UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(MARK ONE)

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

For the quarterly period ended March 31, 2023

OR

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

For the transition period from to

Commission file number 1-10765

UNIVERSAL HEALTH SERVICES, INC.

(Exact name of registrant as specified in its charter)

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

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

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

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

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Class B Common Stock, $0.01 par value	UHS	New York Stock Exchange

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

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

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

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

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

Indicate the number of shares outstanding of each of the issuer's classes of common stock, as of the latest practicable date. Common shares outstanding, as of April 30, 2023:

Class A	6,577,100
Class B	62,928,899
Class C	661,688
Class D	14,100

UNIVERSAL HEALTH SERVICES, INC.

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This Quarterly Report on Form 10-Q is for the quarter ended March 31, 2023. This Report modifies and supersedes documents filed prior to this Report. Information that we file with the Securities and Exchange Commission (the "SEC") in the future will automatically update and supersede information contained in this Report.

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF INCOME

(amounts in thousands, except per share amounts)
(unaudited)

	Three months ended March 31,	
	2023	2022
Net revenues	$ 3,467,518	$ 3,292,956
Operating charges:		
Salaries, wages and benefits	1,753,335	1,692,270
Other operating expenses	878,951	820,934
Supplies expense	379,989	371,073
Depreciation and amortization	141,621	143,784
Lease and rental expense	34,922	32,038
	3,188,818	3,060,099
Income from operations	278,700	232,857
Interest expense, net	50,876	21,673
Other (income) expense, net	13,723	11,201
Income before income taxes	214,101	199,983
Provision for income taxes	51,726	48,962
Net income	162,375	151,021
Less: Net income (loss) attributable to noncontrolling interests	(740)	(2,892)
Net income attributable to UHS	$ 163,115	$ 153,913
Basic earnings per share attributable to UHS	$ 2.31	$ 2.05
Diluted earnings per share attributable to UHS	$ 2.28	$ 2.02
Weighted average number of common shares - basic	70,535	75,030
Add: Other share equivalents	952	1,011
Weighted average number of common shares and equivalents - diluted	71,487	76,041

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

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

	Three months ended March 31,	
	2023	2022
Net income	$ 162,375	$ 151,021
Other comprehensive income (loss):		
Foreign currency translation adjustment	4,198	(18,470)
Other comprehensive income (loss) before tax	4,198	(18,470)
Income tax expense (benefit) related to items of other comprehensive income (loss)	(424)	(944)
Total other comprehensive income (loss), net of tax	4,622	(17,526)
Comprehensive income	166,997	133,495
Less: Comprehensive income (loss) attributable to noncontrolling interests	(740)	(2,892)
Comprehensive income attributable to UHS	$ 167,737	$ 136,387

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

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

	March 31, 2023	December 31, 2022
Assets		
Current assets:		
Cash and cash equivalents	$ 109,969	$ 102,818
Accounts receivable, net	2,032,184	2,017,722
Supplies	216,236	218,517
Other current assets	200,710	198,283
Total current assets	2,559,099	2,537,340
Property and equipment	11,251,315	11,085,852
Less: accumulated depreciation	(5,297,174)	(5,167,394)
	5,954,141	5,918,458
Other assets:		
Goodwill	3,913,906	3,909,456
Deferred income taxes	90,918	68,397
Right of use assets-operating leases	458,189	454,650
Deferred charges	5,987	6,264
Other	573,719	599,623
Total Assets	$ 13,555,959	$ 13,494,188
Liabilities and Stockholders' Equity		
Current liabilities:		
Current maturities of long-term debt	$ 96,235	$ 81,447
Accounts payable and other liabilities	1,636,102	1,760,588
Operating lease liabilities	73,189	67,776
Federal and state taxes	57,858	4,608
Total current liabilities	1,863,384	1,914,419
Other noncurrent liabilities	532,080	487,669
Operating lease liabilities noncurrent	396,488	395,522
Long-term debt	4,707,321	4,726,533
Redeemable noncontrolling interests	4,269	4,695
Equity:		
UHS common stockholders' equity	6,012,108	5,920,582
Noncontrolling interest	40,309	44,768
Total equity	6,052,417	5,965,350
Total Liabilities and Stockholders' Equity	$ 13,555,959	$ 13,494,188

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY
For the Three Months ended March 31, 2023
(amounts in thousands, unaudited)

	Redeemable Noncontrolling Interest	Class A Common	Class B Common	Class C Common	Class D Common	Cumulative Dividends	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	UHS Common Stockholders' Equity	Noncontrolling Interest	Total
Balance, January 1, 2023	$ 4,695	$ 66	$ 637	$ 7	$ 0	$ (604,127)	$ 6,533,667	$ (9,668)	$ 5,920,582	$ 44,768	5,965,350
Common Stock											
Issued/(converted)	—	—	3	—	—	—	3,092	—	3,095	—	3,095
Repurchased	—	—	(7)	—	—	—	(85,819)	—	(85,826)	—	(85,826)
Restricted share-based compensation expense	—	—	—	—	—	—	4,494	—	4,494	—	4,494
Dividends paid and accrued	—	—	—	—	—	(14,199)		—	(14,199)	—	(14,199)
Stock option expense	—	—	—	—	—	—	16,225	—	16,225	—	16,225
Distributions to noncontrolling interests	(750)	—	—	—	—	—	—	—	—	(3,395)	(3,395)
Comprehensive income:								—			
Net income (loss) to UHS / noncontrolling interests	324	—	—	—	—	—	163,115	—	163,115	(1,064)	162,051
Foreign currency translation adjustments, net of income tax	—	—	—	—	—	—	—	4,622	4,622	—	4,622
Subtotal - comprehensive income	324	—	—	—	—	—	163,115	4,622	167,737	(1,064)	166,673
Balance, March 31, 2023	$ 4,269	$ 66	$ 633	$ 7	$ 0	$ (618,326)	$ 6,634,774	$ (5,046)	$ 6,012,108	$ 40,309	$ 6,052,417

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY
For the Three Months ended March 31, 2022
(amounts in thousands, unaudited)

	Redeemable Noncontrolling Interest	Class A Common	Class B Common	Class C Common	Class D Common	Cumulative Dividends	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	UHS Common Stockholders' Equity	Noncontrolling Interest	Total
Balance, January 1, 2022	$ 5,119	$ 66	$ 698	$ 7	$ 0	$ (545,487)	$ 6,604,089	$ 30,291	$ 6,089,664	$ 103,389	$ 6,193,053
Common Stock											
Issued/(converted)	—	—	5	—	—	—	3,640	—	3,645	—	3,645
Repurchased	—	—	(27)	—	—	—	(365,478)	—	(365,505)	—	(365,505)
Restricted share-based compensation expense	—	—	—	—	—	—	3,442	—	3,442	—	3,442
Dividends paid and accrued	—	—	—	—	—	(14,963)	—	—	(14,963)	—	(14,963)
Stock option expense	—	—	—	—	—	—	15,202	—	15,202	—	15,202
Distributions to noncontrolling interests	(650)	—	—	—	—	—	—	—	—	(4,639)	(4,639)
Purchase (sale) of ownership interests by (from) minority members	—	—	—	—	—	—	—	—	—	(1,307)	(1,307)
Comprehensive income:											
Net income (loss) to UHS / noncontrolling interests	(155)	—	—	—	—	—	153,913	—	153,913	(2,737)	151,176
Foreign currency translation adjustments, net of income tax	—	—	—	—	—	—	—	(17,526)	(17,526)	—	(17,526)
Subtotal - comprehensive income	(155)	—	—	—	—	—	153,913	(17,526)	136,387	(2,737)	133,650
Balance, March 31, 2022	$ 4,314	$ 66	$ 676	$ 7	$ 0	$ (560,450)	$ 6,414,808	$ 12,765	$ 5,867,872	$ 94,706	$ 5,962,578

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

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

	Three months ended March 31,	
	2023	2022
Cash Flows from Operating Activities:		
Net income	$ 162,375	$ 151,021
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation & amortization	141,621	143,784
(Gain) loss on sale of assets and businesses	(295)	1,084
Stock-based compensation expense	20,964	19,055
Changes in assets & liabilities, net of effects from acquisitions and dispositions:		
Accounts receivable	(15,723)	(15,073)
Accrued interest	(662)	180
Accrued and deferred income taxes	46,576	47,548
Other working capital accounts	(119,605)	63,308
Medicare accelerated payments and deferred CARES Act and other grants	136	250
Other assets and deferred charges	24,727	26,042
Other	7,030	(4,020)
Accrued insurance expense, net of commercial premiums paid	42,545	41,685
Payments made in settlement of self-insurance claims	(18,936)	(29,431)
Net cash provided by operating activities	290,753	445,433
Cash Flows from Investing Activities:		
Property and equipment additions	(168,752)	(200,002)
Proceeds received from sales of assets and businesses	9,259	10,232
(Outflows) inflows from foreign exchange contracts that hedge our net U.K. investment	(18,818)	20,710
Decrease in capital reserves of commercial insurance subsidiary	0	100
Net cash used in investing activities	(178,311)	(168,960)
Cash Flows from Financing Activities:		
Repayments of long-term debt	(16,489)	(11,966)
Additional borrowings, net	11,300	117,400
Financing costs	(292)	-
Repurchase of common shares	(85,039)	(365,505)
Dividends paid	(14,214)	(14,875)
Issuance of common stock	2,988	3,503
Profit distributions to noncontrolling interests	(4,145)	(5,289)
Sale of ownership interests from minority members	0	(1,307)
Net cash used in financing activities	(105,891)	(278,039)
Effect of exchange rate changes on cash, cash equivalents and restricted cash	1,650	(2,232)
Increase (decrease) in cash, cash equivalents and restricted cash	8,201	(3,798)
Cash, cash equivalents and restricted cash, beginning of period	200,837	178,934
Cash, cash equivalents and restricted cash, end of period	$ 209,038	$ 175,136
Supplemental Disclosures of Cash Flow Information:		
Interest paid	$ 50,279	$ 20,388
Income taxes paid, net of refunds	$ 2,360	$ 4,423
Noncash purchases of property and equipment	$ 61,341	$ 90,730

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

(1) General

This Quarterly Report on Form 10-Q is for the quarterly period ended March 31, 2023. In this Quarterly Report, "we," "us," "our" "UHS" and the "Company" refer to Universal Health Services, Inc. and its subsidiaries.

The condensed consolidated interim financial statements include the accounts of our majority-owned subsidiaries and partnerships and limited liability companies controlled by us, or our subsidiaries, as managing general partner or managing member. The condensed consolidated interim financial statements included herein have been prepared by us, without audit, pursuant to the rules and regulations of the Securities and Exchange Commission ("SEC") and reflect all adjustments (consisting only of normal recurring adjustments) which, in our opinion, are necessary to fairly state results for the interim periods. Certain information and footnote disclosures normally included in audited consolidated financial statements prepared in accordance with accounting principles generally accepted in the United States of America have been condensed or omitted pursuant to such rules and regulations, although we believe that the accompanying disclosures are adequate to make the information presented not misleading. These condensed consolidated interim financial statements should be read in conjunction with the audited consolidated financial statements, significant accounting policies and the notes thereto included in our Annual Report on Form 10-K for the year ended December 31, 2022.

Many of the factors that could affect our future results are beyond our control or ability to predict, including, but not limited to:

- The nationwide shortage of nurses and other clinical staff and support personnel has been a significant operating issue facing us and other healthcare providers. In some areas, the labor scarcity is putting a strain on our resources and staff, which has required us to utilize higher-cost temporary labor and pay premiums above standard compensation for essential workers. These factors, which had a material unfavorable impact on our results of operations during 2022, could continue to have an unfavorable material impact on our results of operations for the foreseeable future.
- The impact of the COVID-19 pandemic, which began during the second half of March, 2020, has had a material effect on our operations and financial results since that time. The length and extent of the disruptions caused by the COVID-19 pandemic are currently unknown; however, we expect such disruptions to continue into the future which could materially affect our financial performance.
- A significant portion of our revenues are derived from federal and state government programs including the Medicare and Medicaid programs. Payments from these programs are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations, requirements for utilization review, and federal and state funding restrictions. Changes to these programs, if adopted, could materially affect program payments which could materially impact our results of operations.
- The increase in interest rates has substantially increased our borrowings costs and reduced our ability to access the capital markets on favorable terms. Additional increases in interest rates could have a significant unfavorable impact on our future results of operations and the resulting effect on the capital markets could adversely affect our ability to carry out our strategy.

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

Relationship with Universal Health Realty Income Trust:

At March 31, 2023, we held approximately 5.7% of the outstanding shares of Universal Health Realty Income Trust (the "Trust"). We serve as Advisor to the Trust under an annually renewable advisory agreement, which is scheduled to expire on December 31st of each year, pursuant to the terms of which we conduct the Trust's day-to-day affairs, provide administrative services and present investment opportunities. The advisory agreement was renewed by the Trust for 2023 at the same rate in place for 2022, 2021 and 2020, providing for an advisory fee computation at 0.70% of the Trust's average invested real estate assets. We earned an advisory fee from the Trust, which is included in net revenues in the accompanying consolidated statements of income, of approximately $1.3 million and $1.2 million during the three-month periods ended March 31, 2023 and 2022, respectively.

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.

Our pre-tax share of income from the Trust was approximately $300,000 during each of the three-month periods ended March 31, 2023 and 2022 and is included in other income, net, on the accompanying consolidated statements of income for each period. We received dividends from the Trust amounting to $563,000 and $555,000 during the three-month periods ended March 31, 2023 and 2022, respectively. The carrying value of our investment in the Trust was approximately $8.1 million and $8.4 million at March 31, 2023 and December 31, 2022, respectively, and is included in other assets in the accompanying consolidated balance sheets. The

market value of our investment in the Trust was $37.9 million at March 31, 2023 and $37.6 million at December 31, 2022, based on the closing price of the Trust's stock on the respective dates.

The Trust commenced operations in 1986 by purchasing certain properties from us and immediately leasing the properties back to our respective subsidiaries. The base rents are paid monthly and the bonus rents, which as of January 1, 2022 are applicable only to McAllen Medical Center, are computed and paid on a quarterly basis, based upon a computation that compares current quarter revenue to a corresponding quarter in the base year. The leases with those subsidiaries are unconditionally guaranteed by us and are cross-defaulted with one another.

On December 31, 2021, we entered into an asset purchase and sale agreement with the Trust, which was amended during the first quarter of 2022, pursuant to the terms of which:

- a wholly-owned subsidiary of ours purchased from the Trust, the real estate assets of the Inland Valley Campus of Southwest Healthcare System located in Wildomar, California, at its fair market value of $79.6 million.
- two wholly-owned subsidiaries of ours transferred to the Trust, the real estate assets of the following properties:
    - Aiken Regional Medical Center ("Aiken"), located in Aiken, South Carolina (which includes a 211-bed acute care hospital and a 62-bed behavioral health facility), at its fair-market value of approximately $57.7 million, and;
    - Canyon Creek Behavioral Health ("Canyon Creek"), located in Temple, Texas, at its fair-market value of approximately $26.0 million.
- in connection with this transaction, since the fair-market value of Aiken and Canyon Creek, which totaled approximately $83.7 million in the aggregate, exceeded the $79.6 million fair-market value of the Inland Valley Campus of Southwest Healthcare System, we received approximately $4.1 million in cash from the Trust. This transaction generated a gain of approximately $68.4 million for the Trust, our share of which (approximately $4.0 million) is included in our consolidated statement of income for the year ended December 31, 2021.

Also on December 31, 2021, Aiken and Canyon Creek (as lessees), entered into a master lease and individual property leases (with the Trust as lessor), as amended, for initial lease terms on each property of approximately twelve years, ending on December 31, 2033. Subject to the terms of the master lease, Aiken and Canyon Creek have the right to renew their leases, at the then current fair market rent (as defined in the master lease), for seven, five-year optional renewal terms. The aggregate annual rental during 2022 pursuant to the leases for these two facilities, amounted to approximately $5.7 million ($3.9 million related to Aiken and $1.8 million related to Canyon Creek). There is no bonus rental component applicable to either of these leases. On each January 1st through 2033, the annual rental will increase by 2.25% on a cumulative and compounded basis.

As a result of the purchase options within the lease agreements for Aiken and Canyon Creek, the asset purchase and sale transaction is accounted for as a failed sale leaseback in accordance with U.S. GAAP. We have accounted for the asset exchange and substitution transaction with the Trust as a financing arrangement and, since we did not derecognize the real property related to Aiken and Canyon Creek, we will continue to depreciate the assets. Our Consolidated Balance Sheet as of March 31, 2023 and December 31, 2022 reflects a financial liability of $80.0 million and $80.9 million, respectively, which is included in debt, for the fair value of real estate assets that we exchanged as part of the transaction. Our monthly lease payments payable to the Trust will be recorded to interest expense and as a reduction to the outstanding financial liability. The amount allocated to interest expense is determined using our incremental borrowing rate and is based on the outstanding financial liability.

The aggregate rental for the leases on the four wholly-owned hospital facilities with the Trust (excluding Clive Behavioral Health Hospital which is discussed below) was approximately $5 million during each of the three months ended March 31, 2023 and 2022.

Pursuant to the Master Leases by certain subsidiaries of ours and the Trust as described in the table below, dated 1986 and 2021 ("the Master Leases") which govern the leases of McAllen Medical Center and Wellington Regional Medical Center (each of which is governed by the Master Lease dated 1986), and Aiken Regional Medical Center and Canyon Creek Behavioral Health (each of which is governed by the Master Lease dated 2021), we have the option to renew the leases at the lease terms described above and below by providing notice to the Trust at least 90 days prior to the termination of the then current term. We also have the right to purchase the respective leased hospitals at their appraised fair market value upon any of the following: (i) at the end of the lease terms or any renewal terms; (ii) upon one month's notice should a change of control of the Trust occur, or; (iii) within the time period as specified in the lease in the event that we provide notice to the Trust of our intent to offer a substitution property/properties in exchange for one (or more) of the hospital properties leased from the Trust should we be unable to reach an agreement with the Trust on the properties to be substituted. In addition, we have rights of first refusal to: (i) purchase the respective leased facilities during and for a specified period 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 a specified period after, the lease term at the same terms and conditions pursuant to any third-party offer.

In addition, we are the managing, majority member in a joint venture with an unrelated third-party that operates Clive Behavioral Health, a 100-bed behavioral health care facility located in Clive, Iowa. The real property of this facility, which was completed and

opened in late, 2020, is also leased from the Trust (annual rental of approximately $2.7 million and $2.6 million during 2023 and 2022, respectively) pursuant to the lease terms as provided in the table below. In connection with the lease on this facility, the joint venture has the right to purchase the leased facility from the Trust at its appraised fair market value upon either of the following: (i) by providing notice at least 270 days prior to the end of the lease terms or any renewal terms, or; (ii) upon 30 days' notice anytime within 12 months of a change of control of the Trust (UHS also has this right should the joint venture decline to exercise its purchase right). Additionally, the joint venture has rights of first offer to purchase the facility prior to any third-party sale.

The table below provides certain details for each of the hospitals leased from the Trust as of March 31, 2023:

Hospital Name	Annual Minimum Rent	End of Lease Term	Renewal Term (years)	
McAllen Medical Center	$ 5,485,000	December, 2026	5	(a)
Wellington Regional Medical Center	$ 6,477,000	December, 2026	5	(b)
Aiken Regional Medical Center/Aurora Pavilion Behavioral Health Services	$ 3,982,000	December, 2033	35	(c)
Canyon Creek Behavioral Health	$ 1,800,000	December, 2033	35	(c)
Clive Behavioral Health Hospital	$ 2,701,000	December, 2040	50	(d)

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

(b) We have one 5-year renewal option at fair market value lease rates (through 2031). Upon the December 31, 2021 expiration of the lease on Wellington Regional Medical Center, a wholly-owned subsidiary of ours exercised its fair market value renewal option and renewed the lease for a 5-year term scheduled to expire on December 31, 2026. The annual rental will increase by 2.5% on a cumulative and compounded basis on January 1st of each year through 2026.

(c) We have seven 5-year renewal options at fair market value lease rates (2034 through 2068). On January 1st of each year through 2033, the annual rent will increase by 2.25% on a cumulative and compounded basis.

(d) This facility is operated by a joint venture in which we are the managing, majority member and an unrelated third-party holds a minority ownership interest. The joint venture has three, 10-year renewal options at computed lease rates as stipulated in the lease (2041 through 2070) and two additional, 10-year renewal options at fair market value lease rates (2071 through 2090). In each January through 2040 (and potentially through 2070 if three, 10-year renewal options are exercised), the annual rental will increase by 2.75% on a cumulative and compounded basis.

In addition, certain of our subsidiaries are tenants in several medical office buildings ("MOBs") and two free-standing emergency departments owned by the Trust or by limited liability companies in which the Trust holds 95% to 100% of the ownership interest.

In January, 2022, the Trust commenced construction on a new 86,000 rentable square feet multi-tenant MOB that is located on the campus of Northern Nevada Sierra Medical Center in Reno, Nevada. Northern Nevada Sierra Medical Center, a 170-bed newly constructed acute care hospital owned and operated by a wholly-owned subsidiary of ours, was completed and opened in April, 2022. In connection with this MOB, which was substantially completed during the first quarter of 2023, a ground lease and a master flex lease was executed between a wholly-owned subsidiary of ours and the Trust, pursuant to the terms of which our subsidiary will master lease approximately 68% of the rentable square feet of the MOB at an initial minimum rent of $1.3 million annually. The master flex lease could be reduced during the term if certain conditions are met. The ground lease and master flex lease each commenced during the first quarter of 2023.

Other Related Party Transactions:

In December, 2010, our Board of Directors approved the Company's entering into supplemental life insurance plans and agreements on the lives of Alan B. Miller (our Executive Chairman of the Board) and his wife. As a result of these agreements, as amended in October, 2016, based on actuarial tables and other assumptions, during the life expectancies of the insureds, we would pay approximately $28 million in premiums, and certain trusts owned by our Executive Chairman of the Board, would pay approximately $9 million in premiums. Based on the projected premiums mentioned above, and assuming the policies remain in effect until the death of the insureds, we will be entitled to receive death benefit proceeds of no less than approximately $37 million representing the $28 million of aggregate premiums paid by us as well as the $9 million of aggregate premiums paid by the trusts. In connection with these policies, we will pay/we paid approximately $1.0 million, net, in premium payments during 2023 and 2022.

In August, 2015, Marc D. Miller, our President and Chief Executive Officer and member of our Board of Directors, was appointed to the Board of Directors of Premier, Inc. ("Premier"), a healthcare performance improvement alliance. During 2013, we entered into a new group purchasing organization agreement ("GPO") with Premier. In conjunction with the GPO agreement, we acquired a minority interest in Premier for a nominal amount. During the fourth quarter of 2013, in connection with the completion of an initial public offering of the stock of Premier, we received cash proceeds for the sale of a portion of our ownership interest in the GPO. Also in connection with this GPO agreement, we received shares of restricted stock of Premier which vested ratably over a seven-year

period (2014 through 2020), contingent upon our continued participation and minority ownership interest in the GPO. During the third quarter of 2020, we entered into an agreement with Premier pursuant to the terms of which, among other things, our ownership interest in Premier was converted into shares of Class A Common Stock of Premier. We have elected to retain a portion of the previously vested shares of Premier, the market value of which is included in other assets on our consolidated balance sheet. Based upon the closing price of Premier's stock on each respective date, the market value of our shares of Premier was approximately $72 million and $78 million as of March 31, 2023 and December 31, 2022, respectively. Any change in market value of our Premier shares since December 31, 2022 was recorded as an unrealized gain/loss and included in "Other (income) expense, net" in our condensed consolidated statements of income for the three-month period ended March 31, 2023. Additionally, Premier declared and paid quarterly cash dividends during each of the first quarters of 2023 and 2022. Our share of the cash dividends amounted to approximately $500,000 and $400,000 for the three-month periods ended March 31, 2023 and 2022, respectively. The dividends are included in "Other (income) expense, net" in our condensed consolidated statements of income.

A member of our Board of Directors and member of the Executive Committee and Finance Committee is a partner in Norton Rose Fulbright US LLP, a law firm engaged by us for a variety of legal services. The Board member and his law firm also provide personal legal services to our Executive Chairman and he acts as trustee of certain trusts for the benefit of our Executive Chairman and his family.

(3) Other Noncurrent liabilities and Redeemable/Noncontrolling Interests

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

As of March 31, 2023, outside owners held noncontrolling, minority ownership interests of: (i) approximately 7% in an acute care facility located in Texas; (ii) 49%, 20%, 30%, 20%, 25%, 48% and 26% in seven behavioral health care facilities located in Arizona, Pennsylvania, Ohio, Washington, Missouri, Iowa and Michigan, respectively, and; (iii) approximately 5% in an acute care facility located in Nevada. The noncontrolling interest and redeemable noncontrolling interest balances of $40 million and $4 million, respectively, as of March 31, 2023, consist primarily of the third-party ownership interests in these hospitals.

In connection with the two behavioral health care facilities located in Pennsylvania and Ohio, the minority ownership interests of which are reflected as redeemable noncontrolling interests on our Condensed Consolidated Balance Sheet, the outside owners have "put options" to put their entire ownership interest to us at any time. If exercised, the put option requires us to purchase the minority member's interest at fair market value. Accordingly, the amounts recorded as redeemable noncontrolling interests on our Condensed Consolidated Balance Sheet reflects the estimated fair market value of these ownership interests.

