,608,657
Liabilities and Stockholders' Equity		
Current liabilities:		
Current maturities of long-term debt	**$ 8,708**	$ 3,116
Accounts payable	**192,078**	175,222
Accrued liabilities		
Compensation and related benefits	**138,257**	122,562
Interest	**5,434**	5,557
Taxes other than income	**20,327**	16,083
Other	**185,912**	165,171
Current federal and state income taxes	**10,409**	—
Total current liabilities	**561,125**	487,711
Other noncurrent liabilities	**407,652**	344,755
Minority interests	**226,735**	210,184
Long-term debt	**990,661**	1,008,786
Deferred income taxes	**12,439**	40,022
Commitments and contingencies		
Common stockholders' equity:		
Class A Common Stock, voting, $.01 par value; authorized 12,000,000 shares: issued and outstanding 3,328,404 shares in 2008 and 3,328,404 shares in 2007	**33**	33
Class B Common Stock, limited voting, $.01 par value; authorized 150,000,000 shares: issued and outstanding 45,757,910 shares in 2008 and 48,877,003 shares in 2007	**458**	489
Class C Common Stock, voting, $.01 par value; authorized 1,200,000 shares: issued and outstanding 335,800 shares in 2008 and 335,800 shares in 2007	**3**	3
Class D Common Stock, limited voting, $.01 par value; authorized 5,000,000 shares: issued and outstanding 22,269 shares in 2008 and 22,717 shares in 2007	**—**	—
Cumulative dividends	**(91,921)**	(75,771)
Retained earnings	**1,666,973**	1,599,326
Accumulated other comprehensive loss	**(31,696)**	(6,881)
	1,543,850	1,517,199
	$ 3,742,462	$ 3,608,657

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF COMMON STOCKHOLDERS' EQUITY
For the Years Ended December 31, 2008, 2007 and 2006
(in thousands, except per share data)

	Class A Common	Class B Common	Class C Common	Class D Common	Capital in Excess of Par Value	Cumulative Dividends	Retained Earnings	Deferred Compensation	Accumulated Other Comprehensive Income (Loss)	Total
Balance, January 1, 2006	$ 33	$503	$ 3	—	—	$(41,157)	$1,259,998	$ (3,561)	$(10,721)	$1,205,098
Adjustment to initially adopt SFAS 158 (net of income tax effect of $1,526)	—	—	—	—	—	—	—	—	(2,569)	(2,569)
Common Stock										
Issued/(converted) including tax benefits from exercise of stock options	—	5	—	—	23,911	—	—	(18,274)	—	5,642
Repurchased	—	(65)	—	—	(314,832)	—	(35,475)	—	—	(350,372)
Amortization of deferred compensation	—	—	—	—	—	—	—	6,576	—	6,576
Conversion of convertible debentures to Class B Common Stock	—	59	—	—	283,552	—	—	—	—	283,611
Dividends paid ($.32 per share)	—	—	—	—	—	(17,445)	—		—	(17,445)
Stock option expense	—	—	—	—	7,369	—	—	—	—	7,369
Comprehensive income:										
Net income	—	—	—	—	—	—	259,458	—	—	259,458
Net cash received for termination of derivative (net of amortization of $170 and income tax effect of $1,258)	—	—	—	—	—	—	—	—	1,965	1,965
Minimum pension liability (net of income tax effect of $1,855)	—	—	—	—	—	—	—	—	3,131	3,131
Subtotal—comprehensive income	—	—	—	—	—	—	259,458	—	5,096	264,554
Balance, January 1, 2007	33	502	3	—	—	(58,602)	1,483,981	(15,259)	(8,194)	1,402,464
Cumulative effect of change in accounting for uncertainties in income taxes (FIN 48)		—	—	—	—	—	11,832	—	—	11,832
Common Stock										
Issued/(converted) including tax benefits from exercise of stock options	—	2	—	—	—	—	4,521	—	—	4,523
Repurchased	—	(15)	—	—	—	—	(74,076)	—	—	(74,091)
Restricted share-based compensation expense	—	—	—	—	—	—	8,380	—	—	8,380
Dividends paid ($.32 per share)	—	—	—	—	—	(17,169)	—	—	—	(17,169)
Stock option expense	—	—	—	—	—	—	8,787	—	—	8,787
Reclassification of deferred compensation	—	—	—	—	—	—	(15,259)	15,259	—	—
After-tax gain on partial sale of subsidiary		—	—	—	—	—	773	—	—	773
Comprehensive income:										
Net income	—	—	—	—	—	—	170,387	—	—	170,387
Amortization of terminated hedge (net of income tax effect of $189)	—	—	—	—	—	—	—	—	(147)	(147)
Unrealized derivative losses on cash flow hedges (net of income tax effect of $1,672)	—	—	—	—	—	—	—	—	(2,754)	(2,754)
Minimum pension liability (net of income tax effect of $2,393)	—	—	—	—	—	—	—	—	4,214	4,214
Subtotal—comprehensive income	—	—	—	—	—	—	170,387	—	1,313	171,700
Balance, January 1, 2008	33	489	3	—	—	(75,771)	1,599,326	—	(6,881)	1,517,199
Common Stock										
Issued/(converted) including tax benefits from exercise of stock options	—	2	—	—	—	—	2,547	—	—	2,549
Repurchased	—	(33)	—	—	—	—	(149,371)	—	—	(149,404)
Restricted share-based compensation expense	—	—	—	—	—	—	4,678	—	—	4,678
Dividends paid ($.32 per share)	—	—	—	—	—	(16,150)	—	—	—	(16,150)
Stock option expense	—	—	—	—	—	—	10,416	—	—	10,416
Comprehensive income:										
Net income	—	—	—	—	—	—	199,377	—	—	199,377
Amortization of terminated hedge (net of income tax effect of $120)	—	—	—	—	—	—	—	—	(216)	(216)
Unrealized derivative losses on cash flow hedges (net of income tax effect of $3,644)	—	—	—	—	—	—	—	—	(5,891)	(5,891)
Minimum pension liability (net of income tax effect of $11,572)	—	—	—	—	—	—	—	—	(18,708)	(18,708)
Subtotal—comprehensive income	—	—	—	—	—	—	199,377	—	(24,815)	174,562
Balance, December 31, 2008	$ 33	$458	$ 3	—	—	$(91,921)	$1,666,973	—	$(31,696)	$1,543,850

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2008	2007	2006
	(Amounts in thousands)		
Cash Flows from Operating Activities:			
Net income	**$ 199,377**	$ 170,387	$ 259,458
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation & amortization	**195,766**	183,281	163,694
Accretion of discount on convertible debentures	**—**	—	6,364
Gains on sales of assets and businesses, net of losses	**(21,464)**	(3,722)	—
Provision for settlements	**25,000**		—
Hurricane related expenses	**—**	—	13,792
Hurricane insurance recoveries accrued	**—**	—	(181,791)
Hurricane insurance recoveries received for operating expenses	**—**	—	43,929
Changes in assets & liabilities, net of effects from acquisitions and dispositions:			
Accounts receivable	**22,445**	(13,050)	(87,328)
Construction management and other receivable	**(20,693)**	1,510	(6,224)
Accrued interest	**(123)**	2,143	796
Accrued and deferred income taxes	**(3,483)**	9,648	(111,438)
Other working capital accounts	**3,878**	(26,547)	18,090
Other assets and deferred charges	**21,003**	(4,700)	2,524
Payment of hurricane related expenses	**—**	—	(14,889)
Other	**16,928**	8,688	15,126
Minority interest in earnings of consolidated entities, net of distributions	**9,614**	10,334	15,536
Accrued insurance expense, net of commercial premiums paid	**73,413**	64,131	76,456
Payments made in settlement of self-insurance claims	**(58,561)**	(53,608)	(44,856)
Net cash provided by operating activities	**463,100**	348,495	169,239
Cash Flows from Investing Activities:			
Property and equipment additions, net of disposals	**(354,537)**	(339,813)	(341,140)
Proceeds received from sales of assets and businesses	**82,062**	6,818	—
Acquisition of assets and businesses	**(23,481)**	(101,792)	(81,800)
Hurricane insurance recoveries received	**—**	—	144,571
Purchase of minority ownership interests in majority owned businesses	**(1,058)**	(14,762)	—
Investment in joint-venture	**(1,249)**	—	—
Settlement proceeds received related to prior year acquisition, net of expenses	**1,539**	—	—
Net cash used in investing activities	**(296,724)**	(449,549)	(278,369)
Cash Flows from Financing Activities:			
Additional borrowings	**151,129**	183,206	494,353
Reduction of long-term debt	**(166,557)**	(8,716)	(34,898)
Repurchase of common shares	**(149,404)**	(74,091)	(350,372)
Dividends paid	**(16,150)**	(17,169)	(17,445)
Issuance of common stock	**2,354**	2,264	5,637
Financing costs	**(975)**	(588)	(2,020)
Net cash received for termination of derivatives	**—**	—	3,393
Capital contributions from minority member	**2,333**	17,563	17,458
Net cash (used in) provided by financing activities	**(177,270)**	102,469	116,106
(Decrease) increase in cash and cash equivalents	**(10,894)**	1,415	6,976
Cash and cash equivalents, beginning of period	**16,354**	14,939	7,963
Cash and cash equivalents, end of period	**$ 5,460**	$ 16,354	$ 14,939
Supplemental Disclosures of Cash Flow Information:			
Interest paid	**$ 62,285**	$ 58,567	$ 35,474
Income taxes paid, net of refunds	**$ 130,379**	$ 93,519	$ 263,465
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.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1) BUSINESS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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, 2009, we owned and/or operated or had under construction, 26 acute care hospitals (including 1 new facility currently being constructed) and 101 behavioral health centers located in 32 states, Washington, D.C. and Puerto Rico. As part of our ambulatory treatment centers division, we manage and/or own outright or in partnerships with physicians, 9 surgical hospitals and surgery and radiation oncology centers located in 6 states and Puerto Rico.

Net revenues from our acute care hospitals, surgical hospitals, surgery centers and radiation oncology centers accounted for 74%, 74% and 75% of our consolidated net revenues in 2008, 2007 and 2006, respectively. Net revenues from our behavioral health care facilities accounted for 25% of our consolidated net revenues during each of 2008, 2007 and 2006. During each of 2008 and 2007, approximately 1% of our consolidated net revenues were recorded in connection with two construction management contracts pursuant to the terms of which we: (i) built a newly constructed acute care hospital for an unrelated third party that was completed during the first quarter of 2008, and; (ii) are building a newly constructed acute care hospital for an unrelated party that is scheduled to be completed during the fourth quarter of 2009.

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 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.

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%, 37% and 38% of our net patient revenues during 2008, 2007 and 2006, respectively. Revenues from managed care entities, including health maintenance organizations and managed Medicare and Medicaid programs accounted for 46%, 44% and 41% of our net patient revenues during 2008, 2007 and 2006, respectively.

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 can not 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 2008 or 2007 and favorably impacted our 2006 after-tax operating results by $5 million ($8 million pre-tax).

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. Our acute care hospitals provided charity care and uninsured discounts, based on charges at established rates, amounting to (amounts include uninsured discounts mentioned above and data related to an acute care facility that is reflected as discontinued operations) $614 million, $562 million and $443 million during 2008, 2007 and 2006, respectively.

C) Provision for Doubtful Accounts: 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 which is the patient's responsibility, primarily co-payments and deductibles. We estimate our provisions for doubtful accounts based on general factors such as payor 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 collectibility 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 is sent at least two statements followed by a series of collection letters. 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. Patients that express an inability to pay are reviewed for write-off as potential charity care. Our accounts receivable are recorded net of established charity care reserves of $83 million as of December 31, 2008 and $81million as of December 31, 2007 (including additional charity care reserves of $13 million established during each of 2008 and 2007).

Uninsured patients that do not qualify as charity patients are extended an uninsured discount of at least 20% of total charges. During the collection process the hospital establishes a partial reserve in the allowance for doubtful accounts for self-pay balances outstanding for greater than 60 days from the date of discharge. All self-pay accounts at the hospital level are fully reserved if they have been outstanding for greater than 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. Potential charity accounts are fully reserved when it is determined the patient may be unable to pay.