(4) Treasury

Credit Facilities and Outstanding Debt Securities:

In June, 2022, we entered into a ninth amendment to our credit agreement dated as of November 15, 2010, as amended and restated as of September, 2012, August, 2014, October, 2018, August, 2021, and September, 2021, among UHS, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders, and JPMorgan Chase Bank, N.A., as administrative agent, (the "Credit Agreement"). The ninth amendment provided for, among other things, the following: (i) a new incremental tranche A term loan facility in the aggregate principal amount of $700 million which is scheduled to mature on August 24, 2026, and; (ii) replaces the option to make Eurodollar borrowings (which bear interest by reference to the LIBO Rate) with Term Benchmark Loans, which will bear interest by reference to the Secured Overnight Financing Rate ("SOFR"). The net proceeds generated from the incremental tranche A term loan facility were used to repay a portion of the borrowings that were previously outstanding under our revolving credit facility.

As of March 31, 2023, our Credit Agreement provided for the following:

- a $1.2 billion aggregate amount revolving credit facility that is scheduled to mature in August, 2026 (which, as of March 31, 2023, had $875 million of aggregate available borrowing capacity net of $322 million of outstanding borrowings and $3 million of letters of credit), and;
- a tranche A term loan facility with $2.32 billion of outstanding borrowings as of March 31, 2023 (including the $700 million increase provided for by the ninth amendment in June, 2022).

The tranche A term loan facility provides for installment payments of $15.0 million per quarter during the period of September, 2022 through September, 2023, and $30.0 million per quarter during the period of December, 2023 through June, 2026. The unpaid principal balance at June 30, 2026 is payable on the August 24, 2026 scheduled maturity date of the Credit Agreement.

Revolving credit and tranche A term loan borrowings under the Credit Agreement bear interest at our election at either (1) the ABR rate which is defined as the rate per annum equal to the greatest of (a) the lender's prime rate, (b) the weighted average of the federal funds rate, plus 0.5% and (c) one month SOFR rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.25% to 0.625%, or (2) the one, three or six month SOFR rate plus 0.1% (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.25% to

1.625%. As of March 31, 2023, the applicable margins were 0.50% for ABR-based loans and 1.50% for SOFR-based loans under the revolving credit and term loan A facilities. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Credit Agreement is secured by certain assets of the Company and our material subsidiaries (which generally excludes asset classes such as substantially all of the patient-related accounts receivable of our acute care hospitals, and certain real estate assets and assets held in joint-ventures with third parties) and is guaranteed by our material subsidiaries.

The Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement also contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens, indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage. We were in compliance with all required covenants as of March 31, 2023 and December 31, 2022.

On August 24, 2021, we completed the following via private offerings to qualified institutional buyers under Rule 144A and to non-U.S. persons outside the United States in reliance on Regulation S under the Securities Act of 1933, as amended:

- Issued $700 million of aggregate principal amount of 1.65% senior secured notes due on September 1, 2026, and;
- Issued $500 million of aggregate principal amount of 2.65% senior secured notes due on January 15, 2032.

On September 13, 2021, we redeemed $400 million of aggregate principal amount of 5.00% senior secured notes, that were scheduled to mature on June 1, 2026, at 102.50% of the aggregate principal, or $410 million.

As of March 31, 2023, we had combined aggregate principal of $2.0 billion from the following senior secured notes:

- $700 million aggregate principal amount of 1.65% senior secured notes due in September, 2026 (“2026 Notes”) which were issued on August 24, 2021.
- $800 million aggregate principal amount of 2.65% senior secured notes due in October, 2030 (“2030 Notes”) which were issued on September 21, 2020.
- $500 million of aggregate principal amount of 2.65% senior secured notes due in January, 2032 (“2032 Notes”) which were issued on August 24, 2021.

Interest on the 2026 Notes is payable on March 1st and September 1st until the maturity date of September 1, 2026. Interest on the 2030 Notes is payable on April 15th and October 15th, until the maturity date of October 15, 2030. Interest on the 2032 Notes is payable on January 15th and July 15th until the maturity date of January 15, 2032.

The 2026 Notes, 2030 Notes and 2032 Notes (collectively “The Notes”) were initially issued only to qualified institutional buyers under Rule 144A and to non-U.S. persons outside the United States in reliance on Regulation S under the Securities Act of 1933, as amended (the “Securities Act”). In December, 2022, we completed a registered exchange offer in which virtually all previously outstanding Notes were exchanged for identical Notes that were registered under the Securities Act, and thereby became freely transferable (subject to certain restrictions applicable to affiliates and broker dealers). Notes originally issued under Rule 144A or Regulation S that were not exchanged in the exchange offer remain outstanding and may not be offered or sold in the United States absent registration under the Securities Act or an applicable exemption from registration requirements thereunder.

The Notes are guaranteed (the “*Guarantees*”) on a senior secured basis by all of our existing and future direct and indirect subsidiaries (the “*Subsidiary Guarantors*”) that guarantee our Credit Agreement, or other first lien obligations or any junior lien obligations. The Notes and the Guarantees are secured by first-priority liens, subject to permitted liens, on certain of the Company’s and the Subsidiary Guarantors’ assets now owned or acquired in the future by the Company or the Subsidiary Guarantors (other than real property, accounts receivable sold pursuant to the Company’s Existing Receivables Facility (as defined in the Indenture pursuant to which The Notes were issued (the “Indenture”)), and certain other excluded assets). The Company’s obligations with respect to The Notes, the obligations of the Subsidiary Guarantors under the Guarantees, and the performance of all of the Company’s and the Subsidiary Guarantors’ other obligations under the Indenture, are secured equally and ratably with the Company’s and the Subsidiary Guarantors’ obligations under the Credit Agreement and The Notes by a perfected first-priority security interest, subject to permitted liens, in the collateral owned by the Company and its Subsidiary Guarantors, whether now owned or hereafter acquired. However, the liens on the collateral securing The Notes and the Guarantees will be released if: (i) The Notes have investment grade ratings; (ii) no default has occurred and is continuing, and; (iii) the liens on the collateral securing all first lien obligations (including the Credit Agreement and The Notes) and any junior lien obligations are released or the collateral under the Credit Agreement, any other first lien obligations and any junior lien obligations is released or no longer required to be pledged. The liens on any collateral securing The Notes and the Guarantees will also be released if the liens on that collateral securing the Credit Agreement, other first lien obligations and any junior lien obligations are released.

On its December, 2022 maturity date, our $20 million accounts receivable securitization program expired and was not renewed or replaced.

As discussed in *Note 2 to the Consolidated Financial Statements-Relationship with Universal Health Realty Income Trust and Other Related Party Transactions*, on December 31, 2021, we (through wholly-owned subsidiaries of ours) entered into an asset purchase

and sale agreement with Universal Health Realty Income Trust (the "Trust"). Pursuant to the terms of the agreement, which was amended during the first quarter of 2022, we, among other things, transferred to the Trust, the real estate assets of Aiken Regional Medical Center ("Aiken") and Canyon Creek Behavioral Health ("Canyon Creek"). In connection with this transaction, Aiken and Canyon Creek (as lessees), entered into a master lease and individual property leases, as amended, (with the Trust as lessor), for initial lease terms on each property of approximately twelve years, ending on December 31, 2033. As a result of our purchase option within the Aiken and Canyon Creek lease agreements, this asset purchase and sale transaction is accounted for as a failed sale leaseback in accordance with U.S. GAAP and we have accounted for the transaction as a financing arrangement. Our lease payments payable to the Trust are recorded to interest expense and as a reduction of the outstanding financial liability, and the amount allocated to interest expense is determined based upon our incremental borrowing rate and the outstanding financial liability. In connection with this transaction, our Consolidated Balance Sheets at March 31, 2023 and December 31, 2022 reflect financial liabilities, which are included in debt, of approximately $80 million and $81 million, respectively.

At March 31, 2023, the carrying value and fair value of our debt were approximately $4.8 billion and $4.5 billion, respectively. At December 31, 2022, the carrying value and fair value of our debt were approximately $4.8 billion and $4.4 billion, respectively. The fair value of our debt was computed based upon quotes received from financial institutions. We consider these to be "level 2" in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with debt instruments.

Foreign Currency Forward Exchange Contracts:

We use forward exchange contracts to hedge our net investment in foreign operations against movements in exchange rates. The effective portion of the unrealized gains or losses on these contracts is recorded in foreign currency translation adjustment within accumulated other comprehensive income and remains there until either the sale or liquidation of the subsidiary. In connection with these forward exchange contracts, we recorded net cash outflows of $19 million during the first quarter of 2023 and net cash inflows of $21 million during the first quarter of 2022.

Derivatives Hedging Relationships:

The following table presents the effects of our foreign currency foreign exchange contracts on our results of operations for the three-month periods ended March 31, 2023 and 2022 (in thousands):

	Gain/(Loss) recognized in AOCI Three months ended	
	March 31, 2023	March 31, 2022
Net Investment Hedge relationships		
Foreign currency foreign exchange contracts	$ (22,144)	$ 17,112

No other gains or losses were recognized in income related to derivatives in Subtopic 815-20.

Cash, Cash Equivalents and Restricted Cash:

Cash, cash equivalents, and restricted cash as reported in the condensed consolidated statements of cash flows are presented separately on our condensed consolidated balance sheets as follows (in thousands):

	March 31, 2023	March 31, 2022	December 31, 2022
Cash and cash equivalents	$ 109,969	$ 105,999	$ 102,818
Restricted cash (a)	99,069	69,137	98,019
Total cash, cash equivalents and restricted cash	$ 209,038	$ 175,136	$ 200,837

(a) Restricted cash is included in other assets on the accompanying consolidated balance sheet.

(5) Fair Value Measurement

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. The following fair value hierarchy classifies the inputs to valuation techniques used to measure fair value into one of three levels:

- Level 1: Unadjusted quoted prices 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 included 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.

The following tables present the assets and liabilities recorded at fair value on a recurring basis:

(in thousands)	Balance at March 31, 2023	Balance Sheet Location	Basis of Fair Value Measurement Level 1	Level 2	Level 3
Assets:					
Money market mutual funds	114,892	Other assets	114,892		
Certificates of deposit	2,200	Other assets		2,200	
Equity securities	72,272	Other assets	72,272		
Deferred compensation assets	39,029	Other assets	39,029		
Foreign currency exchange contracts	184	Other current assets		184	
	$ 228,577		$ 226,193	$ 2,384	-
Liabilities:					
Deferred compensation liability	39,029	Other noncurrent liabilities	39,029		
	$ 39,029		$ 39,029	-	-

(in thousands)	Balance at December 31, 2022	Balance Sheet Location	Basis of Fair Value Measurement Level 1	Level 2	Level 3
Assets:					
Money market mutual funds	113,649	Other assets	113,649		
Certificates of deposit	2,200	Other assets		2,200	
Equity securities	78,099	Other assets	78,099		
Deferred compensation assets	38,032	Other assets	38,032		
Foreign currency exchange contracts	3,142	Other current assets		3,142	
	$ 235,122		$ 229,780	$ 5,342	-
Liabilities:					
Deferred compensation liability	38,032	Other noncurrent liabilities	$ 38,032		
	$ 38,032		$ 38,032	-	-

The fair value of our money market mutual funds, certificates of deposit and equity securities with a readily determinable fair value are computed based upon quoted market prices in an active market. The fair value of deferred compensation assets and the offsetting liability are computed based on market prices in an active market held in a rabbi trust. The fair value of our interest rate swaps are based on quotes from our counter parties. The fair value of our foreign currency exchange contracts is valued using quoted forward exchange rates and spot rates at the reporting date.

(6) Commitments and Contingencies

Professional and General Liability, Workers' Compensation Liability

The vast majority of our subsidiaries are self-insured for professional and general liability exposure up to: (i) $20 million for professional liability and $3 million for general liability per occurrence in 2023, 2022 and 2021; (ii) $10 million and $3 million per occurrence in 2020 (professional liability claims are also subject to an additional annual aggregate self-insured retention of $2.5 million for claims in excess of $10 million for 2020); (iii) $5 million and $3 million per occurrence, respectively, during 2019, 2018 and 2017, and; (iv) $10 million and $3 million per occurrence, respectively, prior to 2017.

These subsidiaries are provided with several excess policies through commercial insurance carriers which provide for coverage in excess of the applicable per occurrence and aggregate self-insured retention or underlying policy limits up to approximately $165 million in 2023; $162 million in 2022; $155 million in 2021 and $250 million during each of 2014 through 2020. In addition, from time to time based upon marketplace conditions, we may elect to purchase additional commercial coverage for certain of our facilities or businesses. Our behavioral health care facilities located in the U.K. have policies through a commercial insurance carrier located in the U.K. that provides for £16 million of professional liability coverage, and £25 million of general liability coverage.

As of March 31, 2023, the total net accrual for our professional and general liability claims was $392 million, of which $55 million was included in current liabilities. As of December 31, 2022, the total net accrual for our professional and general liability claims was $372 million, of which $74 million was included in current liabilities.

As a result of unfavorable trends experienced during the last three years, our results of operations included pre-tax increases to our reserves for self-insured professional and general liability claims amounting to approximately $16 million during 2022 and $52 million during 2021. Our estimated liability for self-insured professional and general liability claims is based on a number of factors including, among other things, the number of asserted claims and reported incidents, estimates of losses for these claims based on recent and historical settlement amounts, estimates of incurred but not reported claims based on historical experience, and estimates of amounts recoverable under our commercial insurance policies. While we continuously monitor these factors, our ultimate liability for professional and general liability claims could change materially from our current estimates due to inherent uncertainties involved in making this estimate. Given our significant self-insured exposure for professional and general liability claims, there can be no

assurance that a sharp increase in the number and/or severity of claims asserted against us will not have a material adverse effect on our future results of operations.

As of March 31, 2023, the total accrual for our workers' compensation liability claims was $128 million, $55 million of which was included in current liabilities. As of December 31, 2022, the total accrual for our workers' compensation liability claims was $125 million, $55 million of which was included in current liabilities.

Although we are unable to predict whether or not our future financial statements will require updates to estimates for our prior year reserves for self-insured general and professional and workers' compensation claims, given the relatively unpredictable nature of these potential liabilities and the factors impacting these reserves, as discussed above, it is reasonably likely that our future financial results may include material adjustments to prior period reserves.

Property Insurance

We have commercial property insurance policies for our properties covering catastrophic losses, including windstorm damage, up to a $1 billion policy limit, subject to a per occurrence/per location deductible of $2.5 million as of June 1, 2020. Losses resulting from named windstorms are subject to deductibles between 3% and 5% of the total insurable value of the property. In addition, we have commercial property insurance policies covering catastrophic losses resulting from earthquake and flood damage, each subject to aggregated loss limits (as opposed to per occurrence losses). Commercially insured earthquake coverage for our facilities is subject to various deductibles and limitations including: (i) $150 million limitation for our facilities located in California; (ii) $100 million limitation for our facilities located in fault zones within the United States; (iii) $40 million limitation for our facilities located in Puerto Rico, and; (iv) $250 million limitation for many of our facilities located in other states. Our commercially insured flood coverage has a limit of $100 million annually. There is also a $10 million sublimit for one of our facilities located in Houston, Texas, and a $1 million sublimit for our facilities located in Puerto Rico. Property insurance for our behavioral health facilities located in the U.K. are provided on an all risk basis up to a £1.5 billion policy limit, with coverage caps per location, that includes coverage for real and personal property as well as business interruption losses.

Legal Proceedings

We operate in a highly regulated and litigious industry which subjects us to various claims and lawsuits in the ordinary course of business as well as regulatory proceedings and government investigations. These claims or suits include claims for damages for personal injuries, medical malpractice, commercial/contractual disputes, wrongful restriction of, or interference with, physicians' staff privileges, and employment related claims. In addition, health care companies are subject to investigations and/or actions by various state and federal governmental agencies or those bringing claims on their behalf. Government action has increased with respect to investigations and/or allegations against healthcare providers concerning possible violations of fraud and abuse and false claims statutes as well as compliance with clinical and operational regulations. Currently, and from time to time, we and some of our facilities are subjected to inquiries in the form of subpoenas, Civil Investigative Demands, audits and other document requests from various federal and state agencies. These inquiries can lead to notices and/or actions including repayment obligations from state and federal government agencies associated with potential non-compliance with laws and regulations. Further, the federal False Claims Act allows private individuals to bring lawsuits (qui tam actions) against healthcare providers that submit claims for payments to the government. Various states have also adopted similar statutes. When such a claim is filed, the government will investigate the matter and decide if they are going to intervene in the pending case. These qui tam lawsuits are placed under seal by the court to comply with the False Claims Act's requirements. If the government chooses not to intervene, the private individual(s) can proceed independently on behalf of the government. Health care providers that are found to violate the False Claims Act may be subject to substantial monetary fines/penalties as well as face potential exclusion from participating in government health care programs or be required to comply with Corporate Integrity Agreements as a condition of a settlement of a False Claims Act matter. In September 2014, the Criminal Division of the Department of Justice ("DOJ") announced that all qui tam cases will be shared with their Division to determine if a parallel criminal investigation should be opened. The DOJ has also announced an intention to pursue civil and criminal actions against individuals within a company as well as the corporate entity or entities. In addition, health care facilities are subject to monitoring by state and federal surveyors to ensure compliance with program Conditions of Participation. In the event a facility is found to be out of compliance with a Condition of Participation and unable to remedy the alleged deficiency(s), the facility faces termination from the Medicare and Medicaid programs or compliance with a System Improvement Agreement to remedy deficiencies and ensure compliance.

The laws and regulations governing the healthcare industry are complex covering, among other things, government healthcare participation requirements, licensure, certification and accreditation, privacy of patient information, reimbursement for patient services as well as fraud and abuse compliance. These laws and regulations are constantly evolving and expanding. Further, the Legislation has added additional obligations on healthcare providers to report and refund overpayments by government healthcare programs and authorizes the suspension of Medicare and Medicaid payments "pending an investigation of a credible allegation of fraud." We monitor our business and have developed an ethics and compliance program with respect to these complex laws, rules and regulations. Although we believe our policies, procedures and practices comply with government regulations, there is no assurance that we will not be faced with the sanctions referenced above which include fines, penalties and/or substantial damages, repayment obligations, payment suspensions, licensure revocation, and expulsion from government healthcare programs. Even if we were to ultimately

prevail in any action brought against us or our facilities or in responding to any inquiry, such action or inquiry could have a material adverse effect on us.

Certain legal matters are described below:

Knight v. Miller, et. al.

In July 2021, a shareholder derivative lawsuit was filed by plaintiff, Robin Knight, in the Chancery Court in Delaware against the members of the Board of Directors of the Company as well as certain officers (C.A. No.: 2021-0581-SG). The Company was named as a nominal defendant. The lawsuit alleges that in March 2020 stock options were awarded with exercise prices that did not reflect the Company's fundamentals and business prospects, and in anticipation of future market rebound resulting in excessive gains. The lawsuit makes claims of breaches of fiduciary duties, waste of corporate assets, and unjust enrichment. The lawsuit seeks monetary damages allegedly incurred by the Company, disgorgement of the March 2020 stock awards as well as any proceeds derived therefrom and unspecified equitable relief. Defendants deny the allegations. We filed a motion to dismiss the complaint and the court granted part and denied part of our motion. During the third quarter of 2022, we have reached a preliminary settlement, which will not have a material impact on our consolidated financial statements. The settlement is currently pending final court approval. We are uncertain as to potential liability or financial exposure, if any, which may be associated with this matter in the event the settlement is not finalized and approved by the court.

Disproportionate Share Hospital Payment Matter:

In late September, 2015, many hospitals in Pennsylvania, including certain of our behavioral health care hospitals located in the state, received letters from the Pennsylvania Department of Human Services (the "Department") demanding repayment of allegedly excess Medicaid Disproportionate Share Hospital payments ("DSH"), primarily consisting of managed care payments characterized as DSH payments, for the federal fiscal year ("FFY") 2011 amounting to approximately $4 million in the aggregate. Since that time, certain of our behavioral health care hospitals in Pennsylvania have received similar requests for repayment for alleged DSH overpayments for FFYs 2012 through 2015. For FFY 2012, the claimed overpayment amounts to approximately $4 million. For FY 2013, FY 2014 and FY 2015 the initial claimed overpayments and attempted recoupment by the Department were approximately $7 million, $8 million and $7 million, respectively. The Department has agreed to a change in methodology which, upon confirmation of the underlying data being accepted by the Department, could reduce the initial claimed overpayments for FY 2013, FY 2014 and FY 2015 to approximately $2 million, $2 million and $3 million, respectively. We filed administrative appeals for all of our facilities contesting the recoupment efforts for FFYs 2011 through 2015 as we believe the Department's calculation methodology is inaccurate and conflicts with applicable federal and state laws and regulations. The Department has agreed to postpone the recoupment of the state's share for FY 2011 to 2013 until all hospital appeals are resolved but started recoupment of the federal share. For FY 2014 and FY 2015, the Department has initiated the recoupment of the alleged overpayments. Starting in FY 2016, the first full fiscal year after the January 1, 2015 effective date of Medicaid expansion in Pennsylvania, the Department no longer characterized managed care payments received by the hospitals as DSH payments. We can provide no assurance that we will ultimately be successful in our legal and administrative appeals related to the Department's repayment demands. If our legal and administrative appeals are unsuccessful, our future consolidated results of operations and financial condition could be adversely impacted by these repayments.

Boley, et al. v. UHS, et al.

Former UHS subsidiary facility employees Mary K. Boley, Kandie Sutter, and Phyllis Johnson, individually and on behalf of a putative class of participants in the UHS Retirement Savings Plan (the "Plan"), filed a complaint in the U.S. District Court for the Eastern District of Pennsylvania against UHS, the Board of Directors of UHS, and the "Plan Committee" of UHS (Case No. 2:20-cv-02644). In subsequent amended complaints, Plaintiffs dropped the Board of Directors and the "Plan Committee" as defendants and added the UHS Retirement Plans Investment Committee as a new defendant. Plaintiffs alleged that UHS breached its fiduciary duties under the Employee Retirement Income Security Act ("ERISA") by offering to participants in the Plan overly expensive investment options when less expensive investment options were available in the marketplace; caused participants to pay excessive recordkeeping fees associated with the Plan; breached its duty to monitor appointed fiduciaries and: in the alternative, engaged in a "knowing breach of trust" separate from the alleged violations under ERISA. UHS disputed Plaintiffs' allegations and actively defended against Plaintiffs' claims. During the third quarter of 2022, the parties reached a preliminary settlement, within the policy limitations of our commercial insurance coverage after satisfaction of specified deductibles, for which the court granted preliminary approval. The court has granted final approval of the settlement and an order of dismissal has been entered.

Other Matters:

Various other suits, claims and investigations, including government subpoenas, arising against, or issued to, us are pending and additional such matters may arise in the future. Management will consider additional disclosure from time to time to the extent it believes such matters may be or become material. The outcome of any current or future litigation or governmental or internal investigations, including the matters described above, cannot be accurately predicted, nor can we predict any resulting penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities. We record accruals for such contingencies to the extent that we conclude it is probable that a liability has been incurred and the amount of the loss can be reasonably estimated. No estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made at this time

regarding the matters described above or that are otherwise pending because the inherently unpredictable nature of legal proceedings may be exacerbated by various factors, including, but not limited to: (i) the damages sought in the proceedings are unsubstantiated or indeterminate; (ii) discovery is not complete; (iii) the matter is in its early stages; (iv) the matters present legal uncertainties; (v) there are significant facts in dispute; (vi) there are a large number of parties, or; (vii) there is a wide range of potential outcomes. It is possible that the outcome of these matters could have a material adverse impact on our future results of operations, financial position, cash flows and, potentially, our reputation.

(7) 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, but not limited to, information technology, purchasing, reimbursement, accounting and finance, taxation, legal, advertising and design and construction. The chief operating decision making group for our acute care services and behavioral health care services is comprised of our Chief Executive Officer and the Presidents of each operating segment. The Presidents for each operating segment also manage the profitability of each respective segment's various facilities. The operating segments are managed separately because each operating segment represents a business unit that offers different types of healthcare services or operates in different healthcare environments. The accounting policies of the operating segments are the same as those described in the summary of significant accounting policies included in our Annual Report on Form 10-K for the year ended December 31, 2022. The corporate overhead allocations, as reflected below, are utilized for internal reporting purposes and are comprised of each period's projected corporate-level operating expenses (excluding interest expense). The overhead expenses are captured and allocated directly to each segment, to the extent possible, based upon each segment's respective percentage of total operating expenses.

	Three months ended March 31, 2023			
	Acute Care Hospital Services	Behavioral Health Services (a)	Other	Total Consolidated
	(Dollar amounts in thousands)			
Gross inpatient revenues	$ 11,401,491	$ 2,627,990		$ 14,029,481
Gross outpatient revenues	$ 7,296,116	$ 272,371		$ 7,568,487
Total net revenues	$ 1,973,532	$ 1,490,489	$ 3,497	$ 3,467,518
Income/(loss) before allocation of corporate overhead and income taxes	$ 133,296	$ 266,356	$ (185,551)	$ 214,101
Allocation of corporate overhead	$ (67,262)	$ (46,642)	$ 113,904	$ 0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 66,034	$ 219,714	$ (71,647)	$ 214,101
Total assets as of March 31, 2023	$ 6,001,135	$ 7,343,276	$ 211,548	$ 13,555,959

	Three months ended March 31, 2022			
	Acute Care Hospital Services	Behavioral Health Services (a)	Other	Total Consolidated
	(Dollar amounts in thousands)			
Gross inpatient revenues	$ 10,239,231	$ 2,436,474	-	$ 12,675,705
Gross outpatient revenues	$ 5,775,539	$ 257,113	-	$ 6,032,652
Total net revenues	$ 1,912,316	$ 1,366,467	$ 14,173	$ 3,292,956
Income/(loss) before allocation of corporate overhead and income taxes	$ 148,680	$ 205,787	$ (154,484)	$ 199,983
Allocation of corporate overhead	$ (62,284)	$ (45,001)	$ 107,285	$ 0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 86,396	$ 160,786	$ (47,199)	$ 199,983
Total assets as of March 31, 2022	$ 5,645,352	$ 7,260,870	$ 238,224	$ 13,144,446

(a) Includes net revenues generated from our behavioral health care facilities located in the U.K. amounting to approximately $168 million and $176 million for the three-month periods ended March 31, 2023 and 2022, respectively. Total assets at our U.K. behavioral health care facilities were approximately $1.265 billion and $1.320 billion as of March 31, 2023 and 2022, respectively.