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. At December 31, 2008 and December 31, 2007, accounts receivable are recorded net of allowance for doubtful accounts of $163 million and $121 million, respectively.

D) Concentration of Revenues: Our five majority owned acute care hospitals in the Las Vegas, Nevada market contributed, on a combined basis, 22% in 2008, 21% in 2007 and 21% in 2006, of our consolidated net revenues. Our facilities in the McAllen/Edinburg, Texas market (consisting of three acute care facilities, a children's hospital and a behavioral health facility) contributed, on a combined basis, 7% in 2008, 7% in 2007 and 8% in 2006, of our consolidated net revenues.

E) Cash and Cash Equivalents: We consider all highly liquid investments purchased with maturities of three months or less to be cash equivalents.

F) 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.

We capitalize interest expense on major construction projects while in progress. During 2008, 2007 and 2006, we capitalized interest on major construction projects amounting to $7.9 million, $9.2 million and $3.4 million, respectively.

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 $176.1 million during 2008, $159.8 million during 2007 and $144.4 million during 2006.

G) Long-Lived Assets: We review our long-lived assets, including amortizable 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.

H) Goodwill: Goodwill is 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, 2008 which indicated no impairment of goodwill. 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.

Changes in the carrying amount of goodwill for the two years ended December 31, 2008 were as follows (in thousands):

	Acute Care Services	Behavioral Health Services	Total Consolidated
Balance, January 1, 2007	$394,601	$325,390	$719,991
Goodwill acquired during the period	22,757	11,325	34,082
Adjustments to goodwill (a)	—	(3,678)	(3,678)
Balance, January 1, 2008	417,358	333,037	750,395
Goodwill acquired during the period	—	10,989	10,989
Goodwill divested during the period	(14,534)	—	(14,534)
Adjustments to goodwill (b)	(11,778)	(2,135)	(13,913)
Balance, December 31, 2008	$391,046	$341,891	$732,937

(a) Consists primarily of adjustments to prior year purchase price allocations.

(b) The reduction to the Acute Care Services' goodwill consists primarily of a reclassification to "assets of facilities held for sale" and represents the goodwill attributable to four acute care facilities located in Louisiana that were severely damaged and closed during 2005 as a result of Hurricane Katrina. The reduction to Behavioral Health Services' goodwill consists primarily of the recording of net settlement proceeds received during 2008 related to a prior year acquisition.

I) Other Assets: Other assets consist primarily of amounts related to: (i) prepaid fees for various software and other applications used by our hospitals; (ii) deposits; (iii) investments in various businesses, including Universal Health Realty Income Trust; (iv) 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; (v) the estimated future payments related to physician-related contractual commitments, recorded pursuant to Interpretation No. 45-3, *Application of FASB Interpretation No. 45 to Minimum Revenue Guarantees Granted to a Business or Its Owners*, as discussed below; (vi) estimates of expected recoveries from various state guaranty funds in connection with PHICO related professional and general liability claims payments, and; (vii) other miscellaneous assets. As of December 31, 2008 and 2007, other intangible assets, net of accumulated amortization, were not material.

J) Physician Guarantees and Commitments: In November, 2005, the FASB issued Interpretation No. 45-3, *Application of FASB Interpretation No. 45 to Minimum Revenue Guarantees Granted to a Business or Its Owners* ("FIN 45-3"). FIN 45-3 amends FIN 45, Guarantor's Accounting and Disclosure Requirements for Guarantees, Including Indirect Guarantees of Indebtedness of Others, to expand the scope to include guarantees granted to a business, such as a physician's practice, or its owner(s), that the revenue of the business for a period will be at least a specified amount. We adopted FIN 45-3 on January 1, 2006. As of December 31, 2008, our accrued liabilities-other, and our other assets include $10 million of estimated future payments related to physician-related contractual commitments entered into since the adoption of FIN 45.3. Pursuant to contractual guarantees outstanding as of December 31, 2008 that are applicable to future years, we have $14 million of potential future financial obligations of which $12 million are potential obligations during 2009 and $2 million are potential obligations during 2010 and later.

K) Self-Insured Risks: We provide for self-insured risks, primarily general and professional liability claims and workers' compensation claims, based on estimates of the ultimate costs for both reported claims and claims incurred but not reported. Estimated losses from asserted and incurred but not reported claims are accrued based on our estimates of the ultimate costs of the claims, which includes costs associated with litigating or settling claims, and the relationship of past reported incidents to eventual claims payments. All relevant information, including our own historical experience, the nature and extent of existing asserted claims and reported incidents, and analyses of this information, is used in estimating the expected amount of claims. We also consider amounts that may be recovered from excess insurance carriers, state guaranty funds and other sources in estimating our ultimate net liability for such risk. 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.

L) 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 carryforwards.

We operate in multiple jurisdictions with varying tax laws. We are subject to audits by any of these taxing authorities. During 2008, the estimated liabilities for uncertain tax positions (including accrued interest and penalties) were increased in the amount of approximately $2 million due to tax positions taken in the current and prior years. Also during 2008, 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. During 2007, the estimated liabilities for uncertain tax positions (including accrued interest and penalties) were reduced due to the lapse of the statue of limitations and the conclusions of income tax audits of varying taxing authorities resulting in a net income tax benefit of approximately $2 million. Our tax returns have been examined by the Internal Revenue Service (IRS) through the year ended December 31, 2002. The IRS has recently commenced an audit for the tax year ended December 31, 2006. We believe that adequate accruals have been provided for federal, foreign and state taxes.

Effective January 1, 2007, we adopted the provisions of FASB issued Interpretation No. 48 ("FIN 48"), Accounting for Uncertainty in Income Taxes. As a result of the implementation of FIN 48, we recognized a $12 million decrease in the liability for unrecognized tax benefits. This decrease in the liability resulted in an increase to the January 1, 2007 balance of retained earnings of approximately $12 million. As of January 1, 2007, after the implementation of FIN 48, our unrecognized tax benefits were approximately $6 million. The amount at implementation that would favorably affect the effective tax rate and provision for income taxes was approximately $4 million, approximately $3 million of which was recorded during 2007. The balance at December 31, 2008 and 2007, if subsequently recognized, that would favorably affect the effective tax rate and provision for income taxes is approximately $2 million and $1 million, respectively.

M) Other Noncurrent Liabilities: Other noncurrent liabilities include the long-term portion of our professional and general liability, workers' compensation reserves and pension liability.

N) Minority Interest: As of December 31, 2008 and 2007, the minority interest liability of $227 million and $210 million, respectively, consists primarily of: (i) an outside ownership interest of approximately 28% in five acute care facilities located in Las Vegas, Nevada; (ii) a 20% outside ownership in an acute care facility located in Washington D.C, and; (iii) an outside ownership interest of approximately 11% in an acute care facility located in Laredo, Texas.

In connection with the five acute care facilities located in Las Vegas, Nevada, the outside owners have certain "put rights" that may require the respective limited liabilities companies ("LLCs") to purchase the minority member's interests 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.

O) Comprehensive Income: Comprehensive income or loss, is comprised of net income, changes in unrealized gains or losses on derivative financial instruments, foreign currency translation adjustments and a pension liability.

P) 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 SFAS 133, "Accounting for Derivative Instruments and Hedging Activities," as amended by SFAS No. 149, 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.

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 under SFAS 133. 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.

Q) Stock-Based Compensation: At December 31, 2008, we have a number of stock-based employee compensation plans. Effective January 1, 2006, we adopted SFAS No. 123R ("123R") and related interpretations and began expensing the grant-date fair value of stock options and other equity-based compensation. 123R also generally requires that a company account for these transactions using the fair-value based method and eliminates a company's ability to account for share-based compensation transactions using the intrinsic value method of accounting provided in APB Opinion No. 25, "Accounting for Stock Issued to Employees," which was permitted under Statement No. 123, as originally issued.

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. 123R requires that cash flows resulting from tax deductions in excess of compensation cost recognized be classified as financing cash flows. During 2008, 2007 and 2006, there were no net excess tax benefits generated.

R) 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,		
	2008	**2007**	**2006**
Basic:			
Income from continuing operations	**$192,941**	$170,642	$159,200
Less: Dividends on unvested restricted stock, net of taxes	**(49)**	(79)	(89)
Income from continuing operations—basic	**$192,892**	$170,563	$159,111
Income/(loss) from discontinued operations, net of taxes	**6,436**	(255)	100,258
Net income—basic	**$199,328**	$170,308	$259,369
Weighted average number of common shares—basic	**50,611**	53,381	54,557
Basic earnings per share:			
From continuing operations	**$ 3.81**	$ 3.20	$ 2.92
From discontinued operations	**0.13**	(0.01)	1.84
Total basic earnings per share	**$ 3.94**	$ 3.19	$ 4.76
Diluted:			
Income from continuing operations	**$192,941**	$170,642	$159,200
Less: Dividends on unvested restricted stock, net of taxes	**(49)**	(79)	(89)
Add: Debenture interest, net of taxes	**—**	—	4,887
Income from continuing operations—diluted	**$192,892**	$170,563	$163,998
Income/(loss) from discontinued operations, net of taxes	**6,436**	(255)	100,258
Net income—diluted	**$199,328**	$170,308	$264,256
Weighted average number of common shares	**50,611**	53,381	54,557
Assumed conversion of discounted convertible debentures	**—**	—	3,117
Net effect of dilutive stock options and grants based on the treasury stock method	**165**	188	234
Weighted average number of common shares and equivalents—diluted	**50,776**	53,569	57,908
Diluted earnings per share:			
From continuing operations	**$ 3.80**	$ 3.18	$ 2.83
From discontinued operations	**0.13**	—	1.73
Total diluted earnings per share	**$ 3.93**	$ 3.18	$ 4.56

S) 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.

T) 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.

U) Recent Accounting Pronouncements:

Fair Value Measurements: In September 2006, the FASB issued SFAS No. 157, "Fair Value Measurements" ("SFAS No. 157"). SFAS No. 157 defines fair value, establishes a framework for measuring fair value and expands disclosures about fair value measurements. SFAS No. 157 is effective for fiscal years beginning after November 15, 2007 and interim periods within those fiscal years. The provisions for SFAS No. 157 are to be applied prospectively as of the beginning of the fiscal year in which it is initially applied, except in limited circumstances including certain positions in financial instruments that trade in active markets as well as certain financial and hybrid financial instruments initially measured under SFAS No. 133 "Accounting for Derivative Instruments and Hedging Activities" ("SFAS No. 133") using the transaction price method. In these circumstances, the transition adjustment, measured as the difference between the carrying amounts and the fair values of those financial instruments at the date SFAS No. 157 is initially applied, shall be recognized as a cumulative-effect adjustment to the opening balance of retained earnings for the fiscal year in which SFAS No. 157 is initially applied. In February, 2008, the FASB decided to issue final staff positions that will: (i) partially defer the effective date of SFAS No. 157 for one year for certain non-financial assets and non-financial liabilities, and; (ii) remove certain leasing transactions from the scope of SFAS No. 157. As permitted by FASB Staff Position No. FAS 157-2, "Effective Date of FASB Statement No. 157", we elected to defer the adoption of SFAS No. 157 for all nonfinancial assets and nonfinancial liabilities, except those that are recognized or disclosed at fair value in the financial statements on a recurring basis. The partial adoption of SFAS No. 157 for financial assets and financial liabilities did not have a material impact on our results of operations or financial position.

SFAS No. 157 discusses valuation techniques, such as the market approach, the income approach and the cost approach. The statement utilizes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value into three broad levels as follows:

- Level 1: Observable inputs such as quoted prices (unadjusted) in active markets for identical assets or liabilities;
- Level 2: Inputs other than quoted prices that are observable for the asset or liability, either directly or indirectly. These include quoted prices for similar assets or liabilities in active markets and quoted prices for identical or similar assets or liabilities in markets that are not active;
- Level 3: Unobservable inputs that reflect the reporting entity's own assumptions.

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 3 in the fair value hierarchy. The fair value of our interest rate swaps was a liability of $14 million at December 31, 2008.

The Fair Value Option for Financial Assets and Financial Liabilities: In February 2007, the FASB issued SFAS No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities—Including an Amendment of FASB Statement No. 115* ("SFAS No. 159"). SFAS No. 159 permits a company to choose to measure many financial instruments and certain other items at fair value at specified election dates. Most of the provisions in SFAS No. 159 are elective; however, it applies to all companies with available-for-sale and trading securities. A company will report unrealized gains and losses on items for which the fair value option has been elected in earnings at each subsequent reporting date. The fair value option: (a) may be applied instrument by instrument, with a few exceptions, such as investments otherwise accounted for by the equity method; (b) is irrevocable (unless a new election date occurs), and; (c) is applied only to entire instruments and not to portions of instruments. SFAS No. 159 is effective as of the beginning of a company's first fiscal year beginning after November 15, 2007. We chose not to elect the fair value option for our financial assets and financial liabilities existing at January 1, 2008, and did not elect the fair value option on financial assets and financial liabilities transacted subsequent to that time. Therefore, the adoption of SFAS No. 159 had no impact on our results of operations or financial position.

Business Combinations: In December 2007, the FASB issued SFAS No. 141 (revised 2007) *Business Combinations* ("SFAS No. 141R"). SFAS No. 141R establishes principles and requirements for how the acquirer of

a business recognizes and measures in its financial statements the identifiable assets acquired, the liabilities assumed, and any noncontrolling interest in the acquiree. SFAS No. 141R also provides guidance for recognizing and measuring the goodwill acquired in the business combination and determines what information to disclose to enable users of the financial statements to evaluate the nature and financial effects of the business combination. SFAS No. 141R applies prospectively to business combinations for which the acquisition date is on or after the beginning of the first annual reporting period beginning on or after December 15, 2008. We are currently evaluating the potential impact, if any, of the adoption of SFAS No. 141R on our consolidated financial statements.

Noncontrolling Interests in Consolidated Financial Statements: In December 2007, the FASB issued SFAS 160, *Noncontrolling Interests in Consolidated Financial Statements—an amendment of ARB No. 51* ("SFAS No. 160"). SFAS No. 160 establishes accounting and reporting standards for the noncontrolling interest in a subsidiary and for the deconsolidation of a subsidiary. It clarifies that a noncontrolling interest in a subsidiary is an ownership interest in the consolidated entity that should be reported as equity in the consolidated financial statements. SFAS No. 160 is effective for fiscal years, and interim periods within those fiscal years, beginning on or after December 15, 2008. SFAS No. 160 requires retroactive adoption of the presentation and disclosure requirements for existing minority interests. All other requirements of SFAS No. 160 shall be applied prospectively. We are currently evaluating the potential impact of the adoption of SFAS No. 160 on our consolidated financial statements.

Disclosures about Derivative Instruments and Hedging Activities: In March 2008, the FASB issued Statement of Financial Accounting Standards No. 161, *Disclosures about Derivative Instruments and Hedging Activities, an amendment of FASB Statement No. 133* ("SFAS No. 161"). This statement is intended to improve transparency in financial reporting by requiring enhanced disclosures of an entity's derivative instruments and hedging activities and their effects on the entity's financial position, financial performance, and cash flows. SFAS No. 161 applies to all derivative instruments within the scope of SFAS No. 133 as well as related hedged items, bifurcated derivatives, and nonderivative instruments that are designated and qualify as hedging instruments. Entities with instruments subject to SFAS No. 161 must provide expanded qualitative and quantitative disclosures. SFAS No. 161 is effective prospectively for financial statements issued beginning after November 15, 2008, with early application permitted. Our adoption of this statement will result in changes related to presentation and disclosure of our interest rate swaps and will not affect our results of operations.

Determination of the Useful Life of Intangible Assets: In April 2008, the FASB issued FASB Staff Position 142-3 ("FSP 142-3"), *Determination of the Useful Life of Intangible Assets.* FSP 142-3 amends the factors that should be considered in developing renewal or extension assumptions used to determine the useful life of a recognized intangible asset under SFAS No. 142*, Goodwill and Other Intangible Assets*. FSP 142-3 is effective for fiscal years beginning after December 15, 2008. We do not currently expect the adoption of FSP 142-3 to have a material impact on our consolidated financial statements.

The Hierarchy of Generally Accepted Accounting Principles: In May 2008, the FASB issued Statement of Financial Accounting Standard No. 162, *The Hierarchy of Generally Accepted Accounting Principles* ("SFAS 162"). SFAS 162 clarifies the sources of accounting principles and the framework to be followed in preparing financial statements in conformity with generally accepted accounting principles in the United States. We do not expect this standard to impact our consolidated financial statements.

Determining Whether Instruments Granted in Share-Based Payment Transactions Are Participating Securities: In June 2008, FASB issued FSP No. EITF 03-6-1, *Determining Whether Instruments Granted in Share-Based Payment Transactions Are Participating Securities*. The FSP concludes that unvested share-based payment awards that contain nonforfeitable rights to dividends are participating securities under FASB No. 128, *Earnings Per Share* and should be included in the computation of earnings per share under the two-class method. The two-class method is an earnings allocation formula that we currently use to determine earnings per share for each class of common stock according to dividends declared and participation rights in undistributed earnings. We do not expect that the adoption of this FSP, effective January 1, 2009, will have a material impact on our results of operations or financial position.

2) ACQUISITIONS AND DIVESTITURES

Year ended December 31, 2008:

2008 Acquisitions of Assets and Businesses:

During 2008, we spent $23 million on the acquisition of businesses and real property, including the following:

- the acquisition of a 76-bed behavioral health facility located in Lawrenceville, Georgia, and;
- the acquisition of previously leased real property assets of a behavioral health facility located in Nevada.

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	$ (1,000)
Property, plant & equipment	13,000
Goodwill	11,000
Cash paid in 2008 for acquisitions	$23,000

Goodwill of the facilities acquired during each of the last there years 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.

Assuming the acquisition of the behavioral health facility located in Georgia occurred on January 1, 2008, the pro forma effect on our 2008 net revenues, income from continuing operations, income from continuing operations per basic and diluted share, net income and net income per basic and diluted share was immaterial. Assuming the acquisition occurred on January 1, 2007, the pro forma effect on our 2007 net revenues, income from continuing operations, income from continuing operations per basic and diluted share, net income and net income per basic and diluted share was immaterial.

Also during 2008, we spent a combined $2 million to purchase/repurchase minority ownership interests in two outpatient surgery centers. We also received $2 million of net settlement proceeds related to a prior year acquisition.

2008 Divestiture of Assets and Businesses:

During 2008, we received $82 million from the divestiture of assets and businesses, including the following:

- the sale of the assets and operations of Central Montgomery Medical Center, a 125-bed acute care facility located in Lansdale, Pennsylvania;
- the sale of our ownership interest in a third-party provider of supply chain services, and;
- the sale of our ownership interest in an outpatient surgery center and certain other real property assets.

The operating results and gain on divestiture of Central Montgomery Medical Center are reflected as “Income/(loss) from discontinued operations, net of income taxes”, on the Consolidated Statements of Income for each period presented. Also during 2008, we commenced divestiture considerations for the real property of our four acute care facilities located in Louisiana that were severely damaged and closed during 2005 as a result

of damage sustained from Hurricane Katrina. The hurricane insurance recoveries in excess of expenses recorded during 2006 in connection with these facilities located in Louisiana, are reflected as "Income/(loss) from discontinued operations, net of income taxes" in the Consolidated Statements of Income for each period presented. See Note 13-*Impact of Hurricane Katrina* for additional disclosure.

The following table shows the results of operations, on a combined basis, for all facilities reflected as discontinued operations (amounts in thousands):

	Year Ended December 31,		
	2008	2007	2006
Net revenues	$58,467	$67,887	$ 66,823
(Loss)/income before hurricane recoveries in excess of expenses, minority interests, gain on divestitures and income taxes	$ (2,996)	$ (398)	$ 1,371
Hurricane insurance recoveries in excess of expenses	—	—	167,229
Minority interests in earnings of consolidated entities	—	(13)	(8,762)
Gain on divestiture	13,413	—	—
Income/(loss) from discontinued operations, before income taxes	10,417	(411)	159,838
Income tax (expense)/benefit	(3,981)	156	(59,580)
Income/(loss) from discontinued operations, net of income taxes	$ 6,436	$ (255)	$100,258

In addition, our 2008 income from continuing operations includes a combined pre-tax gain of $8 million from the sale of our ownership interest in a third-party provider of supply chain services and the sale our ownership interest in an outpatient surgery center and certain other real property assets.

Year ended December 31, 2007:

2007 Acquisitions of Assets and Businesses:

During 2007, we spent $102 million on the acquisition of businesses and real property, including the following:

- the acquisition of certain assets of Texoma Healthcare System located in Texas, including a 153-bed acute care hospital, a 60-bed behavioral health hospital, a 21-bed freestanding rehabilitation hospital and TexomaCare, a 34-physician group practice structured as a 501A corporation (acquired on January 1, 2007);
- the acquisition of previously leased real property assets of a behavioral health facility located in Ohio;
- the acquisition of a 52-bed behavioral health facility located in Delaware;
- the acquisition of a 102-bed behavioral health facility located in Pennsylvania;
- the acquisition of a 78-bed behavioral health facility located in Utah, and;
- the non-cash acquisition of a 40% ownership interest in a limited partnership that owns a now closed surgical hospital in Laredo, Texas (we previously owned a non-controlling, 50% ownership interest in the limited partnership) in exchange for a 10% minority ownership interest in a limited partnership that owns the real property of the closed surgical hospital as well as the real property and operations of a 180-bed acute care facility in Laredo, Texas.

In connection with our January, 2007 acquisition of certain assets of Texoma Healthcare System located in Denison, Texas, including the 153-bed acute-care hospital, we are committed to build a 220-bed replacement facility within three years of the closing date. As of December 31, 2008, we have spent $27 million in connection with construction of this replacement facility which we expect to cost approximately $136 million.

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	$ 15,000
Property, plant & equipment	76,000
Goodwill	34,000
Other assets	1,000
Debt	(15,000)
Other liabilities	(1,000)
Minority interests	(8,000)
Cash paid in 2007 for acquisitions	$102,000

Assuming all these acquisitions occurred on January 1, 2007, our 2007 pro forma net revenues would have been approximately $4.70 billion and the pro forma effect on our income from continuing operations, income from continuing operations per basic and diluted share, net income and net income per basic and diluted share was immaterial. Assuming these acquisitions occurred on January 1, 2006, our 2006 pro forma net revenues would have been approximately $4.30 billion and the pro forma effect on our income from continuing operations, income from continuing operations per basic and diluted share, net income and net income per basic and diluted share was immaterial.

Also during 2007, we spent $15 million to acquire the remaining 10% minority ownership interest in a limited liability company ("LLC") that owns Methodist Hospital and Lakeland Medical Pavilion located in Louisiana that were severely damaged and closed as a result of Hurricane Katrina. Pursuant to the terms of the LLC agreement, the third-party, minority member had certain "put rights" which they elected to exercise thereby requiring us to purchase their ownership interest at the minority member's initial contribution in each facility.

2007 Divestiture of Assets:

During 2007, we received $7 million of combined cash proceeds in connection with the sale of vacant property located in Texas and Kentucky.

Year ended December 31, 2006:

2006 Acquisitions of Assets and Businesses:

During 2006, we spent approximately $82 million on the acquisition of assets and/or businesses, including the following:

- the assets of two closed behavioral health care facilities located in Florida and Georgia which were/are being renovated and reopened/scheduled to be reopened either during 2008 (Florida) or during 2009 (Georgia);
- the assets of a 128-bed behavioral health facility in Utah;
- the assets of an 86-bed behavioral health facility in Colorado, which was renovated and opened in 2007;
- a medical office building in Nevada, and;
- the assets of a 77-bed behavioral health facility located in Kentucky.

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	$ 1,000
Property, plant & equipment	41,000
Goodwill	34,000
Other assets	10,000
Debt	(3,000)
Other liabilities	(1,000)
Cash paid in 2006 for acquisitions	$82,000

Assuming these acquisitions occurred on January 1, 2006, our 2006 pro forma net revenues would have been approximately $4.13 billion and the pro forma effect on our income from continuing operations, income from continuing operations per basic and diluted share, net income and net income per basic and diluted share was immaterial.