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

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

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

	Three months ended March 31,	
	2023	2022
Basic and Diluted:		
Net income attributable to UHS	$ 163,115	$ 153,913
Less: Net income attributable to unvested restricted share grants	(129)	(249)
Net income attributable to UHS – basic and diluted	$ 162,986	$ 153,664
Weighted average number of common shares - basic	70,535	75,030
Net effect of dilutive stock options and grants based on the treasury stock method	952	1,011
Weighted average number of common shares and equivalents - diluted	71,487	76,041
Earnings per basic share attributable to UHS:	$ 2.31	$ 2.05
Earnings per diluted share attributable to UHS:	$ 2.28	$ 2.02

The "Net effect of dilutive stock options and grants based on the treasury stock method", for all periods presented above, excludes

certain outstanding stock options applicable to each period since the effect would have been anti-dilutive. The excluded weighted-average stock options totaled 5.1 million for the three months ended March 31, 2023 and 5.7 million for the three months ended March 31, 2022. All classes of our common stock have the same dividend rights.

Stock-Based Compensation:

During the three-month periods ended March 31, 2023 and 2022, pre-tax compensation costs of $16.2 million and $15.2 million, respectively, was recognized related to outstanding stock options. In addition, during the three-month periods ended March 31, 2023 and 2022, pre-tax compensation cost of approximately $4.5 million and $3.4 million, respectively, was recognized related to restricted stock awards, restricted stock units and performance based restricted stock units. As of March 31, 2023 there was approximately $226.0 million of unrecognized compensation cost related to unvested options, restricted stock awards, restricted stock units and performance based restricted stock units which is expected to be recognized over the remaining weighted average vesting period of 3.0 years. There were 1,885,756 stock options granted during the first three months of 2023 with a weighted-average grant date fair value of $41.79 per option. There were an aggregate of 279,317 restricted units granted during the first three months of 2023, including 93,606 performance based restricted stock units, with a weighted-average grant date fair value of $117.65 per share.

The expense associated with stock-based compensation arrangements is a non-cash charge. In the Condensed Consolidated Statements of Cash Flows, stock-based compensation expense is an adjustment to reconcile net income to cash provided by operating activities and aggregated to $21.0 million and $19.1 million during the three-month periods ended March 31, 2023 and 2022.

(9) Dispositions and acquisitions

Three-month period ended March 31, 2023:

Acquisitions:

During the first three months of 2023, there were no acquisitions.

Divestitures:

During the first three months of 2023, we received $9 million from the sales of assets and businesses.

Three-month period ended March 31, 2022:

Acquisitions:

During the first three months of 2022, there were no acquisitions.

Divestitures:

During the first three months of 2022, we received $10 million from the sales of assets and businesses.

(10) Dividends

We declared and paid dividends of $14.2 million, or $.20 per share, during the first quarter of 2023 and $15.0 million, or $.20 per share, during the first quarter of 2022. Included in the amounts above were dividend equivalents applicable to unvested restricted stock units which were accrued during 2023 and 2022 and will be, or were, paid upon vesting of the restricted stock unit.

(11) Income Taxes

Our effective income tax rates were 24.2% and 24.5% during the three month periods ended March 31, 2023 and 2022, respectively. The decrease in our effective tax rate during the three months ended March 31, 2023, compared with the same period in 2022, was primarily due to the decrease in net loss attributable to noncontrolling interests during the first quarter of 2023 as compared to the first quarter of 2022.

The global intangible low-taxed income ("GILTI") provisions from the TCJA-17 require the inclusion of the earnings of certain foreign subsidiaries in excess of an acceptable rate of return on certain assets of the respective subsidiaries in our U.S. tax return for tax years beginning after December 31, 2017. An accounting policy election was made during 2018 to treat taxes related to GILTI as a period cost when the tax is incurred. We recorded a GILTI tax provision of zero for the three months ended March 31, 2023 and 2022.

As of January 1, 2023, our unrecognized tax benefits were approximately $2 million. The amount, if recognized, that would favorably affect the effective tax rate is approximately $2 million. During the three months ended March 31, 2023, changes to the estimated liabilities for uncertain tax positions (including accrued interest) relating to tax positions taken during prior and current periods did not have a material impact on our financial statements.

We recognize accrued interest and penalties associated with uncertain tax positions as part of the tax provision. As of March 31, 2023, we have less than $1 million of accrued interest and penalties. The U.S. federal statute of limitations remains open for 2019 and subsequent years. Foreign and U.S. state and local jurisdictions have statutes of limitations generally ranging from 3 to 4 years. The statute of limitations on certain jurisdictions could expire within the next twelve months. It is reasonably possible that the amount of uncertain tax benefits will change during the next 12 months, however, it is anticipated that any such change, if it were to occur, would not have a material impact on our results of operations.

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

(12) Revenue

We recognize revenue when we transfer promised goods or services to customers in an amount that reflects the consideration to which we expect to be entitled in exchange for those goods or services. Our estimate for amounts not expected to be collected based on historical experience will continue to be recognized as a reduction to net revenue. However, subsequent changes in estimate of collectability due to a change in the financial status of a payer, for example a bankruptcy, will be recognized as bad debt expense in operating charges.

The performance obligation is separately identifiable from other promises in the customer contract. As the performance obligations are met (i.e.: room, board, ancillary services, level of care), revenue is recognized based upon allocated transaction price. The transaction price is allocated to separate performance obligations based upon the relative standalone selling price. In instances where we determine there are multiple performance obligations across multiple months, the transaction price will be allocated by applying an estimated implicit and explicit rate to gross charges based on the separate performance obligations.

In assessing collectability, we have elected the portfolio approach. This portfolio approach is being used as we have large volume of similar contracts with similar classes of customers. We reasonably expect that the effect of applying a portfolio approach to a group of contracts would not differ materially from considering each contract separately. Management's judgment to group the contracts by portfolio is based on the payment behavior expected in each portfolio category. As a result, aggregating all of the contracts (which are at the patient level) by the particular payer or group of payers, will result in the recognition of the same amount of revenue as applying the analysis at the individual patient level.

We group our revenues into categories based on payment behaviors. Each component has its own reimbursement structure which allows us to disaggregate the revenue into categories that share the nature and timing of payments. The other patient revenue consists primarily of self-pay, government-funded non-Medicaid, and other.

The following table disaggregates our revenue by major source for the three-month periods ended March 31, 2023 and 2022 (in thousands):

	For the three months ended March 31, 2023							
	Acute Care		Behavioral Health		Other		Total	
Medicare	$ 329,446	17 %	$ 76,544	5 %			$ 405,990	12 %
Managed Medicare	344,032	17 %	75,077	5 %			419,109	12 %
Medicaid	110,009	6 %	206,473	14 %			316,482	9 %
Managed Medicaid	192,298	10 %	398,951	27 %			591,249	17 %
Managed Care (HMO and PPOs)	654,795	33 %	391,297	26 %			1,046,092	30 %
UK Revenue	0	0 %	167,789	11 %			167,789	5 %
Other patient revenue and adjustments, net	120,957	6 %	121,677	8 %			242,634	7 %
Other non-patient revenue	221,995	11 %	52,681	4 %	3,497		278,173	8 %
Total Net Revenue	$ 1,973,532	100 %	$ 1,490,489	100 %	$ 3,497		3,467,518	100 %

	For the three months ended March 31, 2022							
	Acute Care		Behavioral Health		Other		Total	
Medicare	$ 337,109	18 %	$ 79,512	6 %			$ 416,621	13 %
Managed Medicare	332,248	17 %	63,850	5 %			396,098	12 %
Medicaid	155,836	8 %	175,403	13 %			331,239	10 %
Managed Medicaid	171,637	9 %	334,165	24 %			505,802	15 %
Managed Care (HMO and PPOs)	638,895	33 %	365,205	27 %			1,004,100	30 %
UK Revenue	0	0 %	176,092	13 %			176,092	5 %
Other patient revenue and adjustments, net	92,110	5 %	120,733	9 %			212,843	6 %
Other non-patient revenue	184,481	10 %	51,507	4 %	14,173		250,161	8 %
Total Net Revenue	$ 1,912,316	100 %	$ 1,366,467	100 %	$ 14,173		$ 3,292,956	100 %

(13) Lease Accounting

Our operating leases are primarily for real estate, including certain acute care facilities, off-campus outpatient facilities, medical office buildings, and corporate and other administrative offices. Our real estate lease agreements typically have initial terms of five to ten years. These real estate leases may include one or more options to renew, with renewals that can extend the lease term from five to

ten years. The exercise of lease renewal options is at our sole discretion. When determining the lease term, we included options to extend or terminate the lease when it is reasonably certain that we will exercise that option.

Five of our hospital facilities are held under operating leases with Universal Health Realty Income Trust with two leases expiring in 2026, two expiring in 2033 and one expiring in 2040 (see Note 2 for additional disclosure). We are also the lessee of the real property of certain facilities from unrelated third parties.

Supplemental cash flow information related to leases for the three-month period ended March 31, 2023 and 2022 are as follows (in thousands):

	Three months ended March 31,	
	2023	2022
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from operating leases	$ 32,043	$ 31,325
Operating cash flows from finance leases	$ 967	$ 1,006
Financing cash flows from finance leases	$ 882	$ 803
Right-of-use assets obtained in exchange for lease obligations:		
Operating leases	$ 24,256	$ 19,037
Finance leases	$ -	$ 1,066

(14) Recent Accounting Standards

From time to time, new accounting guidance is issued by the FASB or other standard setting bodies that is adopted by the Company as of the effective date or, in some cases where early adoption is permitted, in advance of the effective date. The Company has assessed the recently issued guidance that is not yet effective and believes the new guidance will not have a material impact on our results of operations, cash flows or financial position.

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations

Overview

Our principal business is owning and operating, through our subsidiaries, acute care hospitals and outpatient facilities and behavioral health care facilities.

As of March 31, 2023, we owned and/or operated 358 inpatient facilities and 40 outpatient and other facilities including the following located in 39 states, Washington, D.C., the United Kingdom and Puerto Rico:

Acute care facilities located in the U.S.:

- 27 inpatient acute care hospitals;
- 22 free-standing emergency departments, and;
- 7 outpatient centers & 1 surgical hospital.

Behavioral health care facilities (331 inpatient facilities and 10 outpatient facilities):

Located in the U.S.:

- 185 inpatient behavioral health care facilities, and;
- 8 outpatient behavioral health care facilities.

Located in the U.K.:

- 143 inpatient behavioral health care facilities, and;
- 2 outpatient behavioral health care facilities.

Located in Puerto Rico:

- 3 inpatient behavioral health care facilities.

As a percentage of our consolidated net revenues, net revenues from our acute care hospitals, outpatient facilities and commercial health insurer accounted for 57% and 58% during the three-month periods ended March 31, 2023 and 2022, respectively. Net revenues from our behavioral health care facilities and commercial health insurer accounted for 43% and 42% of our consolidated net revenues during the three-month periods ended March 31, 2023 and 2022, respectively.

Our behavioral health care facilities located in the U.K. generated net revenues of approximately $168 million and $176 million during the three-month periods ended March 31, 2023 and 2022, respectively. Total assets at our U.K. behavioral health care facilities were approximately $1.265 billion as of March 31, 2023 and $1.235 billion as of December 31, 2022.

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

Forward-Looking Statements and Risk Factors

You should carefully review the information contained in this Quarterly Report and should particularly consider any risk factors that we set forth in our Annual Report on Form 10-K for the year ended December 31, 2022, this Quarterly Report and in other reports or documents that we file from time to time with the Securities and Exchange Commission (the "SEC"). In this Quarterly Report, we state our beliefs of future events and of our future financial performance. This Quarterly Report contains "forward-looking statements" that reflect our current estimates, expectations and projections about our future results, performance, prospects and opportunities. Forward-looking statements include, among other things, the information concerning our possible future results of operations, business and growth strategies, financing plans, expectations that regulatory developments or other matters will or will not have a material adverse effect on our business or financial condition, our competitive position and the effects of competition, the projected growth of the industry in which we operate, and the benefits and synergies to be obtained from our completed and any future acquisitions, and statements of our goals and objectives, and other similar expressions concerning matters that are not historical facts. Words such as "may," "will," "should," "could," "would," "predicts," "potential," "continue," "expects," "anticipates," "future," "intends," "plans," "believes," "estimates," "appears," "projects" and similar expressions, as well as statements in future tense, identify forward-looking statements. In evaluating those statements, you should specifically consider various factors, including the risks related to healthcare industry trends and those set forth herein in *Item 1A. Risk Factors* and *Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations-Forward Looking Statements and Risk Factors* in our Annual Report on Form 10-K for the year ended December 31, 2022 and in *Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations-Forward Looking Statements and Risk Factors,* as included herein. Those factors may cause our actual results to differ materially from any of our forward-looking statements.

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

- we are subject to risks associated with public health threats and epidemics, including the health concerns relating to the COVID-19 pandemic. In January 2020, the Centers for Disease Control and Prevention ("CDC") confirmed the spread of the disease to the United States. In March 2020, the World Health Organization declared the COVID-19 outbreak a pandemic. The federal government has declared COVID-19 a national emergency, as many federal and state authorities have implemented aggressive measures to "flatten the curve" of confirmed individuals diagnosed with COVID-19 in an attempt to curtail the spread of the virus and to avoid overwhelming the health care system;
- the impact of the COVID-19 pandemic, which began during the second half of March, 2020, has had a material effect on our operations and financial results since that time. The length and extent of the disruptions caused by the COVID-19 pandemic are currently unknown; however, we expect such disruptions to continue into the future. Since the future volumes and severity of COVID-19 patients remain highly uncertain and subject to change, including potential increases in future COVID-19 patient volumes caused by new variants of the virus, as well as related pressures on staffing and wage rates, we are not able to fully quantify the impact that these factors will have on our future financial results. However, developments related to the COVID-19 pandemic could continue to materially affect our financial performance. Even after the COVID-19 pandemic has subsided, we may continue to experience materially adverse impacts on our financial condition and our results of operations as a result of its macroeconomic impact, including the risks of a global recession or a recession in one or more of our key markets, the impact they may have on us and our customers and our assessment of that impact, and any disruptions and inefficiencies in the supply chain, and many of our known risks described in *Item 1A. Risk Factors* section of our Annual Report on Form 10-K for the year ended December 31, 2022;
- the nationwide shortage of nurses and other clinical staff and support personnel has been a significant operating issue facing us and other healthcare providers. Like others in the healthcare industry, we continue to experience a shortage of nurses and other clinical staff and support personnel at our acute care and behavioral health care hospitals in many geographic areas. In some areas, the labor scarcity is putting a strain on our resources and staff, which has required us to utilize higher-cost temporary labor and pay premiums above standard compensation for essential workers. This staffing shortage has required us to hire expensive temporary personnel and/or enhance wages and benefits to recruit and retain nurses and other clinical staff and support personnel. At certain facilities, particularly within our behavioral health care segment, we have been unable to fill all vacant positions and, consequently, have been required to limit patient volumes. These factors, which had a material unfavorable impact on our results of operations during 2022, could continue to have an unfavorable material impact on our results of operations for the foreseeable future;
- the Centers for Medicare and Medicaid Services ("CMS") issued an Interim Final Rule ("IFR") effective November 5, 2021 mandating COVID-19 vaccinations for all applicable staff at all Medicare and Medicaid certified facilities. Under the IFR, facilities covered by this regulation must establish a policy ensuring all eligible staff have received the COVID-19 vaccine prior to providing any care, treatment, or other services. All eligible staff must have received the necessary shots to be fully vaccinated. The regulation also provides for exemptions based on recognized medical conditions or religious beliefs, observances, or practices. Under the IFR, facilities must develop a similar process or plan for permitting exemptions in alignment with federal law. If facilities fail to comply with the IFR by the deadlines established, they are subject to potential termination from the Medicare and Medicaid program for non-compliance. While President Biden has announced that his administration will start the process to end the vaccine requirements for CMS-certified healthcare facilities, we cannot predict at this time the potential viability or impact of any additional vaccination requirements. Implementation of these rules could have an impact on staffing at our facilities for those employees that are not vaccinated in accordance with IFR requirements, and associated loss of revenues and increased costs resulting from staffing issues could have a material adverse effect on our financial results;
- the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"), a stimulus package signed into law on March 27, 2020, authorizes $100 billion in grant funding to hospitals and other healthcare providers to be distributed through the Public Health and Social Services Emergency Fund (the "PHSSEF"). These funds are not required to be repaid provided the recipients attest to and comply with certain terms and conditions, including limitations on balance billing and not using PHSSEF funds to reimburse expenses or losses that other sources are obligated to reimburse. However, since the expenses and losses will be ultimately measured over the life of the COVID-19 pandemic, potential retrospective unfavorable adjustments in future periods, of funds recorded as revenues in prior periods, could occur. The U.S. Department of Health and Human Services ("HHS") initially distributed $30 billion of this funding based on each provider's share of total Medicare fee-for-service reimbursement in 2019. Subsequently, HHS determined that CARES Act funding (including the $30 billion already distributed) would be allocated proportional to providers' share of 2018 net patient revenue. We have received payments from these initial distributions of the PHSSEF as disclosed herein. HHS has

indicated that distributions of the remaining $50 billion will be targeted primarily to hospitals in COVID-19 high impact areas, to rural providers, safety net hospitals and certain Medicaid providers and to reimburse providers for COVID-19 related treatment of uninsured patients. We have received payments from these targeted distributions of the PHSSEF, as disclosed herein. The CARES Act also makes other forms of financial assistance available to healthcare providers, including through Medicare and Medicaid payment adjustments and an expansion of the Medicare Accelerated and Advance Payment Program, which made available accelerated payments of Medicare funds in order to increase cash flow to providers. On April 26, 2020, CMS announced it was reevaluating and temporarily suspending the Medicare Accelerated and Advance Payment Program in light of the availability of the PHSSEF and the significant funds available through other programs. We have received accelerated payments under this program during 2020, and returned early all of those funds during the first quarter of 2021, as disclosed herein. The Paycheck Protection Program and Health Care Enhancement Act (the "PPPHCE Act"), a stimulus package signed into law on April 24, 2020, includes additional emergency appropriations for COVID-19 response, including $75 billion to be distributed to eligible providers through the PHSSEF. A third phase of PHSSEF allocations made $24.5 billion available for providers who previously received, rejected or accepted PHSSEF payments. Applicants that had not yet received PHSSEF payments of 2 percent of patient revenue were to receive a payment that, when combined with prior payments (if any), equals 2 percent of patient care revenue. Providers that have already received payments of approximately 2 percent of annual revenue from patient care were potentially eligible for an additional payment. Recipients will not be required to repay the government for PHSSEF funds received, provided they comply with HHS defined terms and conditions. On December 27, 2020, the Consolidated Appropriations Act, 2021 ("CAA") was signed into law. The CAA appropriated an additional $3 billion to the PHSSEF, codified flexibility for providers to calculate lost revenues, and permitted parent organizations to allocate PHSSEF targeted distributions to subsidiary organizations. The CAA also provides that not less than 85 percent of the unobligated PHSSEF amounts and any future funds recovered from health care providers should be used for additional distributions that consider financial losses and changes in operating expenses in the third or fourth quarters of 2020 and the first quarter of 2021 that are attributable to the coronavirus. The CAA provided additional funding for testing, contact tracing and vaccine administration. Providers receiving payments were required to sign terms and conditions regarding utilization of the payments. Any provider receiving funds in excess of $10,000 in the aggregate will be required to report data elements to HHS detailing utilization of the payments, and we will be required to file such reports. We, and other providers, will report healthcare related expenses attributable to COVID-19 that have not been reimbursed by another source, which may include general and administrative or healthcare related operating expenses. Funds may also be applied to lost revenues, represented as a negative change in year-over-year net patient care operating income. The deadline for using all Provider Relief Fund payments depends on the date of the payment received period; payments received in the first period of April 10, 2020 to June 30, 2020 were to have been expended by June 30, 2021 and payments received in the fourth period of July 1, 2021 to December 31, 2021 were to have been expended by December 31, 2022. The American Rescue Plan Act of 2021 ("ARPA"), enacted on March 11, 2021, included funding directed at detecting, diagnosing, tracing, and monitoring COVID-19 infections; establishing community vaccination centers and mobile vaccine units; promoting, distributing, and tracking COVID-19 vaccines; and reimbursing rural hospitals and facilities for healthcare-related expenses and lost revenues attributable to COVID-19. ARPA increased the eligibility for, and amount of, premium tax credits to purchase health coverage through Patient Protection and Affordable Care Act, as amended by the Health and Education Reconciliation Act (collectively, the "Legislation"). Further, ARPA set the Medicaid program's federal medical assistance percentage ("FMAP") at 100 percent for amounts expended for COVID-19 vaccines and vaccine administration. ARPA also increases the FMAP by 5 percent for eight calendar quarters to incentivize states to expand their Medicaid programs. Finally, ARPA provides subsidies to cover 100 percent of health insurance premiums under the Consolidated Omnibus Budget Reconciliation Act through September 30, 2021. There is a high degree of uncertainty surrounding the implementation of the CARES Act, the PPPHCE Act, the CAA and ARPA, and the federal government may consider additional stimulus and relief efforts, but we are unable to predict whether additional stimulus measures will be enacted or their impact. On December 29, 2022, the Consolidated Appropriations Act, 2023, was signed into law and phases out the enhanced FMAP rate and fully eliminates the increase on December 31, 2023. States are also permitted to begin Medicaid eligibility redeterminations on March 31, 2023, which is anticipated to result in a large decrease in Medicaid enrollment. There can be no assurance as to the total amount of financial and other types of assistance we will receive under the CARES Act, the PPPHCE Act, the CAA and the ARPA, and it is difficult to predict the impact of such legislation on our operations or how they will affect operations of our competitors. Moreover, we are unable to assess the extent to which anticipated negative impacts on us arising from the COVID-19 pandemic will be offset by amounts or benefits received or to be received under the CARES Act, the PPPHCE Act, the CAA and the ARPA;

- HHS had adopted certain reimbursement policies and regulatory flexibilities favorable to providers during the Public Health Emergency ("PHE") declared in response to the COVID-19 pandemic. HHS has published guidance indicating its intent for the PHE to expire on May 11, 2023. Many of the federal and state legislative and regulatory measures allowing for flexibility in delivery of care and various financial supports for healthcare providers are available only for the duration of the PHE. Most states have ended their state-level emergency declarations. The end of the PHE status will result in the

conclusion of those policies over various designated timeframes. We cannot predict whether the loss of any such favorable conditions available to providers during the declared PHE will ultimately have a negative financial impact on us;