3) FINANCIAL INSTRUMENTS

Fair Value Hedges:

During 2008, 2007 and 2006, we had no fair value hedges outstanding.

Cash Flow Hedges:

Our interest expense is sensitive to changes in the general level of interest rates. To mitigate the impact of fluctuations in domestic interest rates, a portion of our debt is fixed rate accomplished by either borrowing on a long-term basis at fixed rates or by, from time to time, entering into interest rate swap transactions. Interest rate swap agreements require us to pay fixed and receive floating interest rates or to pay floating and receive fixed interest rates over the life of the agreements. We may also, from time to time, enter into treasury locks ("T-Locks") to protect from a rise in the yield of the underlying treasury security for a forecasted bond issuance.

During the fourth quarter of 2007, we entered into two interest rate swaps whereby we pay a fixed rate on a total notional principal amount of $150 million and receive 3-month LIBOR. Each of the two interest rate swaps has a notional principal amount of $75 million. The fixed rate payable on the first interest rate swap is 4.7625% and matures on October 5, 2012. The fixed rate payable on the second interest rate swap is 4.865% and the maturity date is October, 17, 2011. The notional amount of the second interest rate swap reduces to $50 million on October 18, 2010. As of December 31, 2006, there were no interest rate swaps outstanding.

4) LONG-TERM DEBT

A summary of long-term debt follows:

	December 31,	
	2008	2007
	(amounts in thousands)	
Long-term debt:		
Notes payable and Mortgages payable (including obligations under capitalized leases of $8,502 in 2008 and $6,513 in 2007) and term loans with varying maturities through 2019; weighted average interest at 5.3 % in 2008 and 6.7% in 2007 (see Note 7 regarding capitalized leases)	**$ 18,988**	$ 19,205
Revolving credit and demand notes	**303,300**	348,200
Revenue bonds, interest at floating rates of .8% and 3.4% at December 31, 2008 and 2007, respectively, with varying maturities through 2015	**5,300**	10,200
Accounts receivable securitization program	**70,000**	183,100
6.75% Senior Notes due 2011, net of the unamortized discount of $29 in 2008 and $40 in 2007, and fair market value adjustment of $1,778 in 2008 and $2,388 in 2007.	**201,749**	202,348
7.125% Senior Notes due 2016, including unamortized net premium of $32 in 2008 and net of unamortized discount of $1,151 in 2007	**400,032**	248,849
	999,369	1,011,902
Less-Amounts due within one year	**(8,708)**	(3,116)
	$990,661	$1,008,786

We have an $800 million, unsecured non-amortizing revolving credit agreement, as amended, ("Credit Agreement") which is scheduled to expire on July 28, 2011. In April, 2007, the Credit Agreement was amended to increase commitments from $650 million to $800 million. The Credit Agreement includes a $100 million sub-limit for letters of credit. The interest rate on the borrowings is determined, at our option, as either: (i) the one, two, three or six month London Inter-Bank Offer Rate ("LIBOR") plus a spread of 0.33% to 0.575%; (ii) the higher of the Agent's prime rate or the federal funds rate plus 0.50%, or; (iii) a competitive bid rate. A facility fee ranging from 0.07% to 0.175% is required on the total commitment. The applicable margins over LIBOR and the facility fee are based upon our credit ratings from Standard & Poor's Ratings Services and Moody's Investors Service, Inc. At December 31, 2008, the applicable margin over the LIBOR rate was 0.50% and the facility fee was 0.125%. There are no compensating balance requirements. As of December 31, 2008, we had $303 million of borrowings outstanding under our revolving credit agreement and $434 million of available borrowing capacity, net of $63 million of outstanding letters of credit. Outstanding borrowings pursuant to a short-term, on-demand credit facility which can be refinanced through available borrowings under the terms of our Credit Agreement are classified as long-term on our balance sheet. There were no borrowings outstanding under the short-term on-demand credit facility at December 31, 2008.

In August, 2007, we entered into a $200 million accounts receivable securitization program ("Securitization") with a group of conduit lenders and liquidity banks. The patient-related accounts receivable ("Receivables") for substantially all of our acute care hospitals serve as collateral for the outstanding borrowings. The interest rate on the borrowings is based on the commercial paper rate plus a spread of .35%. The initial term of this Securitization was 364 days and the term can be extended for incremental 364 day periods upon mutual agreement of the parties. The facility was extended for a second 364-day term in August, 2008. The Securitization has a term-out feature that can be exercised by us if the banks do not extend the Securitization which would extend the maturity date to August, 2010. Under the terms of the term-out provision, the borrowing rate would be the same as our Credit Agreement rate. Outstanding borrowings which can be refinanced through available borrowings under the terms of our Credit Agreement are classified as long-term on our balance sheet. We have accounted for this Securitization as borrowings under SFAS No. 140, "Accounting for Transfers and

Servicing of Financial Assets and Extinguishments of Liabilities". 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 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. As of December 31, 2008, we had $70 million of borrowings outstanding pursuant to this program and $130 million of available borrowing capacity.

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

During 2001, we issued $200 million of senior notes which have a 6.75% coupon rate and which mature on November 15, 2011. The interest on the senior notes is paid semiannually in arrears on May 15 and November 15 of each year. The senior notes can be redeemed in whole at any time and in part from time to time.

The average amounts outstanding during 2008, 2007 and 2006 under the revolving credit, demand notes and accounts receivable securitization program were $431 million, $435 million and $90 million, respectively, with corresponding effective interest rates of 3.9%, 6.0% and 6.4% including commitment and facility fees. The maximum amounts outstanding at any month-end were $566 million in 2008, $531 million in 2007 and $352 million in 2006. The effective interest rate on our revolving credit, demand notes and accounts receivable securitization program, including the respective interest expense/income on designated interest rate swaps, was 4.4% in 2008, 5.9% in 2007 and 6.4% in 2006.

On June 23, 2006, we exercised our right to redeem our convertible debentures due in 2020 (the "Debentures") at a price of $543.41 per $1,000 principal amount of Debenture. The aggregate issue price of the Debentures was $250 million or $587 million aggregate principal amount at maturity. The Debentures were issued at a price of $425.90 per $1,000 principal amount of Debenture. The Debentures' yield to maturity was 5% per annum, .426% of which was cash interest. The Debentures were convertible at the option of the holders into 11.2048 shares of our common stock per $1,000 of Debentures. We had the right to redeem the Debentures any time on or after June 23, 2006 at a price equal to the issue price of the Debentures plus accrued original issue discount and accrued cash interest to the date of redemption. During the second quarter of 2006, approximately 10% of the Debentures were redeemed or repurchased. We spent an aggregate of approximately $31 million to either redeem Debentures at a price of $543.41 per $1,000 principal amount of Debenture or repurchase Debentures on the open market. In late June of 2006, approximately 90% of the holders converted their Debentures into 5.9 million shares of our Class B Common Stock. In connection with this conversion, we reclassified approximately $288 million of long-term debt to capital in excess of par.

Our revolving credit agreement includes a material adverse change clause that must be represented at each draw. The facility also requires compliance with maximum debt to capitalization and minimum fixed charge coverage ratios. We are in compliance with all required covenants as of December 31, 2008.

The fair value of our long-term debt at December 31, 2008 and 2007 was approximately $924 million and $1.05 billion, respectively.

Aggregate maturities follow:

	(000s)
2009	$ 8,708
2010	3,073
2011	576,265
2012	985
2013	1,043
Later	409,295
Total	$999,369

5) COMMON STOCK

Dividends

Cash dividends of $.32 per share ($16.2 million in the aggregate) were declared and paid during 2008, $.32 per share ($17.2 million in the aggregate) were declared and paid during 2007 and $.32 per share ($17.4 million in the aggregate) were declared and paid during 2006.

Stock Repurchase Programs

During 1999, 2004, 2005, 2006 and 2007, our Board of Directors approved stock repurchase programs authorizing us to purchase up to an aggregate of 21.5 million shares of our outstanding Class B Common Stock on the open market at prevailing market prices or in negotiated transactions off the market. There is no expiration date for our stock repurchase program. The following schedule provides information related to our stock repurchase program for each of the three years ended December 31, 2008:

	Additional Shares Authorized For Repurchase	Total number of shares purchased(a)	Average price paid per share for forfeited restricted shares	Total Number of shares purchased as part of publicly announced programs	Average price paid per share for shares purchased as part of publicly announced program	Aggregate purchase price paid (in thousands)	Maximum number of shares that may yet be purchased under the program
Balance as of January 1, 2006							3,603,320
2006	5,000,000	6,536,240	$0.01	6,527,155	$53.68	$350,372	2,076,165
2007	5,000,000	1,462,537	$0.01	1,451,073	$51.06	$ 74,091	5,625,092
2008	—	3,293,568	$0.01	3,268,318	$45.71	$149,404	2,356,774
Total for three year period ended December 31, 2008	10,000,000	11,292,345	$0.01	11,246,546	$51.03	$573,867	

(a.) Includes 9,085, 11,464 and 25,250 restricted shares that were forfeited by former employees pursuant to the terms of our restricted stock purchase plan during 2006, 2007 and 2008, respectively.

Stock-based Compensation Plans

At December 31, 2008, we have a number of stock-based employee compensation plans. Effective January 1, 2006, we adopted SFAS No. 123R ("123R") and related interpretations and began expensing the grant-date fair value of stock options and other equity-based compensation. 123R also generally requires that a company account for these transactions using the fair-value based method and eliminates a company's ability to account for share-based compensation transactions using the intrinsic value method of accounting provided in APB Opinion No. 25, "Accounting for Stock Issued to Employees," which was permitted under Statement No. 123, as originally issued.

Compensation costs related to outstanding stock options were recognized as follows: (i) a pre-tax charge of $10.4 million ($6.4 million after-tax) or $.13 per diluted share during 2008; (ii) a pre-tax charge of $8.8 million ($5.5 million after-tax) or $.10 per diluted share during 2007, and; (iii) a pre-tax charge of $7.4 million ($4.6 million after-tax) or $.08 per diluted share during 2006. In addition, during the years ended 2008, 2007 and 2006, compensation costs of $3.4 million ($2.1 million after-tax), $7.8 million ($4.8 million after-tax) and $6.1 million ($3.8 million after-tax), respectively, were recognized related to restricted stock.

We adopted the 2005 Stock Incentive Plan, as amended in 2008, (the "Stock Incentive Plan") which replaced our Amended and Restated 1992 Stock Option Plan which expired in July of 2005. An aggregate of seven million shares of Class B Common Stock has been reserved under the Stock Incentive Plan. There were 1,445,000, 1,266,500 and 948,250 stock options, net of cancellations, granted during 2008, 2007 and 2006, respectively. The per option weighted-average grant-date fair value of options granted during 2008, 2007 and 2006 was $6.13, $9.39 and $16.07, respectively. Stock options to purchase Class B Common Stock have been granted to our officers, key employees and directors under our above referenced stock option plans. 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.

Compensation cost related to stock options is recognized under the straight-line method over the stated vesting period of the award. The fair value of each option grant was estimated on the date of grant using the Black-Scholes option-pricing model with the following weighted average assumptions derived from averaging the number of options granted during the most recent five-year period that were granted or have vestings after January 1, 2006. The 2006 weighted-average assumptions were based upon twenty-four option grants and each of the 2007 and 2008 weighted-average assumptions were based upon twenty-two option grants.

Year Ended December 31,	2008	2007	2006
Volatility	**28%**	31%	39%
Interest rate	**3%**	4%	4%
Expected life (years)	**3.6**	3.7	3.9
Forfeiture rate	**10%**	6%	6%
Dividend yield	**0.7%**	0.6%	0.5%

The risk-free rate is based on the U.S. Treasury zero coupon four year yield in effect at the time of grant. The expected life of the stock options granted was estimated using the historical behavior of employees. Expected volatility was based on historical volatility for a period equal to the stock option's expected life. Expected dividend yield is based on our actual 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, 2006	1,506,325	$46.39	$54.88 - $37.82
Granted	1,159,000	$58.17	$58.52 - $50.65
Exercised	(265,900)	$41.51	$52.12 - $37.82
Cancelled	(140,375)	$49.28	$58.52 - $38.50
Balance, January 1, 2007	2,259,050	$52.83	$58.52 - $38.50
Granted	1,349,500	$49.17	$59.78 - $48.89
Exercised	(230,525)	$43.07	$54.88 - $38.50
Cancelled	(197,550)	$54.56	$58.52 - $45.14
Balance, January 1, 2008	3,180,475	$51.88	$59.78 - $38.50
Granted	1,445,000	$32.99	$63.40 - $32.44
Exercised	(380,337)	$49.51	$59.78 - $38.50
Cancelled	(186,975)	$52.44	$58.52 - $45.14
Balance, December 31, 2008	4,058,163	$45.35	$63.40 - $32.44
Outstanding options vested and exercisable as of December 31, 2008	1,025,250	$52.76	$59.78 - $43.08

The following table provides information about unvested options for the year December 31, 2008:

	Shares	Weighted Average Grant Date Fair Value
Unvested options as of January 1, 2008	2,508,825	$12.49
Granted	1,445,000	$ 6.13
Vested	(751,562)	$13.27
Cancelled	(169,350)	$12.60
Unvested options as of December 31, 2008	3,032,913	$ 9.26

The following table provides information about all outstanding options, and exercisable options, at December 31, 2008:

	Options Outstanding	Options Exercisable
Number	4,058,163	1,025,250
Weighted average exercise price	$ 45.35	$ 52.76
Aggregate intrinsic value as of December 31, 2008	$7,238,430	$ —
Weighted average remaining contractual life	3.7	2.6

The total in-the-money value of all stock options exercised during the year ended December 31, 2008 was $4.7 million.

The weighted average remaining contractual life for options outstanding and weighted average exercise price per share for exercisable options at December 31, 2008 were as follows:

	Options Outstanding			Exercisable Options		Expected to Vest Options(a)	
Exercise Price	Shares	Weighted Average Exercise Price Per Share	Weighted Average Remaining Contractual Life (in Years)	Shares	Weighted Average Exercise Price Per Share	Shares	Weighted Average Exercise Price Per Share
$32.44 – $43.48	1,423,800	$32.54	4.9	12,800	$43.39	1,273,710	$32.44
$47.80 – $52.12	1,731,238	49.01	3.2	596,575	48.96	1,024,260	49.03
$56.26 – $63.40	903,125	58.53	2.7	415,875	58.49	439,841	58.56
Total	4,058,163	$45.35	3.7	1,025,250	$52.76	2,737,811	$42.84

a. Assumes a weighted average forfeiture rate of 9.7%.

In addition to the Stock Incentive Plan, we have the following stock incentive and purchase plans: (i) a Second Amended and Restated 2001 Employees' Restricted Stock Purchase Plan ("2001 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 58,957, 42,094 and 47,975 shares issued pursuant to the Employee Stock Purchase Plan during 2008, 2007 and 2006, respectively. Compensation expense recorded in connection with this plan was $328,000, $320,000 and $259,000 during 2008, 2007 and 2006, respectively.

We have reserved 2.2 million shares of Class B Common Stock for issuance under these various plans (excluding terminated plans) and have issued approximately 652,000 shares, net of cancellations, pursuant to the terms of these plans (excluding terminated plans) as of December 31, 2008, of which 148,200 became fully vested during 2008, 194,064 became fully vested during 2007 and 103,143 became fully vested during 2006.

During the first quarter of 2008, pursuant to the 2001 Plan, the Compensation Committee of the Board of Directors (the "Committee") approved the issuance of 31,095 restricted shares of our Class B Common Stock at $48.24 per share ($1.5 million in the aggregate) to our Chief Executive Officer ("CEO") and Chairman of the Board. These shares, which were issued pursuant to a provision in our CEO's employment agreement, are scheduled to vest ratably on the first, second, third and fourth anniversary dates of the grant, assuming our CEO remains employed by us. In the event that our CEO's employment is terminated by reason of disability, death, without proper cause or due to breach of the CEO's employment agreement by us, the vesting of these awards will occur immediately. In connection with this grant, we recorded compensation expense of $360,000 during 2008 and the remaining expense associated with this award (estimated at $1.1 million as of December 31, 2008) will be recorded over the remaining vesting periods of the award.

During the fourth quarter of 2007, pursuant to the 2001 Plan, the Committee approved the issuance of 30,681 restricted shares of our Class B Common Stock at $48.89 per share ($1.5 million in the aggregate) to our CEO. These shares are scheduled to vest ratably on the first, second, third and fourth anniversary dates of the grant and are subject to the same conditions and terms as mentioned above in connection with the grant of restricted shares during the first quarter of 2008. 7,670 of these shares became fully vested in 2008. In connection with this grant, we recorded compensation expense of $375,000 during 2008 and $42,000 during 2007 and the remaining expense associated with this award (estimated at $1.1 million as of December 31, 2008) will be recorded over the remaining vesting periods of the award.

Additionally, during 2007, pursuant to the 2001 Plan, the Committee approved the issuance of 11,125 restricted shares of our Class B Common stock at a weighted average of $59.24 per share ($659,000 in the aggregate) to various employees. These shares have various vesting schedules. We recorded compensation expense of $135,000 during 2008 and $93,000 during 2007 in connection with these grants and the remaining expense associated with these awards (estimated at $430,000 as of December 31, 2008) will be recorded over the remaining vesting periods of the awards, assuming the recipients remain employed by us.

During the fourth quarter of 2006, pursuant to the 2001 Plan, the Committee approved the issuance of 133,500 restricted shares (net of cancellations) of our Class B Common Stock at $51.42 per share ($6.9 million in the aggregate) to various officers and employees. These shares are scheduled to vest in November, 2010. In connection with this grant, we recorded compensation expense of $1.4 million during 2008, $2.0 million during 2007 and $270,000 during 2006 and the remaining expense associated with this award (estimated at $3.2 million as of December 31, 2008) will be recorded over the remaining vesting periods of the award, assuming the recipients remain employed by us.

In March 2006, the Committee approved the issuance of 200,000 restricted shares of our Class B Common Stock at $48.05 per share ($9.6 million in the aggregate) to our CEO, pursuant to the 2001 Plan. Subject to the achievement of a specified earnings per share from continuing operations during 2006, as defined, 50% of the shares of restricted stock were scheduled to vest on each of March 15, 2007 and March 15, 2008, if our CEO remains employed by us through each applicable vesting date. The specified earnings per share from continuing operations threshold was achieved during 2006, and therefore 100,000 of these restricted shares became fully vested during March, 2007 and the remaining 100,000 shares of these restricted stock became fully vested during March, 2008. In connection with this grant, we recorded compensation expense of $1.0 million during 2008, $4.8 million during 2007 and $3.8 million during 2006.

In March 2005, our CEO was granted 319,340 restricted shares of our Class B Common Stock, pursuant to the 2001 Plan, which were scheduled to vest ratably on the first, second and third anniversary dates of the award, subject to the satisfaction of certain performance criteria. 200,000 of the restricted shares were subject to forfeiture in the event the Company did not achieve specified earnings per share from continuing operations for 2005, and the remaining 119,340 restricted shares were subject to forfeiture in the event that the Company did not achieve a specified return of capital for 2005. 200,000 shares of restricted stock were forfeited in March, 2006 as a result of the Company's failure to achieve the 2005 earnings per share from continuing operations target required under the terms of the original grant of restricted stock. The Company did achieve the specified return of capital threshold

during 2005 and, therefore, in March 2008, 2007 and 2006, 39,780 shares (in each year), of the 119,340 shares of restricted stock vested. During 2008, 2007 and 2006, compensation expense of $125,000, $800,000 and $1.9 million, respectively, associated with the 119,340 restricted shares has been recorded.

At December 31, 2008, 12,394,341 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.

In connection with the long-term incentive plans described above, we recorded compensation expense of $3.7 million in 2008, $8.1 million in 2007 and $6.4 million in 2006. Including the stock option related compensation expense recorded pursuant to 123R, of $10.4 million in 2008, $8.8 million in 2007 and $7.4 million in 2006, we recorded total stock compensation expense of $14.1 million in 2008, $16.9 million in 2007 and $13.8 million in 2006.

6) INCOME TAXES

Components of income tax expense/(benefit) from continuing operations are as follows (amounts in thousands):

	Year Ended December 31,		
	2008	2007	2006
Current			
Federal	$126,222	$ 89,946	$106,400
Foreign	—	—	(2,900)
State	22,230	12,769	11,100
	$148,452	$102,715	$114,600
Deferred			
Federal and foreign	(22,814)	4,633	(18,151)
State	(2,260)	(2,723)	(3,231)
	(25,074)	1,910	(21,382)
Total	$123,378	$104,625	$ 93,218

We account for income taxes under the provisions of Statement of Financial Accounting Standards No. 109, "Accounting for Income Taxes," ("SFAS 109"). Under SFAS 109, 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,	
	2008	2007
Deferred income tax assets:		
Self-insurance reserves	$ 118,836	$ 112,412
Compensation accruals	27,279	27,848
Other deferred tax assets	81,308	42,546
	$ 227,423	$ 182,806
Less: Valuation Allowance	$ (29,788)	$ (24,979)
Net deferred income tax assets:	$ 197,635	$ 157,827
Deferred income tax liabilities:		
Doubtful accounts and other reserves	$ (18,875)	$ (18,162)
Depreciable and amortizable assets	(156,677)	(156,534)
Net deferred income tax assets (liabilities)	$ 22,083	$ (16,869)

A reconciliation between the federal statutory rate and the effective tax rate on continuing operations is as follows:

	Year Ended December 31,		
	2008	2007	2006
Federal statutory rate	35.0%	35.0%	35.0%
State taxes, net of federal income tax benefit	4.1	2.3	2.0
Other items	(0.1)	0.7	(0.1)
Effective tax rate	39.0%	38.0%	36.9%

The net deferred tax assets and liabilities are comprised as follows (amounts in thousands):

	Year Ended December 31,	
	2008	2007
Current deferred taxes		
Assets	$ 51,460	$ 40,835
Liabilities	(16,938)	(17,682)
Total deferred taxes-current	$ 34,522	$ 23,153
Noncurrent deferred taxes		
Assets	$ 146,174	$ 116,992
Liabilities	(158,613)	(157,014)
Total deferred taxes-noncurrent	(12,439)	(40,022)
Total deferred tax assets (liabilities)	$ 22,083	$ (16,869)

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, 2008, state net operating loss carryforwards (expiring in years 2009 through 2028), and credit carryforwards available to offset future taxable income approximated $438 million, representing approximately $25.4 million in deferred state tax benefit (net of the federal benefit).

Under SFAS 109, 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 $29.8 million and $25.0 million have been reflected as of December 31, 2008 and 2007, respectively. During 2008, the valuation allowance on these state tax benefits increased by $4.8 million.

We have reflected a tax benefit of $2.9 million in the year ended December 31, 2006 for reductions to our tax exposure reserves due to the expiration of the statute of limitations in a foreign jurisdiction.

In July, 2006, the FASB issued Interpretation No. 48 (“FIN 48”), *Accounting for Uncertainty in Income Taxes*. FIN 48 prescribes detailed guidance for the financial statement recognition, measurement and disclosure of uncertain tax positions recognized in an enterprise’s financial statements in accordance with FASB Statement No. 109, *Accounting for Income Taxes*. FIN 48 also prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. Tax positions must meet a more-likely-than-not recognition threshold at the effective date to be recognized upon the adoption of FIN 48 and in subsequent periods. FIN 48 is effective for fiscal years beginning after December 15, 2006 and the provisions of FIN 48 are applied to all tax positions accounted for under Statement No. 109 upon initial adoption. The cumulative effect of applying the provisions of FIN 48 is reported as an adjustment to the opening balance of retained earnings for that fiscal year.