- our ability to comply with the existing laws and government regulations, and/or changes in laws and government regulations;
- an increasing number of legislative initiatives have been passed into law that may result in major changes in the health care delivery system on a national or state level. For example, Congress has reduced to $0 the penalty for failing to maintain health coverage that was part of the original Legislation as part of the Tax Cuts and Jobs Act. President Biden has undertaken and is expected to undertake additional executive actions that will strengthen the Legislation and reverse the policies of the prior administration. To date, the Biden administration has issued executive orders implementing a special enrollment period permitting individuals to enroll in health plans outside of the annual open enrollment period and reexamining policies that may undermine the Legislation or the Medicaid program. The Inflation Reduction Act of 2022 ("IRA") was passed on August 16, 2022, which among other things, allows for CMS to negotiate prices for certain single-source drugs reimbursed under Medicare Part B and Part D. The ARPA's expansion of subsidies to purchase coverage through a Legislation exchange, which the IRA continued through 2025, is anticipated to increase exchange enrollment. The Trump Administration had directed the issuance of final rules (i) enabling the formation of association health plans that would be exempt from certain Legislation requirements such as the provision of essential health benefits, (ii) expanding the availability of short-term, limited duration health insurance, (iii) eliminating cost-sharing reduction payments to insurers that would otherwise offset deductibles and other out-of-pocket expenses for health plan enrollees at or below 250 percent of the federal poverty level, (iv) relaxing requirements for state innovation waivers that could reduce enrollment in the individual and small group markets and lead to additional enrollment in short-term, limited duration insurance and association health plans and (v) incentivizing the use of health reimbursement arrangements by employers to permit employees to purchase health insurance in the individual market. The uncertainty resulting from these Executive Branch policies may have led to reduced Exchange enrollment in 2018, 2019 and 2020. It is also anticipated that these policies, to the extent that they remain as implemented, may create additional cost and reimbursement pressures on hospitals, including ours. In addition, there have been numerous political and legal efforts to expand, repeal, replace or modify the Legislation since its enactment, some of which have been successful, in part, in modifying the Legislation, as well as court challenges to the constitutionality of the Legislation. The U.S. Supreme Court rejected the latest such case on June 17, 2021, when the Court held in *California v. Texas* that the plaintiffs lacked standing to challenge the Legislation's requirement to obtain minimum essential health insurance coverage, or the individual mandate. The Court dismissed the case without specifically ruling on the constitutionality of the Legislation. As a result, the Legislation will continue to remain law, in its entirety, likely for the foreseeable future. On September 7, 2022, the Legislation faced its most recent challenge when a Texas Federal District Court judge, in the case of *Braidwood Management v. Becerra*, ruled that a requirement that certain health plans cover services without cost sharing violates the Appointments Clause of the U.S. Constitution and that the coverage of certain HIV prevention medication violates the Religious Freedom Restoration Act. The government has appealed the decision to the U.S. Circuit Court of Appeals for the Fifth Circuit. Any future efforts to challenge, replace or replace the Legislation or expand or substantially amend its provision is unknown. See below in *Sources of Revenues and Health Care Reform* for additional disclosure;
- under the Legislation, hospitals are required to make public a list of their standard charges, and effective January 1, 2019, CMS has required that this disclosure be in machine-readable format and include charges for all hospital items and services and average charges for diagnosis-related groups. On November 27, 2019, CMS published a final rule on "Price Transparency Requirements for Hospitals to Make Standard Charges Public." This rule took effect on January 1, 2021 and requires all hospitals to also make public their payer-specific negotiated rates, minimum negotiated rates, maximum negotiated rates, and discounted cash rates, for all items and services, including individual items and services and service packages, that could be provided by a hospital to a patient. Failure to comply with these requirements may result in daily monetary penalties. On November 2, 2021, CMS released a final rule amending several hospital price transparency policies and increasing the amount of penalties for noncompliance through the use of a scaling factor based on hospital bed count. On April 26, 2023, CMS announced updated enforcement processes that requires a shortened timeline for coming into compliance when a violation has been identified and the automatic imposition of a civil monetary penalties in certain circumstances of noncompliance;
- as part of the CAA, Congress passed legislation aimed at preventing or limiting patient balance billing in certain circumstances. The CAA addresses surprise medical bills stemming from emergency services, out-of-network ancillary providers at in-network facilities, and air ambulance carriers. The legislation prohibits surprise billing when out-of-network emergency services or out-of-network services at an in-network facility are provided, unless informed consent is received. In these circumstances providers are prohibited from billing the patient for any amounts that exceed in-network cost-sharing requirements. HHS, the Department of Labor and the Department of the Treasury have issued interim final rules, which begin to implement the legislation. The rules are expected to limit our ability to receive payment for services at usually higher out-of-network rates in certain circumstances and prohibit out-of-network payments in other circumstances. On February 28, 2022, a district judge in the Eastern District of Texas invalidated portions of the rule

governing aspects of the Independent Dispute Resolution ("IDR") process. In light of this decision, the government issued a final rule on August 19, 2022 eliminating the rebuttable presumption in favor of the qualifying payment amount ("QPA") by the IDR entity and providing additional factors the IDR entity should consider when choosing between two competing offers. On September 22, 2022, the Texas Medical Association filed a lawsuit challenging the IDR process provided in the updated final rule and alleging that the final rule unlawfully elevates the QPA above other factors the IDR entity must consider. On February 6, 2023, a federal judge vacated parts of the rule, including provisions related to considerations of the QPA;

- possible unfavorable changes in the levels and terms of reimbursement for our charges by third party payers or government based payers, including Medicare or Medicaid in the United States, and government based payers in the United Kingdom;
- our ability to enter into managed care provider agreements on acceptable terms and the ability of our competitors to do the same;
- the outcome of known and unknown litigation, government investigations, false claims act allegations, and liabilities and other claims asserted against us and other matters as disclosed in *Note 6 to the Consolidated Financial Statements - Commitments and Contingencies* and the effects of adverse publicity relating to such matters*;*
- competition from other healthcare providers (including physician owned facilities) in certain markets;
- technological and pharmaceutical improvements that increase the cost of providing, or reduce the demand for healthcare;
- our ability to attract and retain qualified personnel, nurses, physicians and other healthcare professionals and the impact on our labor and related expenses resulting from a shortage of nurses, physicians and other healthcare professionals;
- demographic changes;
- there is a heightened risk of future cybersecurity threats, including ransomware attacks targeting healthcare providers. If successful, future cyberattacks could have a material adverse effect on our business. Any costs that we incur as a result of a data security incident or breach, including costs to update our security protocols to mitigate such an incident or breach could be significant. Any breach or failure in our operational security systems can result in loss of data or an unauthorized disclosure of or access to sensitive or confidential member or protected personal or health information and could result in significant penalties or fines, litigation, loss of customers, significant damage to our reputation and business, and other losses;
- the availability of suitable acquisition and divestiture opportunities and our ability to successfully integrate and improve our acquisitions since failure to achieve expected acquisition benefits from certain of our prior or future acquisitions could result in impairment charges for goodwill and purchased intangibles;
- the impact of severe weather conditions, including the effects of hurricanes and climate change;
- as discussed below in *Sources of Revenue,* we receive revenues from various state and county-based programs, including Medicaid in all the states in which we operate. We receive annual Medicaid revenues of approximately $100 million, or greater, from each of Texas, California, Nevada, Illinois, Pennsylvania, Washington, D.C., Kentucky, Florida and Massachusetts. We also receive Medicaid disproportionate share hospital ("DSH") payments in certain states including Texas and South Carolina. We are therefore particularly sensitive to potential reductions in Medicaid and other state-based revenue programs as well as regulatory, economic, environmental and competitive changes in those states. On April 14, 2023, the Texas Health and Human Services Commission ("THHSC") published a proposed rule that would retroactively modify the Medicaid DSH hospital payments and Medicaid waiver payments to hospitals for uncompensated charity care ("UC") for the period to October 1, 2022 to September 30, 2023. If implemented as proposed, THHSC's financial modeling estimates indicate this proposed rule would reduce our annual Medicaid DSH and UC payments by approximately $32 million. We can provide no assurance that reductions to revenues earned pursuant to these programs, and the effect of the COVID-19 pandemic on state budgets, particularly in the above-mentioned states, will not have a material adverse effect on our future results of operations;
- our ability to continue to obtain capital on acceptable terms, including borrowed funds, to fund the future growth of our business;
- our inpatient acute care and behavioral health care facilities may experience decreasing admission and length of stay trends;
- our financial statements reflect large amounts due from various commercial and private payers and there can be no assurance that failure of the payers to remit amounts due to us will not have a material adverse effect on our future results of operations;

- the Budget Control Act of 2011 (the "2011 Act") imposed annual spending limits for most federal agencies and programs aimed at reducing budget deficits by $917 billion between 2012 and 2021, according to a report released by the Congressional Budget Office. Among its other provisions, the law established a bipartisan Congressional committee, known as the Joint Select Committee on Deficit Reduction (the "Joint Committee"), which was tasked with making recommendations aimed at reducing future federal budget deficits by an additional $1.5 trillion over 10 years. The Joint Committee was unable to reach an agreement by the November 23, 2011 deadline and, as a result, across-the-board cuts to discretionary, national defense and Medicare spending were implemented on March 1, 2013 resulting in Medicare payment reductions of up to 2% per fiscal year with a uniform percentage reduction across all Medicare programs. The Bipartisan Budget Act of 2015, enacted on November 2, 2015, continued the 2% reductions to Medicare reimbursement imposed under the 2011 Act. Recent legislation suspended payment reductions through December 31, 2021 in exchange for extended cuts through 2030. Subsequent legislation extended the payment reduction suspension through March 31, 2022, with a 1% payment reduction from then until June 30, 2022 and the full 2% payment reduction thereafter. The most recent legislation extended these reductions through 2032. We cannot predict whether Congress will restructure the implemented Medicare payment reductions or what other federal budget deficit reduction initiatives may be proposed by Congress going forward. See below in *2019 Novel Coronavirus Disease Medicare and Medicaid Payment Related Legislation – Medicare Sequestration Relief*, for additional disclosure related to the favorable effect the legislative extensions have had on our results of operations;
- uninsured and self-pay patients treated at our acute care facilities unfavorably impact our ability to satisfactorily and timely collect our self-pay patient accounts;
- changes in our business strategies or development plans;
- in June, 2016, the United Kingdom affirmatively voted in a non-binding referendum in favor of the exit of the United Kingdom ("U.K.") from the European Union (the "Brexit") and it was approved by vote of the British legislature. On March 29, 2017, the United Kingdom triggered Article 50 of the Lisbon Treaty, formally starting negotiations regarding its exit from the European Union. On January 31, 2020, the U.K. formally exited the European Union. On December 24, 2020, the United Kingdom and the European Union reached a post-Brexit trade and cooperation agreement that created new business and security requirements and preserved the United Kingdom's tariff- and quota-free access to the European Union member states. The trade and cooperation agreement was provisionally applied as of January 1, 2021 and entered into force on May 1, 2021, following ratification by the European Union. We do not know to what extent Brexit will ultimately impact the business and regulatory environment in the U.K., the European Union, or other countries. Any of these effects of Brexit, and others we cannot anticipate, could harm our business, financial condition and results of operations;
- in 2021, the rate of inflation in the United States began to increase and has since risen to levels not experienced in over 40 years. We are experiencing inflationary pressures, primarily in personnel costs, and we anticipate continuing impacts on other cost areas within the next twelve months. The extent of any future impacts from inflation on our business and our results of operations will be dependent upon how long the elevated inflation levels persist and the extent to which the rate of inflation further increases, if at all, neither of which we are able to predict. If elevated levels of inflation were to persist or if the rate of inflation were to accelerate, our expenses could increase faster than anticipated and we may utilize our capital resources sooner than expected. Further, given the complexities of the reimbursement landscape in which we operate, our payers may be unwilling or unable to increase reimbursement rates to compensate for inflationary impacts. Although we have hedged some of our floating rate indebtedness, the rapid increase in interest rates have increased our interest expense significantly increasing our expenses and reducing our free cash flow and our ability to access the capital markets on favorable terms. As such, the effects of inflation may adversely impact our results of operations, financial condition and cash flows;
- we have exposure to fluctuations in foreign currency exchange rates, primarily the pound sterling. We have international subsidiaries that operate in the United Kingdom. We routinely hedge our exposures to foreign currencies with certain financial institutions in an effort to minimize the impact of certain currency exchange rate fluctuations, but these hedges may be inadequate to protect us from currency exchange rate fluctuations. To the extent that these hedges are inadequate, our reported financial results or the way we conduct our business could be adversely affected. Furthermore, if a financial counterparty to our hedges experiences financial difficulties or is otherwise unable to honor the terms of the foreign currency hedge, we may experience material financial losses;
- the impact of a shift of care from inpatient to lower cost outpatient settings and controls designed to reduce inpatient services on our revenue, and;
- other factors referenced herein or in our other filings with the Securities and Exchange Commission.

Given these uncertainties, risks and assumptions, as outlined above, you are cautioned not to place undue reliance on such forward-looking statements. Our actual results and financial condition could differ materially from those expressed in, or implied by, the

forward-looking statements. Forward-looking statements speak only as of the date the statements are made. We assume no obligation to publicly update any forward-looking statements to reflect actual results, changes in assumptions or changes in other factors affecting forward-looking information, except as may be required by law. All forward-looking statements attributable to us or persons acting on our behalf are expressly qualified in their entirety by this cautionary statement.

Critical Accounting Policies and Estimates

There have been no significant changes to our critical accounting policies or estimates from those disclosed in our 2022 Annual Report on Form 10-K.

Recent Accounting Standards: For a summary of accounting standards, please see *Note 14 to the Condensed Consolidated Financial Statements*, as included herein.

Results of Operations

COVID-19, Clinical Staffing Shortage and Effects of Inflation:

The impact of the COVID-19 pandemic, which began during the second half of March, 2020, has had a material effect on our operations and financial results since that time. The length and extent of the disruptions caused by the COVID-19 pandemic are currently unknown; however, we expect such disruptions to continue into the future which could materially impact our results of operations.

The healthcare industry is labor intensive and salaries, wages and benefits are subject to inflationary pressures, as are supplies expense and other operating expenses. In addition, the nationwide shortage of nurses and other clinical staff and support personnel has been a significant operating issue facing us and other healthcare providers. Like others in the healthcare industry, we continue to experience a shortage of nurses and other clinical staff and support personnel at our acute care and behavioral health care hospitals in many geographic areas. In some areas, the labor scarcity has strained our resources and staff, which has required us to utilize higher-cost temporary labor and pay premiums above standard compensation for essential workers. This staffing shortage has, at times, required us to hire expensive temporary personnel and/or enhance wages and benefits to recruit and retain nurses and other clinical staff and support personnel. At certain facilities, particularly within our behavioral health care segment, there have been occasions when we were unable to fill all vacant positions and, consequently, we were required to limit patient volumes. This staffing shortage could require us to further enhance wages and benefits to recruit and retain nurses and other clinical staff and support personnel or require us to hire expensive temporary personnel. We have also experienced cost increases related to the procurement of medical supplies as well as certain of our other operating expenses which we believe resulted from supply chain disruptions as well as general inflationary pressures. These factors, which had a material unfavorable impact on our results of operations during 2022, have been moderating to a certain degree but are expected to continue to have an unfavorable material impact on our results of operations for the foreseeable future.

Although our ability to pass on increased costs associated with providing healthcare to Medicare and Medicaid patients is limited due to various federal, state and local laws which, in certain circumstances, limit our ability to increase prices, we have begun negotiating increased rates from commercial insurers to defray our increased cost of providing patient care. In addition, we have implemented various productivity enhancement programs and cost reduction initiatives including, but not limited to, the following: team-based patient care initiatives designed to optimize the level of patient care services provided by our licensed nurses/clinicians; efforts to reduce utilization of, and rates paid for, premium pay labor; consolidation of medical supply vendors to increase purchasing discounts; review and reduction of clinical variation in connection with the utilization of medical supplies, and; various other efforts to increase productivity and/or reduce costs including investments in new information technology applications.

Financial results for the three-month periods ended March 31, 2023 and 2022:

The following table summarizes our results of operations and is used in the discussion below for the three-month periods ended March 31, 2023 and 2022 (dollar amounts in thousands):

	Three months ended March 31, 2023		Three months ended March 31, 2022	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 3,467,518	100.0%	$ 3,292,956	100.0%
Operating charges:				
Salaries, wages and benefits	1,753,335	50.6%	1,692,270	51.4%
Other operating expenses	878,951	25.3%	820,934	24.9%
Supplies expense	379,989	11.0%	371,073	11.3%
Depreciation and amortization	141,621	4.1%	143,784	4.4%
Lease and rental expense	34,922	1.0%	32,038	1.0%
Subtotal-operating expenses	3,188,818	92.0%	3,060,099	92.9%
Income from operations	278,700	8.0%	232,857	7.1%
Interest expense, net	50,876	1.5%	21,673	0.7%
Other (income) expense, net	13,723	0.4%	11,201	0.3%
Income before income taxes	214,101	6.2%	199,983	6.1%
Provision for income taxes	51,726	1.5%	48,962	1.5%
Net income	162,375	4.7%	151,021	4.6%
Less: Income (loss) attributable to noncontrolling interests	(740)	(0.0)%	(2,892)	(0.1)%
Net income attributable to UHS	$ 163,115	4.7%	$ 153,913	4.7%

Net revenues increased by 5.3%, or $175 million, to $3.47 billion during the three-month period ended March 31, 2023, as compared to $3.29 billion during the first quarter of 2022. The net increase was primarily attributable to: (i) a $193 million or 6.1% increase in net revenues generated from our acute care hospital services and behavioral health services operated during both periods (which we refer to as “Same Facility”), and; (ii) $18 million of other combined net decreases including $32 million of decreased revenues at Desert Springs Hospital Medical Center ("Desert Springs") located in Las Vegas, Nevada, which, as previously disclosed, discontinued all inpatient operations during the first quarter of 2023.

Income before income taxes (before income attributable to noncontrolling interests) increased by $14 million, or 7%, to $214 million during the three-month period ended March 31, 2023 as compared to $200 million during the first quarter of 2022. The $14 million net increase was due to:

- a decrease of $10 million at our acute care facilities, as discussed below in *Acute Care Hospital Services*;
- an increase of $60 million at our behavioral health care facilities, as discussed below in *Behavioral Health Services*;
- a decrease of $29 million due to an increase in interest expense due to an increase in our aggregate average outstanding borrowings as well as an increase in our weighted average cost of borrowings, as discussed below in *Other Operating Results-Interest Expense*, and;
- $7 million of other combined net decreases.

Net income attributable to UHS increased by $9 million, or 6%, to $163 million during the three-month period ended March 31, 2023 as compared to $154 million during the first quarter of 2022. This increase was attributable to:

- a $14 million increase in income before income taxes, as discussed above;
- a decrease of $2 million due to a decrease in the loss attributable to noncontrolling interests, and;
- a decrease of $3 million resulting from an increase in the provision for income taxes due primarily to the income tax expense recorded in connection with the $12 million increase in pre-tax income.

Acute Care Hospital Services

Same Facility Basis Acute Care Hospital Services

We believe that providing our results on a “Same Facility” basis (which is a non-GAAP measure), which includes the operating results for facilities and businesses operated in both the current year and prior year periods, is helpful to our investors as a measure of our operating performance. Our Same Facility results also neutralize (if applicable) the effect of items that are non-operational in nature including items such as, but not limited to, gains/losses on sales of assets and businesses, impacts of settlements, legal judgments and lawsuits, impairments of long-lived and intangible assets and other amounts that may be reflected in the current or prior year financial statements that relate to prior periods.

Our Same Facility basis results reflected on the table below also exclude from net revenues and other operating expenses, provider tax assessments incurred in each period as discussed below *Sources of Revenue-Various State Medicaid Supplemental Payment Programs*. However, these provider tax assessments are included in net revenues and other operating expenses as reflected in the table below under *All Acute Care Hospital Services*. The provider tax assessments had no impact on the income before income taxes as reflected on the tables below since the amounts offset between net revenues and other operating expenses. To obtain a complete understanding of our financial performance, the Same Facility results should be examined in connection with our net income as determined in accordance with U.S. GAAP and as presented in the condensed consolidated financial statements and notes thereto as contained in this Quarterly Report on Form 10-Q.

The following table summarizes the results of operations for our acute care facilities on a Same Facility basis and is used in the discussion below for the three-month periods ended March 31, 2023 and 2022 (dollar amounts in thousands):

	Three months ended March 31, 2023		Three months ended March 31, 2022	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,889,080	100.0%	$ 1,824,697	100.0%
Operating charges:				
Salaries, wages and benefits	810,553	42.9%	811,643	44.5%
Other operating expenses	492,400	26.1%	434,470	23.8%
Supplies expense	316,256	16.7%	310,082	17.0%
Depreciation and amortization	86,927	4.6%	91,764	5.0%
Lease and rental expense	23,592	1.2%	20,705	1.1%
Subtotal-operating expenses	1,729,728	91.6%	1,668,664	91.4%
Income from operations	159,352	8.4%	156,033	8.6%
Interest expense, net	(577)	(0.0)%	638	0.0%
Other (income) expense, net	6,213	0.3%	201	0.0%
Income before income taxes	$ 153,716	8.1%	$ 155,194	8.5%

Three-month periods ended March 31, 2023 and 2022:

During the three-month period ended March 31, 2023, as compared to the comparable prior year quarter, net revenues from our acute care hospital services, on a Same Facility basis, increased by $64 million or 3.5%. Income before income taxes (and before income attributable to noncontrolling interests) decreased by $1 million, or 1%, amounting to $154 million, or 8.1% of net revenues during the first quarter of 2023, as compared to $155 million, or 8.5% of net revenues during the first quarter of 2022.

During the three-month period ended March 31, 2023, net revenue per adjusted admission decreased by 7.5% while net revenue per adjusted patient day decreased 1.5%, as compared to the comparable quarter of 2022. During the first quarter of 2023, we experienced a decrease in the number of patients with a COVID-19 diagnosis treated in our acute care hospitals, as compared to the comparable quarter in the prior year. As a percentage of total admissions, patients diagnosed with COVID-19 comprised 14% of our inpatient admissions during the first quarter of 2022, but only 4% of our inpatient admissions during the first quarter of 2023. This decline in COVID-19 patients unfavorably impacted our net revenues due to lower acuity and less incremental government reimbursement associated with COVID-19 patients. While overall surgical volumes were robust, increasing by approximately 10% from the first quarter of 2022, there was a continued shift from inpatient surgeries to outpatient surgeries, which further contributed to the lower than expected revenues.

During the three-month period ended March 31, 2023, as compared to the comparable prior year quarter, inpatient admissions to our acute care hospitals increased by 7.2% while adjusted admissions (adjusted for outpatient activity) increased by 10.5%. Patient days at these facilities increased by 0.6% and adjusted patient days increased by 3.7% during the three-month period ended March 31, 2023, as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities was 5.1 days and 5.4 days during the three-month periods ended March 31, 2023 and 2022, respectively. The occupancy rate, based on the average available beds at these facilities, was 70% and 69% during the three-month periods ended March 31, 2023 and 2022, respectively.

On a Same Facility basis during the three-month period ended March 31, 2023, as compared to the comparable quarter of 2022, salaries, wages and benefits expense remained relatively unchanged as the higher labor costs due, in part, to the healthcare labor shortage and utilization of higher-cost temporary labor and pay premiums began to abate.

Other operating expenses increased $58 million, or 13.3%, during the first quarter of 2023, as compared to the comparable quarter of 2022. Operating expenses, consisting primarily of medical costs incurred in connection with our commercial health insurer, increased approximately $19 million during the first quarter of 2023 as compared to the comparable quarter of 2022. Excluding the operating expenses incurred in connection with our commercial health insurer, other operating expenses increased $39 million, or 11.3%. Included in the increase during the first quarter of 2023, as compared to the first quarter of 2022, was a $28 million increase in physician-related expenses.

Supplies expense increased $6 million, or 2.0%, during the first quarter of 2023, as compared to the first quarter of 2022.

All Acute Care Hospitals

The following table summarizes the results of operations for all our acute care operations during the three-month periods ended March 31, 2023 and 2022. These amounts include: (i) our acute care results on a Same Facility basis, as indicated above; (ii) the impact of provider tax assessments which increased net revenues and other operating expenses but had no impact on income before income taxes, and; (iii) certain other amounts including, if applicable, the results of recently acquired/opened ancillary facilities and businesses. Dollar amounts below are reflected in thousands.

	Three months ended March 31, 2023		Three months ended March 31, 2022	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,973,532	100.0%	$ 1,912,316	100.0%
Operating charges:				
Salaries, wages and benefits	843,960	42.8%	843,906	44.1%
Other operating expenses	544,300	27.6%	482,078	25.2%
Supplies expense	328,060	16.6%	321,427	16.8%
Depreciation and amortization	93,326	4.7%	94,534	4.9%
Lease and rental expense	24,154	1.2%	20,852	1.1%
Subtotal-operating expenses	1,833,800	92.9%	1,762,797	92.2%
Income from operations	139,732	7.1%	149,519	7.8%
Interest expense, net	(577)	(0.0)%	638	0.0%
Other (income) expense, net	7,013	0.4%	201	0.0%
Income before income taxes	$ 133,296	6.8%	$ 148,680	7.8%

Three-month periods ended March 31, 2023 and 2022:

During the three-month period ended March 31, 2023, as compared to the comparable prior year quarter, net revenues from our acute care hospital services increased by $61 million, or 3.2%, due to: (i) the $64 million, or 3.5% increase in Same Facility revenues, as discussed above, and; (ii) $3 million of other combined decreases including $32 million of decreased revenues at Desert Springs, located in Las Vegas, Nevada, which discontinued all inpatient operations during the first quarter of 2023, partially offset by revenues generated at facilities and businesses opened or acquired during the past year, including the revenues generated at a new, 170-bed acute care hospital located in Reno, Nevada, that opened in early April, 2022.

Income before income taxes decreased by $15 million, or 10%, to $133 million, or 6.8% of net revenues during the first quarter of 2023, as compared to $149 million, or 7.8% of net revenues during the first quarter of 2022. The $15 million decrease in income before income taxes from our acute care hospital services resulted from the $1 million, or 1%, decrease in income before income taxes at our hospitals, on a Same Facility basis, as discussed above, and $14 million of other combined net decreases related primarily to the increased losses incurred at Desert Springs, which discontinued inpatient operations during the first quarter of 2023, and the new hospital located in Reno, Nevada, that opened in early April, 2022.

During the three-month period ended March 31, 2023, as compared to the comparable quarter of 2022, salaries, wages and benefits expense remained relatively unchanged. Supplies expense increased $7 million, or 2.1%, during the first quarter of 2023, as compared to the first quarter of 2022.

Other operating expenses increased $62 million, or 12.9%, during the first quarter of 2023, as compared to the comparable quarter of 2022. The increase was due primarily to the $58 million, or 13.3%, above-mentioned increase related to our acute care hospital services, on a Same Facility basis.

Please see *Results of Operations - COVID-19, Clinical Staffing Shortage and Effects of Inflation* above for additional disclosure regarding the factors impacting our operating costs.

Charity Care and Uninsured Discounts:

The following tables show the amounts recorded at our acute care hospitals for charity care and uninsured discounts, based on charges at established rates, for the three-month periods ended March 31, 2023 and 2022:

Uncompensated care:

Amounts in millions	Three Months Ended			
	March 31, 2023	%	March 31, 2022	%
Charity care	$ 193	32%	$ 215	46%
Uninsured discounts	418	68%	255	54%
Total uncompensated care	$ 611	100%	$ 470	100%

Estimated cost of providing uncompensated care:

The estimated costs of providing uncompensated care as reflected below were based on a calculation which multiplied the percentage of operating expenses for our acute care hospitals to gross charges for those hospitals by the above-mentioned total uncompensated care amounts. The percentage of cost to gross charges is calculated based on the total operating expenses for our acute care facilities divided by gross patient service revenue for those facilities.

	Three Months Ended	
Amounts in millions	March 31, 2023	March 31, 2022
Estimated cost of providing charity care	$ 19	$ 23
Estimated cost of providing uninsured discounts related care	40	27
Estimated cost of providing uncompensated care	$ 59	$ 50

Behavioral Health Services

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

Our Same Facility basis results reflected on the table below also excludes from net revenues and other operating expenses, provider tax assessments incurred in each period as discussed below *Sources of Revenue-Various State Medicaid Supplemental Payment Programs.* However, these provider tax assessments are included in net revenues and other operating expenses as reflected in the table below under *All Behavioral Health Care Services*. The provider tax assessments had no impact on the income before income taxes as reflected on the tables below since the amounts offset between net revenues and other operating expenses. To obtain a complete understanding of our financial performance, the Same Facility results should be examined in connection with our net income as determined in accordance with U.S. GAAP and as presented in the condensed consolidated financial statements and notes thereto as contained in this Quarterly Report on Form 10-Q.

The following table summarizes the results of operations for our behavioral health care facilities, on a Same Facility basis, and is used in the discussions below for the three-month periods ended March 31, 2023 and 2022 (dollar amounts in thousands):

Same Facility—Behavioral Health

	Three months ended March 31, 2023		Three months ended March 31, 2022	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,459,719	100.0 %	$ 1,330,812	100.0 %
Operating charges:				
Salaries, wages and benefits	805,946	55.2 %	746,160	56.1 %
Other operating expenses	277,369	19.0 %	268,548	20.2 %
Supplies expense	52,330	3.6 %	49,618	3.7 %
Depreciation and amortization	45,001	3.1 %	45,482	3.4 %
Lease and rental expense	10,582	0.7 %	10,261	0.8 %
Subtotal-operating expenses	1,191,228	81.6 %	1,120,069	84.2 %
Income from operations	268,491	18.4 %	210,743	15.8 %
Interest expense, net	1,078	0.1 %	1,227	0.1 %
Other (income) expense, net	(576)	(0.0)%	(115)	(0.0)%
Income before income taxes	$ 267,989	18.4 %	$ 209,631	15.8 %

Three-month periods ended March 31, 2023 and 2022:

During the three-month period ended March 31, 2023, as compared to the comparable prior year quarter, net revenues from our behavioral health services, on a Same Facility basis, increased by $129 million or 9.7%. Income before income taxes (and before income attributable to noncontrolling interests) increased by $58 million, or 28%, amounting to $268 million or 18.4% of net revenues during the first quarter of 2023, as compared to $210 million or 15.8% of net revenues during the first quarter of 2022.

During the three-month period ended March 31, 2023, net revenue per adjusted admission increased by 2.2% while net revenue per adjusted patient day increased by 5.0%, as compared to the comparable quarter of 2022. During the three-month period ended March 31, 2023, as compared to the comparable prior year quarter, inpatient admissions and adjusted admissions to our behavioral health care hospitals each increased by 7.5%. Patient days at these facilities increased by 4.6% and adjusted patient days increased by 4.7% during the three-month period ended March 31, 2023, as compared to the comparable prior year quarter. The average length of

inpatient stay at these facilities was 13.1 days and 13.4 days during the three-month periods ended March 31, 2023 and 2022, respectively. The occupancy rate, based on the average available beds at these facilities, was 73% and 70% during the three-month periods ended March 31, 2023 and 2022, respectively.

On a Same Facility basis during the three-month period ended March 31, 2023, as compared to the comparable quarter of 2022, salaries, wages and benefits expense increased $60 million or 8.0%. The increase during the first quarter of 2023, as compared to the first quarter of 2022, was due, in part, to increased staffing levels related to the increased patient volumes. As a percentage of net revenues during each quarter, salaries, wages and benefits expense decreased to 55.2% during the first quarter of 2023 as compared to 56.1% during the first quarter of 2022.

Other operating expenses increased $9 million, or 3.3%, during the first quarter of 2023, as compared to the comparable quarter of 2022. Supplies expense increased $3 million, or 5.5%, during the first quarter of 2023, as compared to the first quarter of 2022 due, in part, to increased patient volumes.

All Behavioral Health Care Facilities

The following table summarizes the results of operations for all our behavioral health care services during the three-month periods ended March 31, 2023 and 2022. These amounts include: (i) our behavioral health care results on a Same Facility basis, as indicated above; (ii) the impact of provider tax assessments which increased net revenues and other operating expenses but had no impact on income before income taxes, and; (iii) certain other amounts including the results of facilities acquired or opened during the past year (if applicable) as well as the results of certain facilities that were closed or restructured during the past year. Dollar amounts below are reflected in thousands.

	Three months ended March 31, 2023		Three months ended March 31, 2022	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,490,489	100.0 %	$ 1,366,467	100.0 %
Operating charges:				
Salaries, wages and benefits	809,786	54.3 %	753,886	55.2 %
Other operating expenses	305,232	20.5 %	298,467	21.8 %
Supplies expense	52,488	3.5 %	50,178	3.7 %
Depreciation and amortization	45,619	3.1 %	46,079	3.4 %
Lease and rental expense	10,668	0.7 %	10,820	0.8 %
Subtotal-operating expenses	1,223,793	82.1 %	1,159,430	84.8 %
Income from operations	266,696	17.9 %	207,037	15.2 %
Interest expense, net	1,211	0.1 %	1,365	0.1 %
Other (income) expense, net	(871)	(0.1)%	(115)	(0.0)%
Income before income taxes	$ 266,356	17.9 %	$ 205,787	15.1 %

Three-month periods ended March 31, 2023 and 2022:

During the three-month period ended March 31, 2023, as compared to the comparable prior year quarter, net revenues generated from our behavioral health services increased by $124 million, or 9.1%.

Income before income taxes increased by $61 million, or 29%, to $266 million or 17.9% of net revenues during the first quarter of 2023, as compared to $206 million or 15.1% of net revenues during the first quarter of 2022. The increase in income before income taxes at our behavioral health facilities during the first quarter of 2023, as compared to the first quarter of 2022, was primarily attributable to the $58 million, or 28% increase in income before income taxes experienced at our behavioral health facilities, on a Same Facility basis, as discussed above.

During the three-month period ended March 31, 2023, as compared to the comparable quarter of 2022, salaries, wages and benefits expense increased $56 million or 7.4%. The increase was due to our behavioral health services, on a Same Facility basis, as discussed above.

Other operating expenses increased $7 million, or 2.3%, during the first quarter of 2023, as compared to the comparable quarter of 2022. Supplies expense increased $2 million, or 4.6%, during the first quarter of 2023, as compared to the first quarter of 2022.

Please see *Results of Operations - COVID-19, Clinical Staffing Shortage and Effects of Inflation* above for additional disclosure regarding the factors impacting our operating costs.

Sources of Revenue

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

Hospital revenues depend upon inpatient occupancy levels, the medical and ancillary services and therapy programs ordered by physicians and provided to patients, the volume of outpatient procedures and the charges or negotiated payment rates for such

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

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

As described below in the section titled *2019 Novel Coronavirus Disease Medicare and Medicaid Payment Related Legislation,* the federal government has enacted multiple pieces of legislation to assist healthcare providers during the COVID-19 world-wide pandemic and U.S. National Emergency declaration. We have outlined those legislative changes related to Medicare and Medicaid payment and their estimated impact on our financial results, where estimates are possible.

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, impacts on state revenue and expenses resulting from the COVID-19 pandemic, economic recovery stimulus packages, responses to natural disasters, and the federal and state budget deficits in general may affect the availability of government funds to provide additional relief in the future. We are unable to predict the effect of future policy changes on our operations.

On March 23, 2010, President Obama signed into law the Legislation. Two primary goals of the Legislation are to provide for increased access to coverage for healthcare and to reduce healthcare-related expenses.

The Legislation revises reimbursement under the Medicare and Medicaid programs to emphasize the efficient delivery of high-quality care and contains a number of incentives and penalties under these programs to achieve these goals. The Legislation and subsequent revisions provide for reductions to both Medicare DSH and Medicaid DSH payments. The Medicare DSH reductions began in October, 2013 while the Medicaid DSH reductions are scheduled to begin in 2024. The Legislation implemented a value-based purchasing program, which will reward the delivery of efficient care. Conversely, certain facilities will receive reduced reimbursement for failing to meet quality parameters; such hospitals will include those with excessive readmission or hospital-acquired condition rates.

A 2012 U.S. Supreme Court ruling limited the federal government's ability to expand health insurance coverage by holding unconstitutional sections of the Legislation that sought to withdraw federal funding for state noncompliance with certain Medicaid coverage requirements. Pursuant to that decision, the federal government may not penalize states that choose not to participate in the Medicaid expansion by reducing their existing Medicaid funding. Therefore, states can choose to expand or not to expand their Medicaid program without risking the loss of federal Medicaid funding. As a result, many states, including Texas, have not expanded their Medicaid programs without the threat of loss of federal funding. CMS has previously granted section 1115 demonstration waivers providing for work and community engagement requirements for certain Medicaid eligible individuals. CMS has also released guidance to states interested in receiving their Medicaid funding through a block grant mechanism. The Biden administration has signaled its intent to withdraw previously issued section 1115 demonstrations aligned with these policies. However, if implemented, the previously issued section 1115 demonstrations are anticipated to lead to reductions in coverage, and likely increases in uncompensated care, in states where these demonstration waivers are granted.

On December 14, 2018, a Texas Federal District Court deemed the Legislation to be unconstitutional in its entirety. The Court concluded that the Individual Mandate is no longer permissible under Congress's taxing power as a result of the Tax Cut and Jobs Act of 2017 ("TCJA") reducing the individual mandate's tax to $0 (i.e., it no longer produces revenue, which is an essential feature of a tax), rendering the Legislation unconstitutional. The Court also held that because the individual mandate is "essential" to the Legislation and is inseverable from the rest of the law, the entire Legislation is unconstitutional. That ruling was ultimately appealed to the United States Supreme Court, which decided in *California v. Texas* that the plaintiffs in the matter lacked standing to bring their constitutionality claims. The Court did not reach the plaintiffs' merits arguments, which specifically challenged the constitutionality of the Legislation's individual mandate and the entirety of the Legislation itself. As a result, the Legislation will continue to be law, and HHS and its respective agencies will continue to enforce regulations implementing the law. However, on September 7, 2022, the Legislation faced its most recent challenge when a Texas Federal District Court judge, in the case of *Braidwood Management v. Becerra*, ruled that a requirement that certain health plans cover services without cost sharing violates the Appointments Clause of the

U.S. Constitution and that the coverage of certain HIV prevention medication violates the Religious Freedom Restoration Act. The government has appealed the decision to the U.S. Circuit Court of Appeals for the Fifth Circuit.

The various provisions in the Legislation that directly or indirectly affect Medicare and Medicaid reimbursement took effect over a number of years. The impact of the Legislation on healthcare providers will be subject to implementing regulations, interpretive guidance and possible future legislation or legal challenges. Certain Legislation provisions, such as that creating the Medicare Shared Savings Program creates uncertainty in how healthcare may be reimbursed by federal programs in the future. Thus, we cannot predict the impact of the Legislation on our future reimbursement at this time and we can provide no assurance that the Legislation will not have a material adverse effect on our future results of operations.

The Legislation also contained provisions aimed at reducing fraud and abuse in healthcare. The Legislation amends several existing laws, including the federal Anti-Kickback Statute and the False Claims Act, making it easier for government agencies and private plaintiffs to prevail in lawsuits brought against healthcare providers. While Congress had previously revised the intent requirement of the Anti-Kickback Statute to provide that a person is not required to "have actual knowledge or specific intent to commit a violation of" the Anti-Kickback Statute in order to be found in violation of such law, the Legislation also provides that any claims for items or services that violate the Anti-Kickback Statute are also considered false claims for purposes of the federal civil False Claims Act. The Legislation provides that a healthcare provider that retains an overpayment in excess of 60 days is subject to the federal civil False Claims Act. The Legislation also expands the Recovery Audit Contractor program to Medicaid. These amendments also make it easier for severe fines and penalties to be imposed on healthcare providers that violate applicable laws and regulations.

We have partnered with local physicians in the ownership of certain of our facilities. These investments have been permitted under an exception to the physician self-referral law. The Legislation permits existing physician investments in a hospital to continue under a "grandfather" clause if the arrangement satisfies certain requirements and restrictions, but physicians are prohibited from increasing the aggregate percentage of their ownership in the hospital. The Legislation also imposes certain compliance and disclosure requirements upon existing physician-owned hospitals and restricts the ability of physician-owned hospitals to expand the capacity of their facilities. As discussed below, should the Legislation be repealed in its entirety, this aspect of the Legislation would also be repealed restoring physician ownership of hospitals and expansion right to its position and practice as it existed prior to the Legislation.

The impact of the Legislation on each of our hospitals may vary. Because Legislation provisions are effective at various times over the next several years, we anticipate that many of the provisions in the Legislation may be subject to further revision. Initiatives to repeal the Legislation, in whole or in part, to delay elements of implementation or funding, and to offer amendments or supplements to modify its provisions have been persistent. The ultimate outcomes of legislative attempts to repeal or amend the Legislation and legal challenges to the Legislation are unknown. Legislation has already been enacted that eliminated the individual mandate penalty, effective January 1, 2019, related to the obligation to obtain health insurance that was part of the original Legislation. In addition, Congress previously considered legislation that would, in material part: (i) eliminate the large employer mandate to offer health insurance coverage to full-time employees; (ii) permit insurers to impose a surcharge up to 30 percent on individuals who go uninsured for more than two months and then purchase coverage; (iii) provide tax credits towards the purchase of health insurance, with a phase-out of tax credits accordingly to income level; (iv) expand health savings accounts; (v) impose a per capita cap on federal funding of state Medicaid programs, or, if elected by a state, transition federal funding to block grants, and; (vi) permit states to seek a waiver of certain federal requirements that would allow such state to define essential health benefits differently from federal standards and that would allow certain commercial health plans to take health status, including pre-existing conditions, into account in setting premiums.

In addition to legislative changes, the Legislation can be significantly impacted by executive branch actions. President Biden has taken executive actions that will strengthen the Legislation and may reverse the policies of the prior administration. To date, the Biden administration has issued executive orders implementing a special enrollment period permitting individuals to enroll in health plans outside of the annual open enrollment period and reexamining policies that may undermine the ACA or the Medicaid program. The ARPA's expansion of subsidies to purchase coverage through an exchange contributed to increased exchange enrollment in 2021. The IRA's extension of the subsidies through 2025 is expected to increase exchange enrollment in future years. The recent and on-going COVID-19 pandemic and related U.S. National Emergency declaration may significantly increase the number of uninsured patients treated at our facilities extending beyond the most recent CBO published estimates due to increased unemployment and loss of group health plan health insurance coverage. It is also anticipated that these policies may create additional cost and reimbursement pressures on hospitals.

It remains unclear what portions of the Legislation may remain, or whether any replacement or alternative programs may be created by any future legislation. Any such future repeal or replacement may have significant impact on the reimbursement for healthcare services generally, and may create reimbursement for services competing with the services offered by our hospitals. Accordingly, there can be no assurance that the adoption of any future federal or state healthcare reform legislation will not have a negative financial impact on our hospitals, including their ability to compete with alternative healthcare services funded by such potential legislation, or for our hospitals to receive payment for services.

For additional disclosure related to our revenues including a disaggregation of our consolidated net revenues by major source for each of the periods presented herein, please see *Note 12 to the Consolidated Financial Statements-Revenue*.

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

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

In April, 2023, CMS published its IPPS 2023 proposed payment rule which provides for a 2.8% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments, and adjustments mandated by the Legislation are considered, without consideration for the required Medicare DSH payments changes and increase to the Medicare Outlier threshold, the overall increase in IPPS payments is approximately 3.6%. Including DSH payments, an increase to the Medicare Outlier threshold and certain other adjustments, we estimate our overall increase from the proposed IPPS 2024 rule (covering the period of October 1, 2023 through September 30, 2024) will approximate 3.5%.

In August, 2022, CMS published its IPPS 2023 final payment rule which provides for a 4.1% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments, and adjustments mandated by the Legislation are considered, without consideration for the required Medicare DSH payments changes and increase to the Medicare Outlier threshold, the overall increase in IPPS payments is approximately 4.6.%. Including DSH payments, an increase to the Medicare Outlier threshold and certain other adjustments, we estimate our overall increase from the final IPPS 2023 rule (covering the period of October 1, 2022 through September 30, 2023) will approximate 4.4%. This projected impact from the IPPS 2023 final rule includes an increase of approximately 0.5% to partially restore cuts made as a result of the American Taxpayer Relief Act of 2012 ("ATRA"), as required by the 21st Century Cures Act, but excludes the impact of the sequestration reductions related to the 2011 Act, Bipartisan Budget Act of 2015, and Bipartisan Budget Act of 2018.

In June, 2019, the Supreme Court of the United States issued a decision favorable to hospitals impacting prior year Medicare DSH payments (*Azar v. Allina Health Services*, No. 17-1484 (U.S. Jun. 3, 2019)). In *Allina*, the hospitals challenged the Medicare DSH adjustments for federal fiscal year 2012, specifically challenging CMS's decision to include inpatient hospital days attributable to Medicare Part C enrollee patients in the numerator and denominator of the Medicare/SSI fraction used to calculate a hospital's DSH payments. This ruling addresses CMS's attempts to impose the policy espoused in its vacated 2004 rulemaking to a fiscal year in the 2004–2013 time period without using notice-and-comment rulemaking. This decision should require CMS to recalculate hospitals' DSH Medicare/SSI fractions, with Medicare Part C days excluded, for at least federal fiscal year 2012, but likely federal fiscal years 2005 through 2013. In August, 2020, CMS issued a rule that proposed to retroactively negate the effects of the aforementioned Supreme Court decision, which rule has yet to be finalized. Although we can provide no assurance that we will ultimately receive additional funds, we estimate that the favorable impact of this court ruling on certain prior year hospital Medicare DSH payments could range between $18 million to $28 million in the aggregate.

The 2011 Act included the imposition of annual spending limits for most federal agencies and programs aimed at reducing budget deficits by $917 billion between 2012 and 2021, according to a report released by the Congressional Budget Office. Among its other provisions, the law established a bipartisan Congressional committee, known as the Joint Committee, which was responsible for developing recommendations aimed at reducing future federal budget deficits by an additional $1.5 trillion over 10 years. The Joint Committee was unable to reach an agreement by the November 23, 2011 deadline and, as a result, across-the-board cuts to discretionary, national defense and Medicare spending were implemented on March 1, 2013 resulting in Medicare payment reductions of up to 2% per fiscal year. Subsequent legislation has extended this sequestration through 2032. The CARES Act, as amended,

temporarily suspended or limited the application of this sequestration from May 1, 2020 through June 30, 2022, with a return to the full 2% Medicare payment reduction thereafter.

Inpatient services furnished by psychiatric hospitals under the Medicare program are paid under a Psychiatric Prospective Payment System ("Psych PPS"). Medicare payments to psychiatric hospitals are based on a prospective per diem rate with adjustments to account for certain facility and patient characteristics. The Psych PPS also contains provisions for outlier payments and an adjustment to a psychiatric hospital's base payment if it maintains a full-service emergency department.

In April, 2023, CMS published its Psych PPS proposed rule for the federal fiscal year 2024. Under this proposed rule, payments to our behavioral health care hospitals and units are estimated to increase by 3.0% compared to federal fiscal year 2023. This amount includes the effect of the 3.2% net market basket update which reflects the offset of a 0.2% productivity adjustment.

In July, 2022, CMS published its Psych PPS final rule for the federal fiscal year 2023. Under this final rule, payments to our behavioral health care hospitals and units are estimated to increase by 3.8% compared to federal fiscal year 2022. This amount includes the effect of the 4.1% net market basket update which reflects the offset of a 0.3% productivity adjustment.

CMS's calendar year 2018 final OPPS rule, issued on November 13, 2017, substantially reduced Medicare Part B reimbursement for 340B Program drugs paid to hospitals. Beginning January 1, 2018, CMS reimbursement for certain separately payable drugs or biologicals that are acquired through the 340B Program by a hospital paid under the OPPS (and not excepted from the payment adjustment policy) is the average sales price of the drug or biological minus 22.5 percent, an effective reduction of 26.89% in payments for 340B program drugs. In December, 2018, the U.S. District Court for the District of Columbia ruled that HHS did not have statutory authority to implement the 2018 Medicare OPPS rate reduction related to hospitals that qualify for drug discounts under the federal 340B Program and granted a permanent injunction against the payment reduction. On July 31, 2020, the U.S. Court of Appeals for the D.C. Circuit reversed the District Court and held that HHS's decision to lower drug reimbursement rates for 340B hospitals rests on a reasonable interpretation of the Medicare statute. As a result, we recognized $8 million of revenues during 2020 that were previously reserved in a prior year. These payment reductions were challenged before the U.S. Supreme Court, which held in *American Hospital Association v. Becerra* that because HHS did not conduct a survey of hospitals' acquisition costs in 2018 and 2019, its decision to vary reimbursement rates only for 340B hospitals in those years was unlawful. As a result of the Supreme Court's decision, CMS finalized for calendar year 2023 a payment rate of average sales price plus 6% for 340B Program drugs, consistent with CMS policy for drugs not acquired through the program. CMS further implemented a 3.09% reduction to payment rates for non-drug services to achieve budget neutrality for the 340B Program payment rate change for calendar year 2023. CMS will address the remedy for 340B drug payments from 2018-2022 in future rulemaking prior to the calendar year 2024 OPPS proposed rule.

In November, 2022, CMS issued its OPPS final rule for 2023. The hospital market basket increase is 4.1% and the productivity adjustment reduction is -0.3% for a net market basket increase of 3.8%. The final rule provides that in light of the Supreme Court decision in *American Hospital Association v. Becerra*, CMS is applying the default rate, generally average sales price plus 6%, to 340B acquired drugs and biologicals for 2023. CMS stated they will address the remedy for 340B drug payments from 2018-2022 in future rulemaking prior to the CY 2024 OPPS/ASC proposed rule. During the 2018-2022 time period, we recorded an aggregate of approximately $45 million to $50 million of Medicare revenues related to the prior 340B payment policy. When other statutorily required adjustments and hospital patient service mix are considered as well as impact of the aforementioned 340B Program policy change, we estimate that our overall Medicare OPPS update for 2023 will aggregate to a net increase of 0.9% which includes a 0.3% increase to behavioral health division partial hospitalization rates.

On November 2, 2021, CMS issued its OPPS final rule for 2022. The hospital market basket increase is 2.7% and the productivity adjustment reduction is -0.7% for a net market basket increase of 2.0%. When other statutorily required adjustments and hospital patient service mix are considered, we estimate that our overall Medicare OPPS update for 2022 will aggregate to a net increase of 2.4% which includes a 3.0% increase to behavioral health division partial hospitalization rates.

In November, 2019, CMS finalized its Hospital Price Transparency rule that implements certain requirements under the June 24, 2019 Presidential Executive Order related to Improving Price and Quality Transparency in American Healthcare to Put Patients First. Under this final rule, effective January 1, 2021, CMS will require: (1) hospitals make public their standard changes (both gross charges and payer-specific negotiated charges) for all items and services online in a machine-readable format, and; (2) hospitals to make public standard charge data for a limited set of "shoppable services" the hospital provides in a form and manner that is more consumer friendly. On November 2, 2021, CMS released a final rule increasing the monetary penalty that CMS can impose on hospitals that fail to comply with the price transparency requirements. We believe that our hospitals are in full compliance with the applicable federal regulations.

Medicaid: Medicaid is a joint federal-state funded health care benefit program that is administered by the states to provide benefits to qualifying individuals. 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 revenues from various state and county-based programs, including Medicaid in all the states in which we operate. We receive annual Medicaid revenues of approximately $100 million, or greater, from each of Texas, California, Nevada, Illinois, Pennsylvania, Washington, D.C., Kentucky, Florida and Massachusetts. We also receive Medicaid disproportionate share hospital payments in certain states including, most significantly, Texas. We are therefore particularly sensitive to potential reductions in Medicaid and other state-based revenue programs as well as regulatory, economic, environmental and competitive changes in those states. We can provide no assurance that reductions to revenues earned pursuant to these programs, particularly in the above-mentioned states, will not have a material adverse effect on our future results of operations.

The Legislation substantially increases the federally and state-funded Medicaid insurance program, and authorizes states to establish federally subsidized non-Medicaid health plans for low-income residents not eligible for Medicaid starting in 2014. However, the Supreme Court has struck down portions of the Legislation requiring states to expand their Medicaid programs in exchange for increased federal funding. Accordingly, many states in which we operate have not expanded Medicaid coverage to individuals at 133% of the federal poverty level. Facilities in states not opting to expand Medicaid coverage under the Legislation may be additionally penalized by corresponding reductions to Medicaid disproportionate share hospital payments beginning in fiscal year 2024, as discussed below. We can provide no assurance that further reductions to Medicaid revenues, particularly in the above-mentioned states, will not have a material adverse effect on our future results of operations.