We adopted the provisions of FIN 48 effective January 1, 2007. As a result of the implementation of FIN 48, we recognized a $12 million decrease in the liability for unrecognized tax benefits. This decrease in the liability resulted in an increase to the January 1, 2007 balance of retained earnings of approximately $12 million. As of January 1, 2007, after the implementation of FIN 48, our unrecognized tax benefits were approximately $6 million. The amount at implementation, that would favorably affect the effective tax rate and provision for income taxes was approximately $4 million, approximately $3 million of which was recorded during 2007. The balance as of December 31, 2008 and 2007, if subsequently recognized, that would favorably affect the effective tax rate and provision for income taxes is approximately $2 and $1 million, respectively.

During 2008, the estimated liabilities for uncertain tax positions (including accrued interest and penalties) were increased in the amount of approximately $2 million due to tax positions taken in the current and prior years. Also during 2008, 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. During 2007, the estimated liabilities for uncertain tax positions (including accrued interest and penalties) were reduced due to the lapse of the statue of limitations and the conclusions of income tax audits of varying taxing authorities resulting in a net income tax benefit of approximately $2 million.

We recognize accrued interest and penalties associated with uncertain tax positions as part of the tax provision. As of December 31, 2008 and 2007, we have approximately $1 million of accrued interest and penalties. The U.S. federal statute of limitations remains open for the 2005 and subsequent years. The IRS has recently commenced an audit for the tax year ended December 31, 2006. 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 year ended December 31, 2008 and 2007 is a follows (amounts in thousands).

	Year Ended December 31,	
	2008	2007
Balance at January 1,	$ 2,450	$ 6,180
Gross amount of increase and decrease in unrecognized tax benefits as a result of tax positions taken in the prior years	1,641	375
Gross amount of increase and decrease in unrecognized tax benefits as a result of tax positions taken in the current year	750	—
Amount of decrease in unrecognized tax benefits as a result of settlement	—	(906)
Amount of decrease in unrecognized tax benefits as a lapse in statute	(1,082)	(3,199)
Balance at December 31,	$ 3,759	$ 2,450

7) LEASE COMMITMENTS

Certain of our hospital facilities are held under operating leases with Universal Health Realty Income Trust with terms expiring in 2011 through 2014 (see Note 9). Certain of these leases also contain provisions allowing us to purchase the leased assets during the term or at the expiration of the lease at fair market value.

A summary of property under capital lease follows (amounts in thousands):

	Year Ended December 31,	
	2008	2007
Land, buildings and equipment	$ 40,880	$ 38,584
Less: accumulated amortization	(37,363)	(35,446)
	$ 3,517	$ 3,138

Future minimum rental payments under lease commitments with a term of more than one year as of December 31, 2008, are as follows (amounts in thousands):

Year	Capital Leases	Operating Leases
	(000s)	
2009	$ 2,498	$ 40,258
2010	2,206	32,870
2011	1,115	29,582
2012	981	15,971
2013	981	12,755
Later Years	4,494	13,920
Total minimum rental	$12,275	$145,356
Less: Amount representing interest	(3,773)	
Present value of minimum rental commitments	8,502	
Less: Current portion of capital lease obligations	(2,045)	
Long-term portion of capital lease obligations	$ 6,457	

In the ordinary course of business, our facilities routinely lease equipment pursuant to month-to-month lease arrangements that will likely result in future lease & rental expense in excess of the amounts indicated above. Capital lease obligations of $3.4 million in 2008, $6.8 million in 2007 and $100,000 in 2006 were incurred when we assumed capital lease obligations upon the acquisition of facilities or entered into capital leases for new equipment.

8) COMMITMENTS AND CONTINGENCIES

Professional and General Liability Claims and Property Insurance

Effective January 1, 2008, most of our subsidiaries became self-insured for malpractice exposure up to $10 million per occurrence, as compared to $20 million per occurrence in the prior year. We purchased several excess policies through commercial insurance carriers which provide for coverage in excess of $10 million up to $195 million per occurrence and in the aggregate. However, we are liable for 10% of the claims paid pursuant to the commercially insured coverage in excess of $10 million up to $60 million per occurrence and in the aggregate.

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. 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 claims asserted against us will not have a material adverse effect on our future results of operations.

As of December 31, 2008, the total accrual for our professional and general liability claims was $272 million ($271 million net of expected recoveries from state guaranty funds) of which $42 million is included in other current liabilities. As of December 31, 2007, the total accrual for our professional and general liability claims was $258 million ($256 million net of expected recoveries from state guaranty funds), of which $32 million is included in other current liabilities. As a result of a commercial insurer's liquidation in 2002, we became liable for unpaid claims related to our facilities, some of which remain outstanding as of December 31, 2008. The reserve for the estimated future claims payments for these outstanding liabilities is included in the accrual for our professional and general liability claims as of December 31, 2008.

For the years of 1998 through 2001, most of our subsidiaries were covered under commercial insurance policies with PHICO, a Pennsylvania based insurance company that was placed into liquidation in February, 2002. As a result, although PHICO continued to be liable for claims on our behalf that were related to 1998 through 2001, we began paying the claims upon PHICO's liquidation. Since that time, although we preserved our right to receive reimbursement from the PHICO estate, we were not previously able to assess the probability of collection or reasonably quantify our share of the liquidation proceeds. In January, 2009, a court order from the Commonwealth Court of Pennsylvania was executed in connection with the partial liquidation of the PHICO estate. As a result, during the fourth quarter of 2008, based upon our share of the undisputed and resolved claims made against the PHICO estate as of a specified date and as approved by the liquidator to the court, we recorded a $10 million reduction to our professional and general liability self-insured claims expense. Since we received these liquidation proceeds during the first quarter of 2009, the $10 million reimbursement from the PHICO estate is included in accounts receivable, net, as of December 31, 2008. We are also entitled to receive reimbursement from state guaranty funds for certain claims paid by us. Included in other assets was $1 million as of December 31, 2008 and $2 million as of December 31, 2007 related to estimated expected recoveries from various state guaranty funds in connection with payment of these claims.

Effective April 1, 2008, we have commercial property insurance policies covering catastrophic losses resulting from windstorm damage up to a $1 billion policy limit per occurrence. Losses resulting from non-named windstorms are subject to a $250,000 deductible. Losses resulting from named windstorms are subject to a 5% deductible based upon the declared 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, except for facilities in Alaska, California and the New Madrid (which includes certain counties located in Arkansas, Illinois, Kentucky, Mississippi, Missouri and Tennessee) and Pacific Northwest Seismic Zones which are subject to a $100 million limitation. The earthquake limit in Puerto Rico is $25 million. Earthquake losses are subject to a $250,000 deductible for our facilities located in all states except California, Alaska, Washington and Puerto Rico where earthquake losses are subject to a 5% deductible based upon the declared value of the property. Flood losses have a $250,000 deductible except in FEMA designated flood zones A and V (which are located in certain sections of Florida, Oklahoma and Texas) in which case the losses are subject to a $500,000 deductible. Due to an increase in property losses experienced nationwide in recent years, the cost of commercial property insurance has increased. As a result, catastrophic coverage for earthquake and flood has been limited to annual aggregate losses (as opposed to per occurrence losses). Given these insurance market conditions, there can be no assurance that a continuation of these unfavorable trends, or a sharp increase in uninsured property losses sustained by us, will not have a material adverse effect on our future results of operations.

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.

Investigation of South Texas Health System affiliates:

We and our South Texas Health System affiliates, which operate McAllen Medical Center, McAllen Heart Hospital, Edinburg Regional Medical Center and certain other affiliates, were served with a subpoena dated

November 21, 2005, issued by the Office of Inspector General of the Department of Health and Human Services ("OIG"). At that time, the Civil Division of the U.S. Attorney's office in Houston, Texas indicated that the subpoena was part of an investigation under the False Claims Act regarding compliance with Medicare and Medicaid rules and regulations pertaining to the employment of physicians and the solicitation of patient referrals from physicians from January 1, 1999 to the date of the subpoena, related to the South Texas Health System. Documents were produced on a rolling basis pursuant to this subpoena and several additional requests, including an additional March 9, 2007 subpoena, beginning in January of 2006. On February 16, 2007, our South Texas Health System affiliates were served with a search warrant in connection with what we were advised was a related criminal Grand Jury investigation concerning the production of documents. At that time, the government obtained various documents and other property related to the facilities. Follow-up Grand Jury subpoenas for documents and witnesses and other requests for information were subsequently served on South Texas Health System facilities and certain employees and former employees.

We have received notification from the U.S. Department of Justice ("DOJ") that, at this time, the DOJ will not be pursuing criminal prosecutive action against Universal Health Services, Inc. or our South Texas Health System affiliates. The DOJ is still investigating whether or not any individuals independently obstructed justice as it relates to the civil subpoena dated November 21, 2005. Our representatives have been advised that the Civil Division of the U.S. Attorney's office in Houston, Texas is continuing its investigation in connection with the civil subpoena dated November 21, 2005 issued by the OIG. Our legal representatives continue to meet with representatives of the Civil Division to discuss the status of this matter. We understand that, based on those discussions and its investigations to date, the government is focused on certain arrangements entered into by the South Texas Health System affiliates which, the government believes, may have violated Medicare and Medicaid rules and regulations pertaining to payments to physicians and the solicitation of patient referrals from physicians and other matters relating to payments to various individuals which may have constituted improper payments. We are cooperating with the investigations and are responding to the matters raised with us. We have been negotiating a possible settlement of this matter with the government. We expect to continue our discussions with the government to attempt to resolve this matter in a manner satisfactory to us and the government. During 2008, we recorded a pre-tax charge of $25 million to establish a reserve in connection with this matter. However, there is no assurance that a settlement can be reached, and, should a settlement be reached, we are unable at this time to determine the ultimate settlement amount. Should we be unable to ultimately reach a settlement, we are unable at this time to determine the extent of the total financial and/or other exposure to us in connection with this matter

Litigation and Administrative Appeal of CMS's Attempt to Terminate Medicare Participation of Two Rivers Psychiatric Hospital:

In late September, 2008, the Centers for Medicare and Medicaid Services ("CMS") issued a decision to terminate the participation in the Medicare program of Two Rivers Psychiatric Hospital ("Two Rivers"), a behavioral health facility operated by one of our affiliates in Kansas City. This decision was issued after state surveyors found Two Rivers to be allegedly out of compliance with the conditions of participation required for the Medicare program. Two Rivers filed an administrative appeal with the U.S. Department of Health and Human Services, Departmental Appeals Board, Civil Remedies Division, seeking review of that decision. In order to prevent CMS from terminating the facility from the program prior to a hearing in the administrative appeal, Two Rivers filed a complaint in the U.S. District Court for the Western District of Missouri against the Secretary, U.S. Department of Health and Human Services, seeking a temporary restraining order and preliminary injunction against CMS' proceeding with the termination. The Court issued a temporary restraining order in favor of Two Rivers, preventing CMS from terminating Two Rivers from the Medicare program and referring the case to a magistrate judge for a settlement conference prior to a hearing on the preliminary injunction motion. On December 12, 2008, CMS and Two Rivers entered into a settlement agreement under which CMS rescinded its termination action and Two Rivers withdrew the administrative appeal and stipulated to a dismissal of the federal court action. The settlement agreement provides, among other terms, that Two Rivers would retain a monitor for six months to: (a) evaluate Two Rivers' systems for compliance with the Medicare

conditions of participation; (b) make recommendations to Two Rivers based on the evaluation; (c) provide monthly reports to CMS and Two Rivers; and (d) notify CMS if conditions at Two Rivers present a serious threat to patient safety, health or welfare. The settlement agreement also provides that CMS and the Missouri state survey agency will resurvey Two Rivers on or before six and at twelve months after monitoring is initiated. Although Two Rivers is no longer being terminated by CMS from participation in the Medicare program, there is no assurance that during or after the monitoring period a new termination action would not be initiated by CMS should Two Rivers be found to be out of compliance with conditions of participation in Medicare, which could have a material adverse effect on us.

Investigation of Virginia Behavioral Health Facilities:

In late 2007 and again recently, the Office of Inspector General for the Department of Health and Human Services ("OIG") issued subpoenas to two of our facilities, Marion Youth Center and Mountain Youth Academy, seeking documents related to the treatment of Medicaid beneficiaries at the facilities. We believe that the OIG is investigating whether claims for reimbursement submitted by those facilities to the Virginia Medicaid program were supported by adequate documentation of the services provided.