In January, 2020, CMS announced a new opportunity to support states with greater flexibility to improve the health of their Medicaid populations. The new 1115 Waiver Block Grant Type Demonstration program, titled Healthy Adult Opportunity ("HAO"), emphasizes the concept of value-based care while granting states extensive flexibility to administer and design their programs within a defined budget. CMS believes this state opportunity will enhance the Medicaid program's integrity through its focus on accountability for results and quality improvement, making the Medicaid program stronger for states and beneficiaries. The Biden administration has signaled its intent to withdraw the HAO demonstration. Accordingly, we are unable to predict whether the HAO demonstration will impact our future results of operations.

Various State Medicaid Supplemental Payment Programs:

We incur health-care related taxes ("Provider Taxes") imposed by states in the form of a licensing fee, assessment or other mandatory payment which are related to: (i) healthcare items or services; (ii) the provision of, or the authority to provide, the health care items or services, or; (iii) the payment for the health care items or services. Such Provider Taxes are subject to various federal regulations that limit the scope and amount of the taxes that can be levied by states in order to secure federal matching funds as part of their respective state Medicaid programs. As outlined below, we derive a related Medicaid reimbursement benefit from assessed Provider Taxes in the form of Medicaid claims based payment increases and/or lump sum Medicaid supplemental payments.

On April 27, 2023, CMS released two rules addressing access, quality and payment in Medicaid, CHIP, and Medicaid/CHIP Managed Care plans. Together, the Access NPRM and Managed Care NPRM ("Managed Care Rule") include new and updated proposed requirements for states and managed care plans that would establish consistent access standards, and a standardized approach to transparently review and assess Medicaid payment rates across states. The Managed Care rule also proposes standards to allow enrollees to easily compare plans based on quality and access to providers through the state's website.

Importantly, the Managed Care Rule proposes several new requirements related to Medicaid State Directed Payments. These proposed changes would include:

- A broader requirement that states ensure each provider receiving a state directed payment attest that it does not participate in any arrangement that holds taxpayers harmless for the cost of a tax in violation of federal requirements.
- Requiring that provider payment levels for inpatient and outpatient hospital services not exceed the average commercial rate.
- Removing unnecessary regulatory barriers to help states use state directed payments to implement value-based payment arrangements.

The Managed Care proposed rule, if implemented, could have a significant impact on the means by which states finance the non-federal share of their Medicaid programs. Under the proposal, CMS would have the ability to strike down common financing arrangements such as a provider taxes. These changes could have detrimental impacts on state Medicaid programs. If finalized as proposed, the rule could potentially force states to raise taxes or cut their Medicaid budgets. In subsequent years, it could have an unfavorable impact on Medicaid beneficiaries by likely limiting access to providers and requiring states to consider reductions to their Medicaid programs.

As disclosed herein, we receive a significant amount of Medicaid and Medicaid managed care revenue from both base payments and supplemental payments. Although we are unable to estimate the impact of the Managed Care Rule on our future results of operations, if implemented as proposed, Managed Care Rule related changes could have a material adverse impact on our future results of operations.

Included in these Provider Tax programs are reimbursements received in connection with the Texas Uncompensated Care/Upper Payment Limit program ("UC/UPL") and Texas Delivery System Reform Incentive Payments program ("DSRIP"). Additional disclosure related to the Texas UC/UPL and DSRIP programs is provided below.

Texas Uncompensated Care/Upper Payment Limit Payments:

Certain of our acute care hospitals located in various counties of Texas (Grayson, Hidalgo, Maverick, Potter and Webb) participate in Medicaid supplemental payment Section 1115 Waiver indigent care programs. Section 1115 Waiver Uncompensated Care ("UC") payments replace the former Upper Payment Limit ("UPL") payments. These hospitals also have affiliation agreements with third-party hospitals to provide free hospital and physician care to qualifying indigent residents of these counties. Our hospitals receive both supplemental payments from the Medicaid program and indigent care payments from third-party, affiliated hospitals. The supplemental payments are contingent on the county or hospital district making an Inter-Governmental Transfer ("IGT") to the state Medicaid program while the indigent care payment is contingent on a transfer of funds from the applicable affiliated hospitals. However, the county or hospital district is prohibited from entering into an agreement to condition any IGT on the amount of any private hospital's indigent care obligation.

On December 21, 2017, CMS approved the 1115 Waiver for the period January 1, 2018 to September 30, 2022. The Waiver continued to include UC and DSRIP payment pools with modifications and new state specific reporting deadlines that if not met by the Texas Health and Human Services Commission ("THHSC") will result in material decreases in the size of the UC and DSRIP pools. For UC during the initial two years of this renewal, the UC program will remain relatively the same in size and allocation methodology. For year three of this waiver renewal, the federal fiscal year ("FFY") 2020, and through FFY 2022, the size and distribution of the UC pool will be determined based on charity care costs reported to THHSC in accordance with Medicare cost report Worksheet S-10 principles. In September 2019, CMS approved the annual UC pool size in the amount of $3.9 billion for demonstration years ("DYs") 9, 10 and 11 (October 1, 2019 to September 30, 2022). In June 2022, THHSC announced that CMS approved the UC Pool size for Demonstration Years 12 through 16 (October 1, 2022 to September 30, 2027) for the current 1115 Waiver which will be $4.51 billion per year. The UC pool will be resized again in 2027 for DYs 17 through 19 (October 1, 2027 to September 30, 2030). On April 16, 2021, CMS rescinded its January 15, 2021, 1115 Waiver ten year expedited renewal approval that was effective through September 30, 2030. In July, 2021, THHSC submitted another 1115 Waiver renewal application to CMS which reflects the same terms and conditions agreed to by CMS on January 15, 2021, in order to receive an extension beyond September 30, 2022. On April 22, 2022, CMS withdrew its rescission of the 1115 Waiver and now considers the 1115 Waiver approved as extended and governed by the special terms and conditions that CMS approved on January 15, 2021.

Effective April 1, 2018, certain of our acute care hospitals located in Texas began to receive Medicaid managed care rate enhancements under the Uniform Hospital Rate Increase Program ("UHRIP"). The non-federal share component of these UHRIP rate enhancements are financed by Provider Taxes. The Texas 1115 Waiver rules require UHRIP rate enhancements be considered in the Texas UC payment methodology which results in a reduction to our UC payments. The UC amounts reported in the State Medicaid Supplemental Payment Program Table below reflect the impact of this new UHRIP program. In July 2020, THHSC announced CMS approval of an increase to UHRIP pool for the state's 2021 fiscal year to $2.7 billion from its prior funding level of $1.6 billion.

On March 26, 2021, THHSC published a final rule that will apply to program periods on or after September 1, 2021, and UHRIP was re-named the Comprehensive Hospital Increase Reimbursement Program ("CHIRP"). CHIRP will be comprised of a UHRIP component and an Average Commercial Incentive Award component. CHIRP has a pool size of $4.7 billion. On March 25, 2022, CMS approved the CHIRP program retroactive to September 1, 2021 through August 31, 2022. The impact of the CHIRP program is reflected in the State Medicaid Supplemental Payment Program Table below including approximately $12 million of estimated CHIRP revenues which were recorded during the first quarter of 2022, attributable to the period September 1, 2021 through December 31, 2021, net of associated provider taxes. On August 1, 2022, CMS approved the CHIRP program, with a pool of $5.2 billion, for the rate period effective September 1, 2022 to August 31, 2023.

During 2022, certain of our acute care hospitals located in Texas recorded an aggregate of $25 million in Quality Incentive Fund ("QIF") payments, applicable to the period September 1, 2020 to August 31, 2021 in connection with the state's UHRIP program. This revenue was earned pursuant to contract terms with various Medicaid managed care plans which requires the annual payout of QIF funds when a managed care service delivery area's actual claims-based UHRIP payments are less than targeted UHRIP payments for a specific rate year. We also anticipate that these hospitals may be entitled to a comparable amount of aggregate QIF revenue during 2023.

On September 24, 2021, THHSC finalized New Fee-for-Service Supplemental Payment Program: Hospital Augmented Reimbursement Program ("HARP") to be effective October 1, 2021. The HARP program continues the financial transition for providers who have historically participated in the Delivery System Reform Incentive Payment program described below. The program will provide additional funding to hospitals to help offset the cost hospitals incur while providing Medicaid services. THHSC financial model released concurrent with the publication of the final rule indicates net potential incremental Medicaid reimbursements to us of approximately $15 million annually, without consideration of any potential adverse impact on future Medicaid DSH or Medicaid UC payments. This program remains subject to CMS approval.

Texas Delivery System Reform Incentive Payments:

In addition, the Texas Medicaid Section 1115 Waiver included a DSRIP pool to incentivize hospitals and other providers to transform their service delivery practices to improve quality, health status, patient experience, coordination, and cost-effectiveness. DSRIP pool payments are incentive payments to hospitals and other providers that develop programs or strategies to enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. In FFY 2022, DSRIP funding under the waiver is eliminated except for certain carryover DSRIP projects. No revenues were recorded by us during either of the three-month periods ended March 31, 2023 or 2022 in connection with this DSRIP program.

Summary of Amounts Related To The Above-Mentioned Various State Medicaid Supplemental Payment Programs:

The following table summarizes the revenues, Provider Taxes and net benefit related to each of the above-mentioned Medicaid supplemental programs for the three-month periods ended March 31, 2023 and 2022. The Provider Taxes are recorded in other operating expenses on the Condensed Consolidated Statements of Income as included herein.

	(amounts in millions)	
	Three Months Ended	
	March 31, 2023	March 31, 2022
Texas UC/UPL:		
Revenues	$ 41	$ 66
Provider Taxes	(15)	(29)
Net benefit	$ 26	$ 37
Texas DSRIP:		
Revenues	$ 0	$ 0
Provider Taxes	0	0
Net benefit	$ 0	$ 0
Various other state programs:		
Revenues	$ 121	$ 104
Provider Taxes	(42)	(42)
Net benefit	$ 79	$ 62
Total all Provider Tax programs:		
Revenues	$ 161	$ 170
Provider Taxes	(57)	(71)
Net benefit	$ 104	$ 99

We estimate that our aggregate net benefit from the Texas and various other state Medicaid supplemental payment programs will approximate $490 million (net of Provider Taxes of $282 million) during the year ended December 31, 2023. These amounts are based upon various terms and conditions that are out of our control including, but not limited to, the states'/CMS's continued approval of the programs and the applicable hospital district or county making IGTs consistent with 2022 levels.

Future changes to these terms and conditions could materially reduce our net benefit derived from the programs which could have a material adverse impact on our future consolidated results of operations. In addition, Provider Taxes are governed by both federal and state laws and are subject to future legislative changes that, if reduced from current rates in several states, could have a material adverse impact on our future consolidated results of operations. As described below in *2019 Novel Coronavirus Disease Medicare and Medicaid Payment Related Legislation*, a 6.2% increase to the Medicaid Federal Matching Assistance Percentage ("FMAP") is included in the Families First Coronavirus Response Act. The Consolidated Appropriations Act of 2023 ("CAA of 2023") provided for the transitional reduction of the 6.2% enhanced FMAP during 2023 to 5.0% during the second quarter, 2.5% during the third quarter and 1.5% during the fourth quarter of 2023. The impact of the enhanced FMAP Medicaid supplemental and DSH payments are reflected in our financial results for the three-month periods ended March 31, 2023 and 2022. We are unable to estimate the prospective financial impact of this provision at this time as our financial impact is contingent on unknown state action during future eligible federal fiscal quarters.

Texas and South Carolina Medicaid Disproportionate Share Hospital Payments:

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

Upon meeting certain conditions and serving a disproportionately high share of Texas' and South Carolina's low income patients, five of our facilities located in Texas and one facility located in South Carolina received additional reimbursement from each state's DSH fund. The South Carolina and Texas DSH programs were renewed for each state's 2023 DSH fiscal year (covering the period of October 1, 2022 through September 30, 2023).

In connection with these DSH programs, included in our financial results was an aggregate of approximately $12 million and $11 million during the three-month periods ended March 31, 2023 and 2022, respectively. Assuming the proposed payment methodology changes in Texas as discussed below are not implemented, we expect the aggregate reimbursements to our hospitals pursuant to the Texas and South Carolina 2023 fiscal year programs to be approximately $48 million. However, on April 14, 2023, the THHSC published a proposed rule that would retroactively modify both the Medicaid DSH and Medicaid UC payment methodologies for the period of October 1, 2022 to September 30, 2023. If implemented as proposed, THHSC financial modeling estimates indicate this proposed rule would reduce our annual Medicaid DSH and Medicaid UC payments by approximately $32 million.

The Legislation and subsequent federal legislation provides for a significant reduction in Medicaid disproportionate share payments beginning in federal fiscal year 2024 (see above in *Sources of Revenues and Health Care Reform-Medicaid* for additional disclosure related to the delay of these DSH reductions). HHS is to determine the amount of Medicaid DSH payment cuts imposed on each state based on a defined methodology. As Medicaid DSH payments to states will be cut, consequently, payments to Medicaid-participating providers, including our hospitals in Texas and South Carolina, will be reduced in the coming years. Based on the CMS final rule published in September, 2019, beginning in fiscal year 2024 (as amended by the CARES Act and the CAA), annual Medicaid DSH payments in South Carolina and Texas could be reduced by approximately 65% and 41%, respectively, from 2022 DSH payment levels.

Our behavioral health care facilities in Texas have been receiving Medicaid DSH payments since FFY 2016. As with all Medicaid DSH payments, hospitals are subject to state audits that typically occur up to three years after their receipt. DSH payments are subject to a federal Hospital Specific Limit ("HSL") and are not fully known until the DSH audit results are concluded. In general, freestanding psychiatric hospitals tend to provide significantly less charity care than acute care hospitals and therefore are at more risk for retroactive recoupment of prior year DSH payments in excess of their respective HSL. In light of the retroactive HSL audit risk for freestanding psychiatric hospitals, we have established DSH reserves for our facilities that have been receiving funds since FFY 2016. These DSH reserves are also impacted by the resolution of federal DSH litigation related to Children's Hospital Association of Texas v. Azar ("CHAT") where the calculation of HSL was being challenged. In August, 2019, DC Circuit Court of Appeals issued a unanimous decision in CHAT and reversed the judgment of the district court in favor of CMS and ordered that CMS's "2017 Rule" (regarding Medicaid DSH Payments—Treatment of Third Party Payers in Calculating Uncompensated Care Costs) be reinstated. CMS has not issued any additional guidance post the ruling. In April 2020, the plaintiffs in the case have petitioned the Supreme Court of the United States to hear their case. Additionally, there have been separate legal challenges on this same issue in the Fifth and Eight Circuits. On November 4, 2019, in *Missouri Hosp. Ass'n v. Azar*, the United States Court of Appeals for the Eighth Circuit issued an opinion upholding the 2017 Rule. On April 20, 2020, in *Baptist Memorial Hospital v. Azar*, the United States Court of Appeals of the Fifth Circuit issued a decision also upholding the 2017 Rule. In light of these court decisions, we continue to maintain reserves in the financial statements for cumulative Medicaid DSH and UC reimbursements related to our behavioral health hospitals located in Texas that amounted to $48 million as of March 31, 2023 and $42 million as of December 31, 2022.

Nevada SPA and SDP:

State Plan Amendment ("SPA")

CMS initially approved an SPA in Nevada in August, 2014 and this SPA has been approved for additional state fiscal years, including the 2023 fiscal year covering the period of July 1, 2022 through June 30, 2023.

In connection with this program, included in our financial results for the three-month periods ended March 31, 2023 and 2022 was approximately $7 million and $5 million, respectively. We estimate that our reimbursements pursuant to this program will approximate $24 million during the year ended December 31, 2023.

State Directed Payment Program ("SDP")

On February 7, 2023, the Division of Health Care Financing and Policy ("DHCFP") held a public workshop that outlined a new provider fee on private hospitals located in Nevada that would effectively capture new Medicaid federal share for certain categories of services eligible for the new payment programs. Final approval of each of these Medicaid supplemental payment programs is subject to various state and federal actions. If ultimately approved, DHCFP intends to have both components implemented retroactively to January 1, 2023.

DHCFP indicated the new Medicaid supplemental payments will include two components as follows:

- Medicaid fee for service upper payment limit component.

- We anticipate state and federal approval of the fee for service upper payment limit component to occur during 2023. If approved, we estimate that our aggregate net reimbursements pursuant to this program (net of related provider taxes) will approximate $25 million during the year ended December 31, 2023 (which we expect to record during the fourth quarter of 2023).

- Medicaid managed care component.
  - We cannot predict whether or not the managed care component will ultimately receive state and federal approval. If approved, we cannot predict the timing or amount of aggregate net reimbursements, which could be material, that we may receive in connection with this program.

California SPA:

In California, the state continues to operate Medicaid supplemental payment programs consisting of three components Fee For Service Payment, Managed Care-Pass-Through Payment and Managed Care-Directed Payment. The non-federal share for these programs are financed by a statewide provider tax.

The Directed Payment method will be based on actual concurrent hospital Medicaid managed care in-network patient volume whereas the other programs are based on prior year Medicaid utilization. The CMS program approval status is outlined in the table below.

California Hospital Fee Program CMS Approval Status:

Hospital Fee Program Component	CMS Methodology Approval Status	CMS Rate Setting Approval Status
Fee For Service Payment	Approved through December 31, 2022	Approved through December 31, 2021; Paid through September 30, 2022
Managed Care-Pass-Through Payment	Approved through December 31, 2022	Approved through December 31, 2020; Paid in advance of approval through December 31, 2021
Managed Care-Directed Payment	Approved through December 31, 2022	Approved through December 31, 2020; Paid in advance of approval through June 30, 2021

In connection with the existing program, included in our financial results was approximately $10 million and $14 million during the three-month periods ended March 31, 2023 and 2022, respectively. We estimate that our reimbursements pursuant to this program will approximate $48 million during the year ended December 31, 2023. The aggregate impact of the California supplemental payment program, as outlined above, is included in the above *State Medicaid Supplemental Payment Program* table.

Kentucky Hospital Rate Increase Program ("HRIP"):

In early 2021, CMS approved the Kentucky Medicaid Managed Care Hospital Rate Increase Program ("HRIP"). Included in our financial results during the three-month periods ended March 31, 2023 and 2022 was approximately $19 million and $17 million, respectively.

Programs such as HRIP require an annual state submission and approval by CMS. In February, 2023,, CMS approved the program for the period of January 1, 2023 through December 31, 2023 at rates comparable to the prior year. We estimate that our reimbursements pursuant to HRIP will approximate $64 million during the year ended December 31, 2023.

Florida Medicaid Managed Care Directed Payment Program ("DPP"):

The Florida DPP provides for an additional payment for Medicaid managed care contracted services. The DPP requires various related legislative and regulatory approvals each year. We did not record any revenues in connection with this program during the three-month periods ended March 31, 2023 or 2022. We estimate that our reimbursements pursuant to this DPP will approximate $34 million during the year ended December 31, 2023.

Oklahoma Transition to Managed Care and Implementation of a Medicaid Managed Care DPP

In May, 2022, Oklahoma enacted legislation (SB 1337 and SB 1396) that directs the Oklahoma Health Care Authority ("OHCA") to: (i) transition its Medicaid program from a fee for service payment model to a managed care payment model by no later than October 1, 2023, and: (ii) concurrently implement a Medicaid managed care DPP using a managed care gap of ninety percent (90%) average commercial rates. In December, 2022, the OHCA delayed the implementation date of the Medicaid managed care change and related DPP until April 1, 2024. Although we estimate that the DPP as enacted may have a favorable impact on our future results of operations, we are unable to quantify the ultimate impact since implementation of this legislation is subject to various administrative and regulatory steps including the awarding of managed care contracts as well as CMS' approval of the DPP.

Illinois Medicaid Supplemental Payment Programs

The Illinois Medicaid Supplemental Payment Programs are comprised of three components: (1) Medicaid managed care directed payment program; (2) Medicaid managed care pass-through program, and; (3) Medicaid fee for service supplemental payment program. The results of this program are included in the above *State Medicaid Supplemental Payment Program* table. These programs require various related legislative and regulatory approvals each year.

In connection with this program, included in our financial results during the three-month periods ended March 31, 2023 and 2022, was approximately $8 million and $6 million, respectively. We estimate that our reimbursements pursuant to these supplemental payment programs will approximate $34 million during the year ended December 31, 2023.

Idaho Medicaid Upper Payment Limit ("UPL") Program

During the first quarter of 2023, Idaho modified their Medicaid UPL program for the period July 1, 2022 to June 30, 2023, which resulted in the state increasing the amount of the UPL pool size. As a result of this UPL program change, we recorded approximately $11 million in incremental revenues during the three-month period ended March 31, 2023, approximately $7 million of which related to the prior year. We anticipate that future UPL program payments will be made at comparable levels. We estimate that our revenues pursuant to this UPL program will approximate $22 million during the year ended December 31, 2023.

Risk Factors Related To State Supplemental Medicaid Payments:

As outlined above, we receive substantial reimbursement from multiple states in connection with various supplemental Medicaid payment programs. The states include, but are not limited to, Texas, Kentucky, California, Illinois, Indiana and Nevada. Failure to renew these programs beyond their scheduled termination dates, failure of the public hospitals to provide the necessary IGTs for the states' share of the DSH programs, failure of our hospitals that currently receive supplemental Medicaid revenues to qualify for future funds under these programs, or reductions in reimbursements, could have a material adverse effect on our future results of operations.

In April, 2016, CMS published its final Medicaid Managed Care Rule which explicitly permits but phases out the use of pass-through payments (including supplemental payments) by Medicaid Managed Care Organizations ("MCO") to hospitals over ten years but allows for a transition of the pass-through payments into value-based payment structures, delivery system reform initiatives or payments tied to services under a MCO contract. Since we are unable to determine the financial impact of this aspect of the final rule, we can provide no assurance that the final rule will not have a material adverse effect on our future results of operations. In November, 2020, CMS issued a final rule permitting pass-through supplemental provider payments during a time-limited period when states transition populations or services from fee-for-service Medicaid to managed care.

HITECH Act: In July 2010, HHS published final regulations implementing the health information technology ("HIT") provisions of the American Recovery and Reinvestment Act (referred to as the "HITECH Act"). The final regulation defines the "meaningful use" of Electronic Health Records ("EHR") and establishes the requirements for the Medicare and Medicaid EHR payment incentive programs. The final rule established an initial set of standards and certification criteria. The implementation period for these Medicare and Medicaid incentive payments started in federal fiscal year 2011 and can end as late as 2016 for Medicare and 2021 for the state Medicaid programs. State Medicaid program participation in this federally funded incentive program is voluntary but all of the states in which our eligible hospitals operate have chosen to participate. Our acute care hospitals qualified for these EHR incentive payments upon implementation of the EHR application assuming they meet the "meaningful use" criteria. The government's ultimate goal is to promote more effective (quality) and efficient healthcare delivery through the use of technology to reduce the total cost of healthcare for all Americans and utilizing the cost savings to expand access to the healthcare system.

All of our acute care hospitals have met the applicable meaningful use criteria. However, under the HITECH Act, hospitals must continue to meet the applicable meaningful use criteria in each fiscal year or they will be subject to a market basket update reduction in a subsequent fiscal year. Failure of our acute care hospitals to continue to meet the applicable meaningful use criteria would have an adverse effect on our future net revenues and results of operations.

In the 2019 IPPS final rule, CMS overhauled the Medicare and Medicaid EHR Incentive Program to focus on interoperability, improve flexibility, relieve burden and place emphasis on measures that require the electronic exchange of health information between providers and patients. We can provide no assurance that the changes will not have a material adverse effect on our future results of operations.

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 payers than we do from traditional indemnity insurers, however, during the past few years we have secured price increases from many of our commercial payers including managed care companies.

Commercial Insurance: Our hospitals also provide services to individuals covered by private health care insurance. Private insurance carriers typically make direct payments to hospitals or, in some cases, reimburse their policy holders, based upon the particular

hospital's established charges and the particular coverage provided in the insurance policy. Private insurance reimbursement varies among payers and states and is generally based on contracts negotiated between the hospital and the payer.

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.

Surprise Billing Interim Final Rule: On September 30, 2021, the Department of Labor, and the Department of the Treasury, along with the Office of Personnel Management ("OPM"), released an interim final rule with comment period, entitled "Requirements Related to Surprise Billing; Part II." This rule is related to Title I (the "No Surprises Act") of Division BB of the Consolidated Appropriations Act, 2021, and establishes new protections from surprise billing and excessive cost sharing for consumers receiving health care items/services. It implements additional protections against surprise medical bills under the No Surprises Act, including provisions related to the independent dispute resolution process, good faith estimates for uninsured (or self-pay) individuals, the patient-provider dispute resolution process, and expanded rights to external review. On February 28, 2022, a district judge in the Eastern District of Texas invalidated portions of the rule governing aspects of the Independent Dispute Resolution ("IDR") process. In light of this decision, the government issued a final rule on August 19, 2022 eliminating the rebuttable presumption in favor of the qualifying payment amount ("QPA") by the IDR entity and providing additional factors the IDR entity should consider when choosing between two competing offers. On September 22, 2022, the Texas Medical Association filed a lawsuit challenging the IDR process provided in the updated final rule and alleging that the final rule unlawfully elevates the QPA above other factors the IDR entity must consider. The American Hospital Association and American Medical Association have announced their intent to join this case as amici supporting the Texas Medical Association. On February 10, 2023, CMS instructed certified IDR entities to hold all payment determinations until further guidance is issued by the departments of Health & Human Services, Labor, and Treasury. This decision stems from the February 6, 2023, court decision that vacated the federal government's revised IDR process for determining payment for out-of-network services under the No Surprises Act. Certified IDR entities have also been instructed to recall any payment determinations issued after February 6, 2023. We do not expect the interim final rule or the August 19, 2022, final rule to have a material impact on our 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 hospitals' indigent and charity care policy. Patients without health care coverage who do not qualify for Medicaid or indigent care write-offs are offered substantial discounts in an effort to settle their outstanding account balances.