On August 4, 2008, the Office of the Attorney General for the Commonwealth of Virginia issued a subpoena to Keystone Newport News, another of our facilities. We believe the Office of Attorney General is investigating whether Keystone Newport News complied with various Virginia laws and regulations, including documentation requirements.

In response to these subpoenas, we have been producing the requested documents on a rolling basis and we are cooperating with the investigations in all respects. We also have met with representatives of the OIG, the Virginia Attorney General, the United States Attorney for the Western District of Virginia, and the United States Department of Justice Civil Division to discuss a possible resolution of this matter. There is no assurance that we will be able to satisfactorily negotiate a resolution to this issue. At this time we are unable to evaluate the extent of any potential financial and/or other exposure in connection with this matter.

Ethridge v. Universal Health Services et. al:

In June, 2008, we and one of our acute care facilities, Lancaster Community Hospital, were named as defendants in a wage and hour lawsuit in Los Angeles County Superior Court. This is a purported class action lawsuit alleging that the hospital failed to provide sufficient meal and break periods to certain employees. We have denied liability and are defending the case vigorously which has not yet been certified as a class action by the court. Given the early stage of this case and the uncertainty of the nature, legal viability and extent of the claims, we are unable to determine the extent of potential financial exposure at this time. Further, some of the issues in this lawsuit may have been settled by a previous settlement related to a previously filed class action wage and hour suit against the hospital.

The healthcare industry is subject to numerous laws and regulations which include, among other things, matters such as government healthcare participation requirements, various licensure 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. Providers that are found to have violated these laws and regulations may be excluded from participating in government healthcare programs, 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, from time to time, we are subjected to inquiries or actions with respect to

our facilities. 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 above. Even if we were to ultimately prevail, such inquiries and/or actions could have a material adverse effect on us.

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.

Other

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, 2008 as follows: (i) combined estimated future construction commitments of $180 million related to the construction of a new 171-bed acute care facility located in Palmdale, California ($71 million) and a commitment to build a new 220-bed acute care replacement hospital in connection with our January, 2007 acquisition of Texoma Healthcare System located in Texas ($109 million); (ii) other combined estimated future purchase obligations of $137 million related to a long-term contract with a third-party to provide certain data processing services and laboratory information system and order management technology for our acute care facilities ($125 million), estimated minimum liabilities for physician commitments recorded in connection with the adoption of Interpretation No. 45-3, "Application of FASB Interpretation No. 45 to Minimum Revenue Guarantees Granted to Business or Its Owners" ($10 million), and the remaining commitment in connection with the funding of a portion of our Chief Executive Officer's gift to the College of William & Mary ($2 million), and; (iii) combined estimated future payments of $234 million related to our non-contributory, defined benefit pension plan ($218 million consisting of estimated payments through 2086) and other retirement plan liabilities ($16 million).

As of December 31, 2008, we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds. Our outstanding letters of credit and surety bonds as of December 31, 2008 totaled $79 million consisting of: (i) $63 million related to our self-insurance programs; (ii) $14 million related pending appeals of legal judgments, and; (iii) $2 million of other debt guarantees related to public utilities and entities in which we own a minority interest.

9) RELATIONSHIP WITH UNIVERSAL HEALTH REALTY INCOME TRUST AND RELATED PARTY TRANSACTIONS

Relationship with Universal Health Realty Income Trust:

At December 31, 2008, we held approximately 6.6% 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 $1.6 million during 2008 and $1.4 million during each of 2007 and 2006. Our pre-tax share of income from the Trust was $900,000 during 2008 and $1.5 million during 2007 and is included in net revenues in the accompanying consolidated statements of income for each year. Our pre-tax share of income from the Trust was $2.3 million in 2006, of which $1.4 million is included in net revenues and the remaining $900,000 was recorded as a reduction to our hurricane related expenses and is included in income/(loss) from discontinued operations, net of income taxes. The carrying value of this investment was $8.9 million and $9.9 million December 31, 2008 and 2007, respectively, and is included in other assets in the accompanying consolidated balance sheets. The market value of this investment was $25.9 million at December 31, 2008 and $27.9 million at December 31, 2007, based on the closing price of the Trust's stock on the respective dates.

Total rent expense under the operating leases on the hospital facilities with the Trust was $16.1 million during each of 2008 and 2007 and $16.0 million during 2006. In addition, certain of our subsidiaries are tenants in several medical office buildings owned by limited liability companies in which the Trust holds non-controlling ownership interests.

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.

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 the appraised fair market value. In addition, during 2006, as part of the overall exchange and substitution transaction relating to Chalmette Medical Center ("Chalmette") which was completed during the third quarter of 2006, as well as the early five year lease renewals on Southwest Healthcare System-Inland Valley Campus ("Inland Valley"), Wellington Regional Medical Center ("Wellington"), McAllen Medical Center and The Bridgeway ("Bridgeway"), the Trust agreed to amend the Master Lease to include a change of control provision. The change of control provision grants us the right, upon one month's notice should a change of control of the Trust occur, to purchase any or all of the four leased hospital properties at their appraised fair market value purchase price.

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

Hospital Name	Type of Facility	Annual Minimum Rent	End of Lease Term	Renewal Term (years)
McAllen Medical Center	Acute Care	$5,485,000	December, 2011	20(a)
Wellington Regional Medical Center	Acute Care	$3,030,000	December, 2011	20(b)
Southwest Healthcare System, Inland Valley Campus	Acute Care	$2,648,000	December, 2011	20(b)
The Bridgeway	Behavioral Health	$ 930,000	December, 2014	10(c)

(a) We have four 5-year renewal options at existing lease rates (through 2031).
(b) We have two 5-year renewal options at existing lease rates (through 2021) and two 5-year renewal options at fair market value lease rates (2022 through 2031).
(c) We have two 5-year renewal options at fair market value lease rates (2015 through 2024).

Other Related Party Transactions:

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 $19.8 million, $16.9 million and $14.5 million in 2008, 2007 and 2006, 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, 2008 and 2007:

	2008	2007
	(000s)	
Change in benefit obligation:		
Benefit obligation at beginning of year	**$ 76,466**	$81,126
Service cost	**1,192**	1,342
Interest cost	**4,827**	4,364
Benefits paid	**(3,733)**	(3,394)
Actuarial loss (gain)	**5,731**	(6,972)
Benefit obligation at end of year	**$ 84,483**	$76,466
Change in plan assets:		
Fair value of plan assets at beginning of year	**$ 64,515**	$53,781
Actual return on plan assets	**(19,020)**	3,851
Employer contributions	**5,130**	10,842
Benefits paid	**(3,733)**	(3,394)
Administrative expenses	**(460)**	(566)
Fair value of plan assets at end of year	**$ 46,432**	$64,514
Net pension liability recognized at end of year	**$ 38,051**	$11,952
Additional year end information for Pension Plan		
Projected benefit obligation	**$ 84,483**	$76,466
Accumulated benefit obligation	**81,596**	73,341
Fair value of plan assets	**46,432**	64,514

	2008	2007	2006
		(000s)	
Components of net periodic cost (benefit)			
Service cost	**$1,192**	$ 1,342	$ 1,393
Interest cost	**4,827**	4,365	4,398
Expected return on plan assets	**(5,345)**	(4,772)	(3,742)
Recognized actuarial loss	**276**	1,121	1,775
Net periodic cost	**$ 950**	$ 2,056	$ 3,824

	2008	2007
Measurement Dates		
Benefit obligations	12/31/2008	12/31/2007
Fair value of plan assets	12/31/2008	12/31/2007

	2008	2007
Weighted average assumptions as of December 31		
Discount rate	**5.87%**	6.48%
Rate of compensation increase	**4.00%**	4.00%

	2008	2007	2006
Weighted-average assumptions for net periodic benefit cost calculations			
Discount rate	**6.48%**	5.50%	5.66%
Expected long-term rate at return on plan assets	**8.00%**	8.00%	8.00%
Rate of compensation increase	**4.00%**	4.00%	4.00%

The accumulated benefit obligation was $81.6 million and $73.3 million as of December 31, 2008 and 2007, respectively. The accumulated benefit obligation exceeded the fair value of plan assets as of December 31, 2008 and 2007. The accrued pension cost is included in non-current liabilities in the accompanying Consolidated Balance Sheet.

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.

Estimated Future Benefit Payments (000s)	
2009	$ 4,253
2010	$ 4,503
2011	$ 4,747
2012	$ 4,997
2013	$ 5,260
2014-2018	$29,721

	2008	2007
Plan Assets		
Asset Category		
Equity securities	55%	64%
Fixed income securities	42%	32%
Other	3%	4%
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:

	Policy	As of 12/31/08	Permitted Range
Total Equity	58%	55%	51-61%
Total Fixed Income	36%	42%	32-42%
Other	6%	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. Net revenues and income (loss) before income taxes exclude discontinued operations. The chief operating decision making group for our acute care hospital services and behavioral health care services is comprised of the President and Chief Executive Officer, and the co-lead/lead executive of each operating segment. The lead executives 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, 2008.

2008	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
		(amounts in thousands)		
Gross inpatient revenues	$9,292,596	$1,951,560	—	$11,244,156
Gross outpatient revenues	$3,655,051	$ 258,022	$ 73,699	$ 3,986,772
Total net revenues	$3,669,504	$1,251,116	$ 101,797	$ 5,022,417
Income/(loss) before income taxes	$ 244,235	$ 244,525	$(172,441)	$ 316,319
Total assets	$2,517,208	$ 970,524	$ 254,731	$ 3,742,462

2007	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
		(amounts in thousands)		
Gross inpatient revenues	$8,375,435	$1,806,835	—	$10,182,270
Gross outpatient revenues	$3,382,862	$ 235,920	$ 82,208	$ 3,700,990
Total net revenues	$3,410,368	$1,146,078	$ 126,704	$ 4,683,150
Income/(loss) before income taxes	$ 229,339	$ 219,891	$(173,963)	$ 275,267
Total assets	$2,411,994	$ 951,883	$ 244,780	$ 3,608,657

2006	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
		(amounts in thousands)		
Gross inpatient revenues	$7,309,115	$1,663,509	—	$8,972,624
Gross outpatient revenues	$2,713,593	$ 206,453	$ 85,294	$3,005,340
Total net revenues	$3,039,775	$1,028,967	$ 55,950	$4,124,692
Income/(loss) before income taxes	$ 205,209	$ 202,338	$(155,129)	$ 252,418
Total assets	$2,184,420	$ 845,755	$ 246,867	$3,277,042

12) QUARTERLY RESULTS (unaudited)

The following tables summarize the quarterly financial data for the two years ended December 31, 2008 and 2007:

2008	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Total
	(amounts in thousands, except per share amounts)				
Revenues	$1,277,977	$1,262,576	$1,244,462	$1,237,402	$5,022,417
Income from continuing operations	$ 60,059	$ 55,184	$ 37,223	$ 40,475	$ 192,941
Income/(loss) from discontinued operations	$ 1,604	$ (944)	$ (226)	$ 6,002	$ 6,436
Net income	$ 61,663	$ 54,240	$ 36,997	$ 46,477	$ 199,377
Earnings per share-Basic:					
From continuing operations	$ 1.17	$ 1.09	$ 0.73	$ 0.81	$ 3.81
From discontinued operations	$ 0.03	$ (0.02)	$ —	$ 0.12	$ 0.13
Total basic earnings per share	$ 1.20	$ 1.07	$ 0.73	$ 0.93	$ 3.94
Earnings per share-Diluted:					
From continuing operations	$ 1.17	$ 1.09	$ 0.73	$ 0.81	$ 3.80
From discontinued operations	$ 0.03	$ (0.02)	$ —	$ 0.12	$ 0.13
Total diluted earnings per share	$ 1.20	$ 1.07	$ 0.73	$ 0.93	$ 3.93

The 2008 quarterly financial data presented above includes the following:

Third Quarter:

- (i) an $8.0 million pre-tax charge ($5.0 million, or $.10 per diluted share, net of taxes) to establish a reserve in connection with the government's investigation of our South Texas Health Systems affiliates, as discussed in *Item 3. Legal Proceedings*; (ii) a $4.6 million pre-tax gain ($2.8 million, or $.06 per diluted share, net of taxes) realized on the sale of our ownership interest in a third-party provider of supply chain services, and; (iii) a $3.4 million pre-tax gain ($2.1 million, or $.04 per diluted share, net of taxes) realized on the sale of real property, and;

Fourth Quarter:

- (i) a $15.0 million pre-tax charge ($9.2 million, or $.18 per diluted share, net of taxes) to establish a reserve in connection with the government's investigation of our South Texas Health Systems affiliates, as discussed in *Item 3. Legal Proceedings*, and; (ii) a $9.9 million pre-tax reduction to our professional and general liability expense ($6.0 million, or $.12 per diluted share, net of taxes) from the expected receipt of liquidation proceeds from the PHICO estate, as discussed in *Note 8—Commitments and Contingencies, Professional and General Liability Claims and Property Insurance.*

Net revenues in 2008 include $42.5 million of additional revenues received from Medicaid disproportionate share hospital funds in Texas and South Carolina. Of this amount, $10.4 million was recorded in the first quarter, $10.4 million in the second quarter, $9.0 million in the third quarter and $12.7 million in the fourth quarter. These amounts were recorded in periods that we met all of the requirements to be entitled to these reimbursements.

2007	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Total
	(amounts in thousands, except per share amounts)				
Revenues	$1,179,678	$1,162,530	$1,163,605	$1,177,337	$4,683,150
Income from continuing operations	$ 48,745	$ 52,821	$ 29,386	$ 39,690	$ 170,642
Income/(loss) from discontinued operations	$ 763	$ (750)	$ (532)	$ 264	$ (255)
Net income	$ 49,508	$ 52,071	$ 28,854	$ 39,954	$ 170,387
Earnings per share-Basic:					
From continuing operations	$ 0.91	$ 0.99	$ 0.55	$ 0.75	$ 3.20
From discontinued operations	$ 0.02	$ (0.02)	$ (0.01)	$ —	$ (0.01)
Total basic earnings per share	$ 0.93	$ 0.97	$ 0.54	$ 0.75	$ 3.19
Earnings per share-Diluted:					
From continuing operations	$ 0.91	$ 0.98	$ 0.55	$ 0.75	$ 3.18
From discontinued operations	$ 0.01	$ (0.01)	$ (0.01)	$ —	$ —
Total diluted earnings per share	$ 0.92	$ 0.97	$ 0.54	$ 0.75	$ 3.18

The 2007 quarterly financial data presented above includes the following:

First Quarter:

- a $2.2 million pre-tax gain ($1.4 million, or $.03 per diluted share, net of taxes) on the sale of real property;

Second Quarter:

- a $17.6 million pre-tax and pre-minority interest reduction to prior year reserves for professional and general liability self-insured claims ($10.0 million, or $.19 per diluted share, net of minority interest and taxes) based on the results of a reserve analysis, and;

Third Quarter:

- (i) a $5.5 million pre-tax charge ($3.4 million, or $.07 per diluted share, net of taxes) to record the unfavorable prior period effect of Texas Medicaid supplemental payments; (ii) a $3.7 million pre-tax charge ($2.3 million, or $.04 per diluted share, net of taxes) to establish a reserve for a legal judgment; (iii) a $2.6 million pre-tax write-down ($1.6 million, or $.03 per diluted share, net of taxes) of investment in joint venture, and; (iv) a $2.0 million, or $.04 per diluted share, favorable income tax adjustment.

Net revenues in 2007 include $41.0 million of additional revenues received from Medicaid disproportionate share hospital funds in Texas and South Carolina. Of this amount, $10.3 million was recorded in the first quarter, $11.8 million in the second quarter, $12.5 million in the third quarter and $6.4 million in the fourth quarter. These amounts were recorded in periods that we met all of the requirements to be entitled to these reimbursements.

13) IMPACT OF HURRICANE KATRINA

In August, 2005, our Methodist Hospital and Lakeland Medical Pavilion, each located in New Orleans, Louisiana, and our Chalmette Medical Center and Virtue Street Pavilion, each located in Chalmette, Louisiana, were severely damaged from Hurricane Katrina. Since the Hurricane, all facilities remain closed and non-operational. The Chalmette Medical Center building has been razed as a result of the substantial hurricane damage sustained. During 2008, we commenced divestiture considerations for the real property of these facilities. The hurricane related expenses and hurricane insurance recoveries related to these facilities recorded during 2006, which are summarized below, are reflected as "Income/(loss) from discontinued operations, net of income taxes" in the Consolidated Statement of Income included herein.

Summary of 2006 hurricane related expenses and hurricane insurance recoveries (amounts in thousands):

	2006
Hurricane insurance recoveries (A)	$181,791
Hurricane related expenses:	
Property write-down (B)	$ 11,124
Recovery of provision for doubtful accounts and allowance for unbilled revenue (C)	(8,438)
Building remediation and other expenses, net of gain (D)	11,876
Subtotal—hurricane-related expenses	14,562
Hurricane insurance recoveries in excess of expenses, before minority interests and income taxes	167,229
Minority interests in hurricane insurance recoveries in excess of expenses	(8,718)
Hurricane insurance recoveries in excess of expenses, before income taxes	158,511
Income tax expense	(59,085)
After-tax hurricane insurance recoveries in excess of expenses included in "Income/(loss) from discontinued operations, net of income taxes"	$ 99,426

A. During 2006, we reached an agreement with our insurance carrier to settle all claims related to damage sustained at our facilities located in Louisiana as a result of Hurricane Katrina. Including amounts collected from our other insurance carriers in 2005 and 2006, we received total insurance proceeds of $264 million which represented approximately 95% of our insurance policy limits. Included in our financial results were after-tax hurricane related insurance recoveries amounting to $107 million ($182 million pre-tax and pre-minority interest) during 2006 and $49 million ($82 million pre-tax and pre-minority interest) during 2005.

B. The property write-down charge of $11 million recorded during 2006 related primarily to the equipment at Methodist Hospital, the carrying-value of which has been reduced to zero since the equipment has either been disposed of or will likely require refurbishment and certification before reuse.

C. During 2005, we fully reserved all accounts receivable outstanding for each facility as of December 31, 2005 since the Hurricane left many patients without the financial resources required to pay bills. In addition, a provision was recorded during 2005 to fully reserve for all net patient revenue that was unbilled at the time of the Hurricane. During 2006, we collected $8.4 million of the previously reserved accounts.

D. Consists of: (i) expenses incurred in connection with remediation of the Hurricane-damaged properties including removal of damaged property and debris and sealing of the buildings to prevent further weather-related deterioration; (ii) various other expenses related to the Hurricane and its aftermath, and; (iii) a $2.6 million pre-tax gain realized by us from the repurchase of the minority member's 10% ownership interest in the Methodist Hospital and Lakeland Medical Pavilion facilities. Note: This amount excludes a $770,000 net hurricane expense recovery recorded during 2006 related to a hospital located in Florida.

SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS

(amounts in thousands)

Description	Balance at beginning of period	Charges to costs and expenses	Acquisitions of business	Write-off of uncollectible accounts	Balance at end of period
Allowance for doubtful accounts receivable:					
Year ended December 31, 2008	$121,321	$484,138	$ —	$(442,484)	$162,975
Year ended December 31, 2007	$110,324	$415,961	$2,452	$(407,416)	$121,321
Year ended December 31, 2006	$105,345	$349,030	$ 771	$(344,822)	$110,324

Included in the charges to costs and expenses are $7,393 in 2008, $5,418 in 2007 and $5,647 in 2006, related to an acute care facility that was divested during 2008.

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Corporate Information

EXECUTIVE OFFICES

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(610) 768-3300

REGIONAL OFFICES

Development
1504 East Franklin Street
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Chapel Hill, NC 27514
(919) 928-8214

Central Region
3801 South Capital of Texas Highway
Suite 275
Austin, TX 78704
(512) 347-3490

Western Region
1635 Village Center Circle
Suite 180
Las Vegas, NV 89134
(702) 360-9040

Universal Health Network
639 Isbell Road
Suite 400
Reno, NV 89509
(775) 356-1159

Behavioral Health Regional Office
3401 West End Avenue
Suite 400
Nashville, TN 37203
(615) 250-0000

ANNUAL MEETING

May 20, 2009, 10:00 a.m.
Universal Corporate Center
367 South Gulph Road
King of Prussia, PA 19406

COMPANY COUNSEL

Fulbright & Jaworski, L.L.P.
New York, New York

AUDITORS

PricewaterhouseCoopers LLP
Philadelphia, Pennsylvania

TRANSFER AGENT AND REGISTRAR

Mellon Investor Services, LLC
Newport Office Center VII
480 Washington Blvd.
Jersey City, NJ 07310
Telephone: 1-800-756-3353
www.melloninvestor.com

Please contact Mellon Investor Services for prompt assistance on address changes, lost certificates, consolidation of duplicate accounts or related matters.

INTERNET ADDRESS

The Company can be accessed on the World Wide Web at http://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.
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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 2008. 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, 2009, 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.

Board of Directors

Alan B. Miller[3,4]
Chairman of the Board, President and Chief Executive Officer

Leatrice Ducat[1,2,5]
President and Founder, National Disease Research Interchange since 1980; President and Founder, Human Biological Data Interchange since 1988; Founder, Juvenile Diabetes Foundation, National and International Organization

John H. Herrell[1]
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

Marc D. Miller[4]
Senior Vice President of the Company

Anthony Pantaleoni[3,4]
Of Counsel, Fulbright & Jaworski, L.L.P., New York, NY

Rick Santorum[2,5]
Consultant to Eckert Seamans Cherin & Mellott, LLC, Washington, DC; Senior Fellow, Ethics and Public Policy Center, Washington, DC; U.S. Senator, PA, 1995-2007; U.S. Representative, PA, 1991-1995; Former Chairman of the Senate Republican Conference, 2001-2007 and third-ranking member of the Republican leadership

John F. Williams, Jr., M.D., Ed. D.[2,5]
Provost, Vice President for Health Affairs and Dean, The George Washington University, Washington, DC

Committees of the Board: [1]Audit Committee, [2]Compensation Committee, [3]Executive Committee, [4]Finance Committee, [5]Nominating/Corporate Governance Committee

Officers

CORPORATE

Alan B. Miller
President and
Chief Executive Officer

Steve G. Filton
Senior Vice President and
Chief Financial Officer

Michael Marquez
Senior Vice President

Marc D. Miller
Senior Vice President

Debra K. Osteen
Senior Vice President

Charles F. Boyle
Vice President and Controller

John Paul Christen
Vice President, Acute Finance

Larry Harrod
Vice President, Behavioral Finance

Matthew D. Klein
Vice President and General Counsel

Michael S. Nelson
Vice President, Information Services

Cheryl K. Ramagano
Vice President and Treasurer

Richard C. Wright
Vice President, Development

Paul Yakulis
Vice President, Human Resources

DIVISION

Acute Care

Michael Marquez
Co-Head

Marc D. Miller
Co-Head

David E. Bussone
Senior Vice President

Moody L. Chisholm
Vice President

Joseph B. "Skip" Courtney
Interim Vice President

Douglas A. Matney
Vice President

Karla J. Perez
Vice President

Behavioral Health

Debra K. Osteen
President

Martin C. Schappell
Senior Vice President

Joe C. Crabtree
Vice President

Robert A. Deney
Vice President

Gary M. Gilberti
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Vice President

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Regional Vice President

Matthew W. Crouch
Regional Vice President

Craig L. Nuckles
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Group Director

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Group Director

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Isa Diaz
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Carothers H. Evans
Vice President

Karen E. Johnson
Vice President

Michael R. Lyons
Vice President

Robert E. Minor
Vice President

Tasha Hoffmann
Assistant Vice President

superior performance | consistent
results | consistent growth | stabil
superior performance | consistent
performance | investment grade | s
investment grade | results | super
grade | results | superior performa
results | superior performance | co

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