Health Care Reform: Listed below are the Medicare, Medicaid and other health care industry changes which have been, or are scheduled to be, implemented as a result of the Legislation.

***Medicaid Federal DSH Allotment**:*

Although the implementation has been delayed several times, the Legislation (as amended by subsequent federal legislation) requires annual aggregate reductions in federal Medicaid DSH allotment from FFY 2024 through FFY 2027. Commencing in federal fiscal year 2024, and continuing through 2027, DSH payments are scheduled to be reduced by $8 billion annually.

Value-Based Purchasing:

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

The Legislation required HHS to implement a value-based purchasing program for inpatient hospital services which became effective on October 1, 2012. The Legislation requires HHS to reduce inpatient hospital payments for all discharges by 2% in FFY 2017 and subsequent years. HHS will pool the amount collected from these reductions to fund payments to reward hospitals that meet or exceed certain quality performance standards established by HHS. HHS will determine the amount each hospital that meets or exceeds the quality performance standards will receive from the pool of dollars created by these payment reductions. As part of the FFY 2022 IPPS final rule and FFY 2023 final rule, as discussed above, and as a result of the on-going COVID-19 pandemic, CMS has implemented a budget neutral payment policy to fully offset the 2% VBP withhold during each of FFY 2022 and FFY 2023.

Hospital Acquired Conditions:

The Legislation prohibits the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat hospital acquired conditions ("HAC"). Beginning in FFY 2015, hospitals that fall into the top 25% of national risk-adjusted HAC rates for all hospitals in the previous year will receive a 1% reduction in their total Medicare payments. As part of the FFY 2023

final rule discussed above, and as a result of the on-going COVID-19 pandemic, CMS will suppress all six measures in the HAC Reduction Program for the FY 2023 program year and eliminate the HAC reduction program's one percent payment penalty.

Readmission Reduction Program:

In the Legislation, Congress also mandated implementation of the hospital readmission reduction program ("HRRP"). Hospitals with excessive readmissions for conditions designated by HHS will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard. The HRRP currently assesses penalties on hospitals having excess readmission rates for heart failure, myocardial infarction, pneumonia, acute exacerbation of chronic obstructive pulmonary disease (COPD) and elective total hip arthroplasty (THA) and/or total knee arthroplasty (TKA), excluding planned readmissions, when compared to expected rates. In the fiscal year 2015 IPPS final rule, CMS added readmissions for coronary artery bypass graft (CABG) surgical procedures beginning in fiscal year 2017. To account for excess readmissions, an applicable hospital's base operating DRG payment amount is adjusted for each discharge occurring during the fiscal year. Readmissions payment adjustment factors can be no more than a 3 percent reduction. As part of the FFY 2023 IPPS final rule discussed above, CMS will modify all of the condition-specific readmission measures to include an adjustment for patient history of COVID-19 for FFY 2024.

Accountable Care Organizations:

The Legislation requires HHS to establish a Medicare Shared Savings Program that promotes accountability and coordination of care through the creation of accountable care organizations ("ACOs"). The ACO program allows providers (including hospitals), physicians and other designated professionals and suppliers to voluntarily work together to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS will be eligible to share in a portion of the amounts saved by the Medicare program. CMS is also developing and implementing more advanced ACO payment models that require ACOs to assume greater risk for attributed beneficiaries. On December 21, 2018, CMS published a final rule that, in general, requires ACO participants to take on additional risk associated with participation in the program. On April 30, 2020, CMS issued an interim final rule with comment in response to the COVID-19 national emergency permitting ACOs with current agreement periods expiring on December 31, 2020 the option to extend their existing agreement period by one year, and permitting certain ACOs to retain their participation level through 2021. It remains unclear to what extent providers will pursue federal ACO status or whether the required investment would be warranted by increased payment.

2019 Novel Coronavirus Disease Medicare and Medicaid Payment Related Legislation

In response to the growing threat of COVID-19, on March 13, 2020 a national emergency was declared. The declaration empowered the HHS Secretary to waive certain Medicare, Medicaid and Children's Health Insurance Program ("CHIP") program requirements and Medicare conditions of participation under Section 1135 of the Social Security Act. Having been granted this authority by HHS, CMS issued a broad range of blanket waivers, which eased certain requirements for impacted providers, including:

- Waivers and Flexibilities for Hospitals and other Healthcare Facilities including those for physical environment requirements and certain Emergency Medical Treatment & Labor Act provisions
- Provider Enrollment Flexibilities
- Flexibility and Relief for State Medicaid Programs including those under section 1135 Waivers
- Suspension of Certain Enforcement Activities

In addition to the national emergency declaration, Congress passed and Presidents Trump and Biden have signed various forms of legislation intended to support state and local authority responses to COVID-19 as well as provide fiscal support to businesses, individuals, financial markets, hospitals and other healthcare providers.

Some of the financial support included in the various legislative actions include:

Medicaid FMAP Enhancement

- The FMAP was increased by 6.2% retroactive to the federal fiscal quarter beginning January 1, 2020 and each subsequent federal fiscal quarter for all states and U.S. territories during the declared public health emergency through December 31, 2022, in accordance with specified conditions. The CAA of 2023, signed into law on December 29, 2022, provides for the transitional reduction of the 6.2% enhanced FMAP during 2023 to 5.0% during the second quarter, 2.5% during the third quarter and 1.5% during the fourth quarter of 2023.
- Effective April 1, 2023, the CAA of 2023 allows states to initiate Medicaid renewals, post-enrollment verifications, and redeterminations over a 12-month period for all individuals who are enrolled in such plan (or waiver) as of April 1, 2023. This activity was previously prohibited as a condition for the receipt of the enhanced FMAP during the PHE. This Medicaid enrollment related activity is likely to reduce Medicaid beneficiary enrollment. In the states

in which we operate, we cannot predict the extent to which disenrolled Medicaid beneficiaries will be able to replace their Medicaid coverage with employer-based insurance coverage or via coverage obtained through the ACA Health Insurance Exchange. We are therefore unable to estimate the impact of this Medicaid enrollment activity on our results of operations.

Public Health Emergency Declaration

- The HHS Secretary renewed the PHE effective January 11, 2023, for 90 days. As a result, certain Medicare payment provisions contingent on the PHE are extended including the twenty percent (20%) Medicare add-on for inpatient hospital COVID-19 patients noted below. However, HHS has published guidance indicating its intent for the PHE to expire on May 11, 2023. We cannot predict whether the loss of any such favorable payment provisions available to providers during the declared PHE will ultimately have a negative financial impact on us.

Reimburse hospitals at Medicare rates for uncompensated COVID-19 care for the uninsured

- Our financial results for the quarter ended March 31, 2022 include approximately $17 million, respectively, of revenues recorded in connection with this COVID-19 uninsured program. No revenue was recorded in the quarter ended March 31, 2023. Revenue for the eligible patient encounters is recorded in the period in which the encounter is deemed eligible for this program net of any normal accounting reserves.
- Effective March 22, 2022, HHS announced that the HRSA COVID-19 Uninsured Program and Coverage Assistance Fund is no longer accepting claims due to insufficient funding.

Medicare Sequestration Relief

- Suspension of the 2% Medicare sequestration offset for Medicare services provided from May 1, 2020 through December 31, 2021 by various legislative extensions. In December, 2021, the suspended 2% payment reduction was extended until March 31, 2022 and partially suspended at a 1% payment reduction for an additional three-month period that ended on June 30, 2022, with a return to the full 2% Medicare payment reduction thereafter.
- Our financial results for the three-month period ended March 31, 2023, did not include any revenues related to the Medicare Sequestration Relief. Our financial results for the three-month period ended March 31, 2022, included approximately $11 million of revenues recorded in connection with the Medicare sequestration relief program.

Medicare add-on for inpatient hospital COVID-19 patients

- Increases the payment that would otherwise be made to a hospital for treating a Medicare patient admitted with COVID-19 by twenty percent (20%) for the duration of the COVID-19 public health emergency.
- Our financial results for the quarters ended March 31, 2023 and 2022 include approximately $5 million and $16 million, respectively, of revenues recorded in connection with the COVID-19 Medicare add-on program. These payments were intended to offset the increased expenses associated with the treatment of Medicare COVID-19 patients.

In addition to statutory and regulatory changes to the Medicare program 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 payers could have a material adverse effect on our financial position and our results.

Other Operating Results

Interest Expense:

As reflected on the schedule below, interest expense was $51 million and $22 million during the three-month periods ended March 31, 2023 and 2022, respectively (amounts in thousands):

	Three Months Ended March 31, 2023	Three Months Ended March 31, 2022
Revolving credit & demand notes (a.)	$ 5,627	$ 2,335
Tranche A term loan facility (a.)	36,062	6,026
$800 million, 2.65% Senior Notes due 2030 (b.)	5,356	5,356
$700 million, 1.65% Senior Notes due 2026 (c.)	2,932	2,932
$500 million, 2.65% Senior Notes due 2032 (d.)	3,345	3,345
Accounts receivable securitization program (e.)	-	10
Subtotal-revolving credit, demand notes, Senior Notes, term loan facilities and accounts receivable securitization program	53,322	20,004
Amortization of financing fees	1,258	1,105
Other combined interest expense	435	1,905
Capitalized interest on major projects	(4,009)	(1,328)
Interest income	(130)	(13)
Interest expense, net	$ 50,876	$ 21,673

(a.) As of March 31, 2023, our credit agreement dated November 15, 2010, as amended, provided for the following:

- a $1.2 billion aggregate amount revolving credit facility that is scheduled to mature in August, 2026 (which, as of March 31, 2023, had $875 million of aggregate available borrowing capacity net of $322 million of outstanding borrowings and $3 million of letters of credit), and;
- a tranche A term loan facility with $2.32 billion of outstanding borrowings as of March 31, 2023 (including the $700 million increase provided for by the ninth amendment in June, 2022).

(b.) In September, 2020 we completed the offering of $800 million aggregate principal amount of 2.65% Senior Notes due in 2030.

(c.) In August, 2021 we completed the offering of $700 million aggregate principal amount of 1.65% Senior Notes due in 2026.

(d.) In August, 2021 we completed the offering of $500 million aggregate principal amount of 2.65% Senior Notes due in 2032.

(e.) The accounts receivable securitization program expired on its maturity date in December, 2022 and was not renewed or replaced.

Interest expense increased approximately $29 million, or 135%, during the three-month period ended March 31, 2023, as compared to the three-month period ended March 31, 2022. The increase was primarily due to: (i) a net $33 million increase in aggregate interest expense on our revolving credit, demand notes, senior notes, term loan facilities and accounts receivable securitization program (as applicable), resulting from an increase in our aggregate average cost of borrowings pursuant to these facilities (4.6% during 2023 as compared to 1.9% during 2022), as well as an increase in the aggregate average outstanding borrowings pursuant to these facilities ($4.67 billion during 2023 as compared to $4.26 billion during 2022), partially offset by; (ii) a net $1 million decrease in other combined interest expenses, including a $3 million increase in capitalized interest on major projects . The average effective interest rates, including amortization of deferred financing costs and original issue discount, on borrowings outstanding under our revolving credit, demand notes, senior notes, term loan A facility and accounts receivable securitization program (as applicable), which amounted to approximately $4.67 billion and $4.26 billion during the first quarters of 2023 and 2022, respectively, were 4.7% and 2.0% during the three-month periods ended March 31, 2023 and 2022, respectively.

Provision for Income Taxes and Effective Tax Rates:

The effective tax rates, as calculated by dividing the provision for income taxes by income before income taxes, were as follows for the three-month periods ended March 31, 2023 and 2022 (dollar amounts in thousands):

	Three months ended	
	March 31, 2023	March 31, 2022
Provision for income taxes	$ 51,726	$ 48,962
Income before income taxes	214,101	199,983
Effective tax rate	24.2%	24.5%

The provision for income taxes increased $3 million during the three-month period ended March 31, 2023, as compared to the first quarter of 2022, due primarily to the income tax expense recorded in connection with the $12 million increase in pre-tax income.

Liquidity

Net cash provided by operating activities

Net cash provided by operating activities was $291 million during the three-month period ended March 31, 2023 and $445 million during the first three months of 2022. The net decrease of $155 million was attributable to the following:

- an unfavorable change of $183 million from other working capital accounts due primarily to the timing of disbursements for accrued compensation and accounts payable;
- a favorable change of $11 million in accrued insurance expense, net of commercial premiums paid and payments made in settlement of self-insured claims;
- a favorable change of $10 million resulting from an increase in net income plus depreciation and amortization expense, stock-based compensation expense and gain/loss on sale of assets and businesses, and;
- $7 million of other combined net favorable changes.

Days sales outstanding ("DSO"): Our DSO are calculated by dividing our net revenue by the number of days in the three-month periods. The result is divided into the accounts receivable balance at March 31st of each year to obtain the DSO. Our DSO were 53 days and 48 days at March 31, 2023 and 2022, respectively. The increase in our DSO at March 31, 2023, as compared to March 31, 2022, was due, in part, to an increase in receivables at the new acute care hospital located in Reno, Nevada, that opened in early April, 2022.

Net cash used in investing activities

During the first three months of 2023, we used $178 million of net cash in investing activities as follows:

- $169 million spent on capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities;
- $19 million paid in connection with net cash outflows from forward exchange contracts that hedge our investment in the U.K. against movements in exchange rates, and;
- $9 million received from the sales of assets and businesses.

During the first three months of 2022, we used $169 million of net cash in investing activities as follows:

- $200 million spent on capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities;
- $21 million received in connection with net cash inflows from forward exchange contracts that hedge our investment in the U.K. against movements in exchange rates, and;
- $10 million received from the sales of assets and businesses.

Net cash used in financing activities

During the first three months of 2023, we used $106 million of net cash in financing activities as follows:

- spent $85 million to repurchase shares of our Class B Common Stock in connection with: (i) open market purchases pursuant to our stock repurchase program ($79 million), and; (ii) income tax withholding obligations related to stock-based compensation programs ($6 million);
- spent $16 million on net repayments of debt as follows: (i) $15 million related to our tranche A term loan facility, and; (ii) $1 million related to other debt facilities;
- spent $14 million to pay quarterly cash dividends of $.20 per share;
- generated $11 million of additional borrowings pursuant to our revolving credit facility;

- spent $4 million to pay profit distributions related to noncontrolling interests in majority owned businesses, and;
- generated $3 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

During the first three months of 2022, we used $278 million of net cash in financing activities as follows:

- spent $366 million to repurchase shares of our Class B Common Stock in connection with: (i) open market purchases pursuant to our stock repurchase program ($350 million), and; (ii) income tax withholding obligations related to stock-based compensation programs ($16 million);
- generated $117 million of additional borrowings pursuant to our revolving credit facility;
- spent $12 million on net repayments of debt as follows: (i) $11 million related to our tranche A term loan facility, and; (ii) $1 million related to other debt facilities;
- spent $15 million to pay quarterly cash dividends of $.20 per share;
- spent $5 million to pay profit distributions related to noncontrolling interests in majority owned businesses;
- generated $4 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans, and;
- spent $1 million in connection with the purchase of ownership interests from minority members.

Expected capital expenditures during remainder of 2023

During the full year of 2023, we expect to spend approximately $725 million to $875 million on capital expenditures which includes expenditures for capital equipment, construction of new facilities, and renovations and expansions at existing hospitals. During the first three months of 2023, we spent approximately $169 million on capital expenditures. During the remaining nine months of 2023, we expect to spend approximately $556 million to $706 million on capital expenditures.

We believe that our capital expenditure program is adequate to expand, improve and equip our existing hospitals. We expect to finance all capital expenditures and acquisitions with internally generated funds and/or additional funds, as discussed below.

Capital Resources

Credit Facilities and Outstanding Debt Securities

In June, 2022, we entered into a ninth amendment to our credit agreement dated as of November 15, 2010, as amended and restated as of September, 2012, August, 2014, October, 2018, August, 2021, and September, 2021, among UHS, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders, and JPMorgan Chase Bank, N.A., as administrative agent, (the "Credit Agreement"). The ninth amendment provided for, among other things, the following: (i) a new incremental tranche A term loan facility in the aggregate principal amount of $700 million which is scheduled to mature on August 24, 2026, and; (ii) replaces the option to make Eurodollar borrowings (which bear interest by reference to the LIBO Rate) with Term Benchmark Loans, which will bear interest by reference to the Secured Overnight Financing Rate ("SOFR"). The net proceeds generated from the incremental tranche A term loan facility were used to repay a portion of the borrowings that were previously outstanding under our revolving credit facility.

As of March 31, 2023, our Credit Agreement provided for the following:

- a $1.2 billion aggregate amount revolving credit facility that is scheduled to mature in August, 2026 (which, as of March 31, 2023, had $875 million of aggregate available borrowing capacity net of $322 million of outstanding borrowings and $3 million of letters of credit), and;
- a tranche A term loan facility with $2.32 billion of outstanding borrowings as of March 31, 2023 (including the $700 million increase provided for by the ninth amendment in June, 2022).

The tranche A term loan facility provides for installment payments of $15.0 million per quarter during the period of September, 2022 through September, 2023, and $30.0 million per quarter during the period of December, 2023 through June, 2026. The unpaid principal balance at June 30, 2026 is payable on the August 24, 2026 scheduled maturity date of the Credit Agreement.

Revolving credit and tranche A term loan borrowings under the Credit Agreement bear interest at our election at either (1) the ABR rate which is defined as the rate per annum equal to the greatest of (a) the lender's prime rate, (b) the weighted average of the federal funds rate, plus 0.5% and (c) one month SOFR rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.25% to 0.625%, or (2) the one, three or six month SOFR rate plus 0.1% (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.25% to 1.625%. As of March 31, 2023, the applicable margins were 0.50% for ABR-based loans and 1.50% for SOFR-based loans under the revolving credit and term loan A facilities. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Credit Agreement is secured by certain assets of the Company and our material subsidiaries (which generally excludes asset classes

such as substantially all of the patient-related accounts receivable of our acute care hospitals, and certain real estate assets and assets held in joint-ventures with third parties) and is guaranteed by our material subsidiaries.

The Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement also contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens, indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage. We were in compliance with all required covenants as of March 31, 2023 and December 31, 2022.

On August 24, 2021, we completed the following via private offerings to qualified institutional buyers under Rule 144A and to non-U.S. persons outside the United States in reliance on Regulation S under the Securities Act of 1933, as amended:

- Issued $700 million of aggregate principal amount of 1.65% senior secured notes due on September 1, 2026, and;
- Issued $500 million of aggregate principal amount of 2.65% senior secured notes due on January 15, 2032.

On September 13, 2021, we redeemed $400 million of aggregate principal amount of 5.00% senior secured notes, that were scheduled to mature on June 1, 2026, at 102.50% of the aggregate principal, or $410 million.

As of March 31, 2023, we had combined aggregate principal of $2.0 billion from the following senior secured notes:

- $700 million aggregate principal amount of 1.65% senior secured notes due in September, 2026 (“2026 Notes”) which were issued on August 24, 2021.
- $800 million aggregate principal amount of 2.65% senior secured notes due in October, 2030 (“2030 Notes”) which were issued on September 21, 2020.
- $500 million of aggregate principal amount of 2.65% senior secured notes due in January, 2032 (“2032 Notes”) which were issued on August 24, 2021.

Interest on the 2026 Notes is payable on March 1st and September 1st until the maturity date of September 1, 2026. Interest on the 2030 Notes is payable on April 15th and October 15th, until the maturity date of October 15, 2030. Interest on the 2032 Notes is payable on January 15th and July 15th until the maturity date of January 15, 2032.

The 2026 Notes, 2030 Notes and 2032 Notes (collectively “The Notes”) were initially issued only to qualified institutional buyers under Rule 144A and to non-U.S. persons outside the United States in reliance on Regulation S under the Securities Act of 1933, as amended (the “Securities Act”). In December, 2022, we completed a registered exchange offer in which virtually all previously outstanding Notes were exchanged for identical Notes that were registered under the Securities Act, and thereby became freely transferable (subject to certain restrictions applicable to affiliates and broker dealers). Notes originally issued under Rule 144A or Regulation S that were not exchanged in the exchange offer remain outstanding and may not be offered or sold in the United States absent registration under the Securities Act or an applicable exemption from registration requirements thereunder.

The Notes are guaranteed (the “*Guarantees*”) on a senior secured basis by all of our existing and future direct and indirect subsidiaries (the “*Subsidiary Guarantors*”) that guarantee our Credit Agreement, or other first lien obligations or any junior lien obligations. The Notes and the Guarantees are secured by first-priority liens, subject to permitted liens, on certain of the Company’s and the Subsidiary Guarantors’ assets now owned or acquired in the future by the Company or the Subsidiary Guarantors (other than real property, accounts receivable sold pursuant to the Company’s Existing Receivables Facility (as defined in the Indenture pursuant to which The Notes were issued (the “Indenture”)), and certain other excluded assets). The Company’s obligations with respect to The Notes, the obligations of the Subsidiary Guarantors under the Guarantees, and the performance of all of the Company’s and the Subsidiary Guarantors’ other obligations under the Indenture, are secured equally and ratably with the Company’s and the Subsidiary Guarantors’ obligations under the Credit Agreement and The Notes by a perfected first-priority security interest, subject to permitted liens, in the collateral owned by the Company and its Subsidiary Guarantors, whether now owned or hereafter acquired. However, the liens on the collateral securing The Notes and the Guarantees will be released if: (i) The Notes have investment grade ratings; (ii) no default has occurred and is continuing, and; (iii) the liens on the collateral securing all first lien obligations (including the Credit Agreement and The Notes) and any junior lien obligations are released or the collateral under the Credit Agreement, any other first lien obligations and any junior lien obligations is released or no longer required to be pledged. The liens on any collateral securing The Notes and the Guarantees will also be released if the liens on that collateral securing the Credit Agreement, other first lien obligations and any junior lien obligations are released.

On its December, 2022 maturity date, our $20 million accounts receivable securitization program expired and was not renewed or replaced.

As discussed in *Note 2 to the Consolidated Financial Statements-Relationship with Universal Health Realty Income Trust and Other Related Party Transactions*, on December 31, 2021, we (through wholly-owned subsidiaries of ours) entered into an asset purchase and sale agreement with Universal Health Realty Income Trust (the “Trust”). Pursuant to the terms of the agreement, which was amended during the first quarter of 2022, we, among other things, transferred to the Trust, the real estate assets of Aiken Regional Medical Center (“Aiken”) and Canyon Creek Behavioral Health (“Canyon Creek”). In connection with this transaction, Aiken and

Canyon Creek (as lessees), entered into a master lease and individual property leases, as amended, (with the Trust as lessor), for initial lease terms on each property of approximately twelve years, ending on December 31, 2033. As a result of our purchase option within the Aiken and Canyon Creek lease agreements, this asset purchase and sale transaction is accounted for as a failed sale leaseback in accordance with U.S. GAAP and we have accounted for the transaction as a financing arrangement. Our lease payments payable to the Trust are recorded to interest expense and as a reduction of the outstanding financial liability, and the amount allocated to interest expense is determined based upon our incremental borrowing rate and the outstanding financial liability. In connection with this transaction, our Consolidated Balance Sheets at March 31, 2023 and December 31, 2022 reflect financial liabilities, which are included in debt, of approximately $80 million and $81 million, respectively.

At March 31, 2023, the carrying value and fair value of our debt were approximately $4.8 billion and $4.5 billion, respectively. At December 31, 2022, the carrying value and fair value of our debt were approximately $4.8 billion and $4.4 billion, respectively. The fair value of our debt was computed based upon quotes received from financial institutions. We consider these to be “level 2” in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with debt instruments.

Our total debt as a percentage of total capitalization was approximately 44% at March 31, 2023 and 45% at December 31, 2022.

We expect to finance all capital expenditures and acquisitions and pay dividends and potentially repurchase shares of our common stock utilizing internally generated and additional funds. Additional funds may be obtained through: (i) borrowings under our existing revolving credit facility, which had $875 million of available borrowing capacity as of March 31, 2023, or through refinancing the existing Credit Agreement; (ii) the issuance of other short-term and/or long-term debt, and/or; (iii) the issuance of equity. We believe that our operating cash flows, cash and cash equivalents, available commitments under existing agreements, as well as access to the capital markets, provide us with sufficient capital resources to fund our operating, investing and financing requirements for the next twelve months. However, in the event we need to access the capital markets or other sources of financing, there can be no assurance that we will be able to obtain financing on acceptable terms or within an acceptable time. Our inability to obtain financing on terms acceptable to us could have a material unfavorable impact on our results of operations, financial condition and liquidity.

Supplemental Guarantor Financial Information

As of March 31, 2023, we had combined aggregate principal of $2.0 billion from The Notes:

- $700 million aggregate principal amount of the 2026 Notes;
- $800 million aggregate principal amount of the 2030 Notes, and;
- $500 million of aggregate principal amount of the 2032 Notes.

The Notes are fully and unconditionally guaranteed pursuant to the Guarantees on a senior secured basis by the Subsidiary Guarantors. The Notes and the Guarantees are secured by first-priority liens, subject to permitted liens, on certain of the Company’s and the Subsidiary Guarantors’ assets now owned or acquired in the future by the Company or the Subsidiary Guarantors (other than real property, accounts receivable sold pursuant to the Company’s existing receivables facility (as defined in the Indentures pursuant to which The Notes were issued), and certain other excluded assets). The Company’s obligations with respect to The Notes, the obligations of the Subsidiary Guarantors under the Guarantees, and the performance of all of the Company’s and the Subsidiary Guarantors’ other obligations under the Indentures, are secured equally and ratably with the Company’s and the Subsidiary Guarantors’ obligations under the Credit Agreement and The Notes by a perfected first-priority security interest, subject to permitted liens, in the collateral owned by the Company and its Subsidiary Guarantors, whether now owned or hereafter acquired. However, the liens on the collateral securing The Notes and the Guarantees will be released if: (i) The Notes have investment grade ratings; (ii) no default has occurred and is continuing, and; (iii) the liens on the collateral securing all first lien obligations (including the Credit Agreement and The Notes) and any junior lien obligations are released or the collateral under the Credit Agreement, any other first lien obligations and any junior lien obligations is released or no longer required to be pledged. The liens on any collateral securing The Notes and the Guarantees will also be released if the liens on that collateral securing the Credit Agreement, other first lien obligations and any junior lien obligations are released.

The Notes will be structurally subordinated to all obligations of our existing and future subsidiaries that are not and do not become Subsidiary Guarantors of The Notes. No appraisal of the value of the collateral has been made, and the value of the collateral in the event of liquidation will depend on market and economic conditions, the availability of buyers and other factors. Consequently, liquidating the collateral securing The Notes may not produce proceeds in an amount sufficient to pay any amounts due on The Notes.

We and our subsidiaries may be able to incur significant additional indebtedness in the future. Although our Credit Agreement contains restrictions on the incurrence of additional indebtedness and our Credit Agreement and The Notes contain restrictions on our ability to incur liens to secure additional indebtedness, these restrictions are subject to a number of qualifications and exceptions, and the additional indebtedness incurred in compliance with these restrictions could be substantial. These restrictions also will not prevent us from incurring obligations that do not constitute indebtedness. In addition, if we incur any additional indebtedness secured by liens that rank equally with The Notes, subject to collateral arrangements, the holders of that debt will be entitled to share ratably with you in any proceeds distributed in connection with any insolvency, liquidation, reorganization, dissolution or other winding up of our company. This may have the effect of reducing the amount of proceeds paid to holders of The Notes.

Federal and state fraudulent transfer and conveyance statutes may apply to the issuance of The Notes and the incurrence of the Guarantees. Under federal bankruptcy law and comparable provisions of state fraudulent transfer or conveyance laws, which may vary from state to state, The Notes or the Guarantees (or the grant of collateral securing any such obligations) could be voided as a fraudulent transfer or conveyance if we or any of the Subsidiary Guarantors, as applicable, (a) issued The Notes or incurred the Guarantees with the intent of hindering, delaying or defrauding creditors or (b) under certain circumstances received less than reasonably equivalent value or fair consideration in return for either issuing The Notes or incurring the Guarantees.

Basis of Presentation

The following tables include summarized financial information of Universal Health Services, Inc. and the other obligors in respect of debt issued by Universal Health Services, Inc. The summarized financial information of each obligor group is presented on a combined basis with balances and transactions within the obligor group eliminated. Investments in and the equity in earnings of non-guarantor subsidiaries, which would otherwise be consolidated in accordance with GAAP, are excluded from the below summarized financial information pursuant to SEC Regulation S-X Rule 13-01.

The summarized balance sheet information for the consolidated obligor group of debt issued by Universal Health Services, Inc. is presented in the table below:

(in thousands)	March 31, 2023	December 31, 2022
Current assets	$ 2,077,032	$ 2,062,900
Noncurrent assets (1)	8,787,435	8,773,036
Current liabilities	1,626,494	1,686,005
Noncurrent liabilities	5,610,263	5,587,141
Due to non-guarantors	926,531	942,731

(1) Includes goodwill of $3,267 million and $3,273 million as of March 31, 2023 and December 31, 2022, respectively.

The summarized results of operations information for the consolidated obligor group of debt issued by Universal Health Services, Inc. is presented in the table below:

(in thousands)	Three Months Ended March 31, 2023	Twelve Months Ended December 31, 2022
Net revenues	$ 2,819,290	$ 10,853,259
Operating charges	2,545,238	9,947,778
Interest expense, net	52,127	193,486
Other (income) expense, net	12,691	7,487
Net income	$ 150,615	$ 532,047

Affiliates Whose Securities Collateralize the Senior Secured Notes

The Notes and the Guarantees are secured by, among other things, pledges of the capital stock of our subsidiaries held by us or by our secured Guarantors, in each case other than certain excluded assets and subject to permitted liens. Such collateral securities are secured equally and ratably with our and the Guarantors' obligations under our Credit Agreement. For a list of our subsidiaries the capital stock of which has been pledged to secure The Notes, see Exhibit 22.1 to this Report.

Upon the occurrence and during the continuance of an event of default under the indentures governing The Notes, subject to the terms of the Security Agreement relating to The Notes provide for (among other available remedies) the foreclosure upon and sale of the Collateral (including the pledged stock) and the distribution of the net proceeds of any such sale to the holders of The Notes, the lenders under the Credit Agreement and the holders of any other permitted first priority secured obligations on a pro rata basis, subject to any prior liens on the collateral.

No appraisal of the value of the collateral securities has been made, and the value of the collateral securities in the event of liquidation will depend on market and economic conditions, the availability of buyers and other factors. Consequently, liquidating the collateral securities securing The Notes may not produce proceeds in an amount sufficient to pay any amounts due on The Notes.

The security agreement relating to The Notes provides that the representative of the lenders under our Credit Agreement will initially control actions with respect to that collateral and, consequently, exercise of any right, remedy or power with respect to enforcing interests in or realizing upon such collateral will initially be at the direction of the representative of the lenders.

No trading market exists for the capital stock pledged as collateral.

The assets, liabilities and results of operations of the combined affiliates whose securities are pledged as collateral are not materially different than the corresponding amounts presented in the consolidated financial information of Universal Health Services, Inc.

Off-Balance Sheet Arrangements

During the three months ended March 31, 2023 there have been no material changes in the off-balance sheet arrangements consisting of standby letters of credit and surety bonds.

As of March 31, 2023 we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds which totaled $180 million consisting of: (i) $170 million related to our self-insurance programs, and; (ii) $10 million of other debt and public utility guarantees.

Item 3. Quantitative and Qualitative Disclosures About Market Risk

There have been no material changes in the quantitative and qualitative disclosures about market risk during the three months ended March 31, 2023. Reference is made to *Item 7A. Quantitative and Qualitative Disclosures About Market Risk* in our Annual Report on Form 10-K for the year ended December 31, 2022.

Item 4. Controls and Procedures

As of March 31, 2023, under the supervision and with the participation of our management, including our Chief Executive Officer ("CEO") and Chief Financial Officer ("CFO"), we performed an evaluation of the effectiveness of our disclosure controls and procedures, as defined in Rule 13a-15(e) or Rule 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "1934 Act"). Based on this evaluation, the CEO and CFO have concluded that our disclosure controls and procedures are effective to ensure that material information is recorded, processed, summarized and reported by management on a timely basis in order to comply with our disclosure obligations under the 1934 Act and the SEC rules thereunder.

Changes in Internal Control Over Financial Reporting

There have been no changes in our internal control over financial reporting or in other factors during the first quarter of 2023 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II. OTHER INFORMATION

Item 1. Legal Proceedings

See *Note 6-Commitments and Contingencies* to our condensed consolidated financial statements in Item 1 of Part I of this report for a description of our legal proceedings. Such information is hereby incorporated by reference.

Item 1A. Risk Factors

Our Annual Report on Form 10-K for the year ended December 31, 2022 includes a listing of risk factors to be considered by investors in our securities. During the first quarter of 2023, there have been no material changes in our risk factors from those set forth in our Annual Report on Form 10-K for the year ended December 31, 2022.

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

As of December 31, 2022, we had an aggregate available repurchase authorization of $947.37 million pursuant to our stock repurchase program. Pursuant to this program, shares of our Class B Common Stock may be repurchased, from time to time as conditions allow, on the open market or in negotiated private transactions. There is no expiration date for our stock repurchase program.

As reflected below, during the three-month period ended March 31, 2023, we have repurchased 650,000 shares at an aggregate cost of approximately $78.66 million (approximately $121.02 per share) pursuant to the terms of our stock repurchase program. In addition, during the three-month period ended March 31, 2023, 49,902 shares were repurchased in connection with income tax withholding obligations resulting from stock-based compensation programs.

During the period of January 1, 2023 through March 31, 2023, we repurchased the following shares:

	Additional Dollars Authorized For Repurchase (in thousands)	Total number of shares purchased	Total number of shares cancelled	Average price paid per share for forfeited restricted shares	Total Number of shares purchased as part of publicly announced programs	Average price paid per share for shares purchased as part of publicly announced program	Aggregate purchase price paid for shares purchased as part of publicly announced program (in thousands)	Maximum number of shares that may yet be purchased under the program	Maximum number of dollars that may yet be purchased under the program (in thousands)
January, 2023	$ -	7,973	95	$ 0.01	—	$ -	$ -	—	$ 947,368
February, 2023	$ -	3,753	27	$ 0.01	—	$ -	$ -	—	$ 947,368
March, 2023	$ -	688,176	512	$ 0.01	650,000	$ 121.02	$ 78,661	—	$ 868,707
Total January through March, 2023	$ -	699,902	634	$ 0.01	650,000	121.02	$ 78,661		

Dividends

During the quarter ended March 31, 2023, we declared and paid dividends of $.20 per share. Dividend equivalents are accrued on unvested restricted stock units and will be paid upon vesting of the restricted stock unit.

Item 6. Exhibits

22.1	List of Guarantor Subsidiaries and Issuers of Guaranteed Securities and Affiliates Whose Securities Collateralize Securities of the Registrant.
31.1	Certification of the Company's Chief Executive Officer pursuant to Rule 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934.
31.2	Certification of the Company's Chief Financial Officer pursuant to Rule 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934.
32.1	Certification of the Company's Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of the Company's Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	Inline XBRL Instance Document –the instance document does not appear in the Interactive Data file because its XBRL tags are embedded within the Inline XBRL document.
101.SCH	Inline XBRL Taxonomy Extension Schema Document
101.CAL	Inline XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase Document
101.LAB	Inline XBRL Taxonomy Extension Label Linkbase Document
101.PRE	Inline XBRL Taxonomy Extension Presentation Linkbase Document
104	The cover page from the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2023, has been formatted in Inline XBRL.

Signatures

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

Universal Health Services, Inc.
(Registrant)

Date: May 8, 2023

/s/ Marc D. Miller

Marc D. Miller,
President and Chief Executive Officer
(Principal Executive Officer)

/s/ Steve Filton

Steve Filton,
Executive Vice President and
Chief Financial Officer
(Principal Financial Officer)

Subsidiary Guarantors and Issuers of Guaranteed Securities and Affiliates Whose Securities Collateralize Securities of the Registrant

Guaranteed Securities

The following securities (collectively, the "UHS Senior Secured Notes") issued by Universal Health Services, Inc., a Delaware corporation (the "Company"), were outstanding as of March 31, 2023.

Description of Notes

1.650% Senior Secured Notes due 2026
2.650% Senior Secured Notes due 2030
2.650% Senior Secured Notes due 2032

Obligors

The obligors under the UHS Senior Secured Notes consisted of the Company, as issuer, and its subsidiaries listed in the following table, as Guarantors.

Name of Subsidiary	Jurisdiction of Organization	Obligor Type
ABS LINCS KY, LLC	Virginia	Guarantor
ABS LINCS SC, Inc.	South Carolina	Guarantor
ABS LINCS VA, Inc.	Virginia	Guarantor
Aiken Regional Medical Centers, LLC	South Carolina	Guarantor
Alliance Health Center, Inc.	Mississippi	Guarantor
Alternative Behavioral Services, Inc.	Virginia	Guarantor
Ascend Health Corporation	Delaware	Guarantor
Atlantic Shores Hospital, LLC	Delaware	Guarantor
AZ Holding 4, LLC	Arizona	Guarantor
Beach 77, LP	Delaware	Guarantor
Behavioral Health Management, LLC	Delaware	Guarantor
Behavioral Health Realty, LLC	Delaware	Guarantor
Behavioral Healthcare LLC	Delaware	Guarantor
Benchmark Behavioral Health System, Inc.	Utah	Guarantor
BHC Alhambra Hospital, Inc.	Tennessee	Guarantor
BHC Belmont Pines Hospital, Inc.	Tennessee	Guarantor
BHC Fairfax Hospital, Inc.	Tennessee	Guarantor

Name of Subsidiary	Jurisdiction of Organization	Obligor Type
BHC Fox Run Hospital, Inc.	Tennessee	Guarantor
BHC Fremont Hospital, Inc.	Tennessee	Guarantor
BHC Health Services of Nevada, Inc.	Nevada	Guarantor
BHC Heritage Oaks Hospital, Inc.	Tennessee	Guarantor
BHC Holdings, Inc.	Delaware	Guarantor
BHC Intermountain Hospital, Inc.	Tennessee	Guarantor
BHC Mesilla Valley Hospital, LLC	Delaware	Guarantor
BHC Montevista Hospital, Inc.	Nevada	Guarantor
BHC Northwest Psychiatric Hospital, LLC	Delaware	Guarantor
BHC Of Indiana, General Partnership	Tennessee	Guarantor
BHC Pinnacle Pointe Hospital, LLC	Tennessee	Guarantor
BHC Properties, LLC	Tennessee	Guarantor
BHC Sierra Vista Hospital, Inc.	Tennessee	Guarantor
BHC Streamwood Hospital, Inc.	Tennessee	Guarantor
Bloomington Meadows, General Partnership	Tennessee	Guarantor
Brentwood Acquisition - Shreveport, Inc.	Delaware	Guarantor
Brentwood Acquisition, Inc.	Tennessee	Guarantor
Brynn Marr Hospital, Inc.	North Carolina	Guarantor
Calvary Center, Inc.	Delaware	Guarantor
Canyon Ridge Hospital, Inc.	California	Guarantor
CAT Realty, LLC	Delaware	Guarantor
CAT Seattle, LLC	Delaware	Guarantor
CCS/Lansing, Inc.	Michigan	Guarantor
Cedar Springs Hospital, Inc.	Delaware	Guarantor
Children’s Comprehensive Services, Inc.	Tennessee	Guarantor
Columbus Hospital Partners, LLC	Tennessee	Guarantor
Coral Shores Behavioral Health, LLC	Delaware	Guarantor
Cumberland Hospital Partners, LLC	Delaware	Guarantor
Cumberland Hospital, LLC	Virginia	Guarantor
Del Amo Hospital, Inc.	California	Guarantor
DHP 2131 K St, LLC	Delaware	Guarantor
Diamond Grove Center, LLC	Delaware	Guarantor
District Hospital Partners, L.P.	District of Columbia	Guarantor
DVH Hospital Alliance LLC	Delaware	Guarantor

Name of Subsidiary	Jurisdiction of Organization	Obligor Type
Emerald Coast Behavioral Hospital, LLC	Delaware	Guarantor
Fannin Management Services, LLC	Texas	Guarantor
First Hospital Corporation of Virginia Beach	Virginia	Guarantor
Forest View Psychiatric Hospital, Inc.	Michigan	Guarantor
Fort Duncan Medical Center, L.P.	Delaware	Guarantor
Fort Lauderdale Hospital, Inc.	Florida	Guarantor
FRN, INC.	Delaware	Guarantor
Frontline Behavioral Health, Inc.	Delaware	Guarantor
Frontline Hospital, LLC	Delaware	Guarantor
Frontline Residential Treatment Center, LLC	Delaware	Guarantor
Garfield Park Hospital, LLC	Illinois	Guarantor
Great Plains Hospital, Inc.	Missouri	Guarantor
Gulf Coast Treatment Center, Inc.	Florida	Guarantor
Gulph Mills Associates, LLC	Pennsylvania	Guarantor
H. C. Corporation	Alabama	Guarantor
H.C. Partnership	Alabama	Guarantor
Harbor Point Behavioral Health Center, Inc.	Virginia	Guarantor
Havenwyck Hospital, Inc.	Michigan	Guarantor
HHC Augusta, Inc.	Georgia	Guarantor
HHC Delaware, Inc.	Delaware	Guarantor
HHC Indiana, Inc.	Indiana	Guarantor
HHC Ohio, Inc.	Ohio	Guarantor
HHC Pennsylvania, LLC	Delaware	Guarantor
HHC Poplar Springs, LLC	Virginia	Guarantor
HHC River Park, Inc.	West Virginia	Guarantor
HHC South Carolina, Inc.	South Carolina	Guarantor
HHC St. Simons, Inc.	Georgia	Guarantor
Hickory Trail Hospital, L.P.	Delaware	Guarantor
Holly Hill Hospital, LLC	Tennessee	Guarantor
Horizon Health Austin, Inc.	Texas	Guarantor
Horizon Health Corporation	Delaware	Guarantor
Horizon Health Hospital Services, LLC	Delaware	Guarantor
Horizon Mental Health Management, LLC	Texas	Guarantor
HSA Hill Crest Corporation	Alabama	Guarantor

Name of Subsidiary	Jurisdiction of Organization	Obligor Type
Hughes Center, LLC	Virginia	Guarantor
Independence Physician Management, LLC	Delaware	Guarantor
Keys Group Holdings LLC	Delaware	Guarantor
Keystone Continuum, LLC	Tennessee	Guarantor
Keystone Education And Youth Services, LLC	Tennessee	Guarantor
Keystone Marion, LLC	Virginia	Guarantor
Keystone Memphis, LLC	Tennessee	Guarantor
Keystone Newport News, LLC	Virginia	Guarantor
Keystone NPS LLC	California	Guarantor
Keystone Richland Center LLC	Ohio	Guarantor
Keystone WSNC, L.L.C.	North Carolina	Guarantor
Keystone/CCS Partners LLC	Delaware	Guarantor
Kids Behavioral Health of Utah, Inc.	Utah	Guarantor
Kingwood Pines Hospital, LLC	Texas	Guarantor
KMI Acquisition, LLC	Delaware	Guarantor
La Amistad Residential Treatment Center, LLC	Florida	Guarantor
Lancaster Hospital Corporation	California	Guarantor
Laurel Oaks Behavioral Health Center, Inc.	Delaware	Guarantor
Lebanon Hospital Partners, LLC	Tennessee	Guarantor
Liberty Point Behavioral Healthcare, LLC	Delaware	Guarantor
Manatee Memorial Hospital, L.P.	Delaware	Guarantor
Mayhill Behavioral Health, LLC	Texas	Guarantor
McAllen Hospitals, L.P.	Delaware	Guarantor
McAllen Medical Center, Inc.	Delaware	Guarantor
Meridell Achievement Center, Inc.	Texas	Guarantor
Merion Building Management, Inc.	Delaware	Guarantor
Michigan Psychiatric Services, Inc.	Michigan	Guarantor
Millwood Hospital, L.P.	Texas	Guarantor
Milwaukee Behavioral Health, LLC	Wisconsin	Guarantor
Neuro Institute of Austin, L.P.	Texas	Guarantor
North Spring Behavioral Healthcare, Inc.	Tennessee	Guarantor
Northern Indiana Partners, LLC	Tennessee	Guarantor
Northwest Texas Healthcare System, Inc.	Texas	Guarantor

Name of Subsidiary	Jurisdiction of Organization	Obligor Type
Oak Plains Academy Of Tennessee, Inc.	Tennessee	Guarantor
Ocala Behavioral Health, LLC	Delaware	Guarantor
Palm Point Behavioral Health, LLC	Florida	Guarantor
Palmetto Behavioral Health Holdings, LLC	Delaware	Guarantor
Palmetto Behavioral Health System, L.L.C.	South Carolina	Guarantor
Palmetto Lowcountry Behavioral Health, L.L.C.	South Carolina	Guarantor
Park Healthcare Company	Tennessee	Guarantor
Pasteur Healthcare Properties, LLC	Delaware	Guarantor
Pendleton Methodist Hospital, L.L.C.	Delaware	Guarantor
Pennsylvania Clinical Schools, Inc.	Pennsylvania	Guarantor
Premier Behavioral Solutions Of Florida, Inc.	Delaware	Guarantor
Premier Behavioral Solutions, Inc.	Delaware	Guarantor
PSJ Acquisition, LLC	North Dakota	Guarantor
Psychiatric Realty, LLC	Delaware	Guarantor
Psychiatric Solutions Hospitals, LLC	Delaware	Guarantor
Psychiatric Solutions Of Virginia, Inc.	Tennessee	Guarantor
Psychiatric Solutions, Inc.	Delaware	Guarantor
Ramsay Managed Care, LLC	Delaware	Guarantor
Ramsay Youth Services of Georgia, Inc.	Delaware	Guarantor
Ridge Outpatient Counseling, L.L.C.	Kentucky	Guarantor
River Oaks, Inc.	Louisiana	Guarantor
Riveredge Hospital Holdings, Inc.	Delaware	Guarantor
Riverside Medical Clinic Patient Services, L.L.C.	California	Guarantor
Rolling Hills Hospital, LLC	Tennessee	Guarantor
RR Recovery, LLC	Delaware	Guarantor
Salt Lake Behavioral Health, LLC	Delaware	Guarantor
Salt Lake Psychiatric Realty, LLC	Delaware	Guarantor
Samson Properties, LLC	Florida	Guarantor
Schick Shadel Of Florida, LLC	Florida	Guarantor
Shadow Mountain Behavioral Health System, LLC	Delaware	Guarantor
SHC-KPH, LP	Texas	Guarantor

Name of Subsidiary	Jurisdiction of Organization	Obligor Type
Southeastern Hospital Corporation	Tennessee	Guarantor
SP Behavioral, LLC	Florida	Guarantor
Sparks Family Hospital, Inc.	Nevada	Guarantor
Springfield Hospital, Inc.	Delaware	Guarantor
Stonington Behavioral Health, Inc.	Delaware	Guarantor
Summit Oaks Hospital, Inc.	New Jersey	Guarantor
Sunstone Behavioral Health, LLC	Tennessee	Guarantor
TBD Acquisition II, LLC	Delaware	Guarantor
TBD Acquisition, LLC	Delaware	Guarantor
TBJ Behavioral Center, LLC	Delaware	Guarantor
Temecula Valley Hospital, Inc.	California	Guarantor
Temple Behavioral Healthcare Hospital, Inc.	Texas	Guarantor
Tennessee Clinical Schools, LLC	Tennessee	Guarantor
Texas Cypress Creek Hospital, L.P.	Texas	Guarantor
Texas Hospital Holdings, Inc.	Delaware	Guarantor
Texas Laurel Ridge Hospital, L.P.	Texas	Guarantor
Texas Oaks Psychiatric Hospital, L.P.	Texas	Guarantor
Texas San Marcos Treatment Center, L.P.	Texas	Guarantor
Texas West Oaks Hospital, L.P.	Texas	Guarantor
The Arbour, Inc.	Massachusetts	Guarantor
The Bridgeway, LLC	Arkansas	Guarantor
The National Deaf Academy, LLC	Florida	Guarantor
Three Rivers Behavioral Health, LLC	South Carolina	Guarantor
Three Rivers Healthcare Group, LLC	South Carolina	Guarantor
Toledo Holding Co., LLC	Delaware	Guarantor
Turning Point Care Center, LLC	Georgia	Guarantor
Two Rivers Psychiatric Hospital, Inc.	Delaware	Guarantor
UBH of Oregon, LLC	Delaware	Guarantor
UBH of Phoenix Realty, LLC	Delaware	Guarantor
UBH of Phoenix, LLC	Delaware	Guarantor
UHP, LP	Delaware	Guarantor
UHS Capitol Acquisition, LLC	Delaware	Guarantor
UHS Children Services, Inc.	Delaware	Guarantor
UHS Funding, LLC	Delaware	Guarantor

Name of Subsidiary	Jurisdiction of Organization	Obligor Type
UHS Holding Company, Inc.	Nevada	Guarantor
UHS Kentucky Holdings, L.L.C.	Delaware	Guarantor
UHS Midwest Behavioral Health, LLC	Delaware	Guarantor
UHS of Anchor, L.P.	Delaware	Guarantor
UHS of Benton, LLC	Delaware	Guarantor
UHS of Bowling Green, LLC	Delaware	Guarantor
UHS of Centennial Peaks, L.L.C.	Delaware	Guarantor
UHS of Cornerstone Holdings, Inc.	Delaware	Guarantor
UHS of Cornerstone, Inc.	Delaware	Guarantor
UHS of D.C., Inc.	Delaware	Guarantor
UHS of Delaware, Inc.	Delaware	Guarantor
UHS of Denver, Inc.	Delaware	Guarantor
UHS of Dover, L.L.C.	Delaware	Guarantor
UHS of Doylestown, L.L.C.	Delaware	Guarantor
UHS of Fairmount, Inc.	Delaware	Guarantor
UHS of Fuller, Inc.	Massachusetts	Guarantor
UHS of Georgia Holdings, Inc.	Delaware	Guarantor
UHS of Georgia, Inc.	Delaware	Guarantor
UHS of Greenville, LLC	Delaware	Guarantor
UHS of Hampton, Inc	New Jersey	Guarantor
UHS of Hartgrove, Inc.	Illinois	Guarantor
UHS of Lakeside, LLC	Delaware	Guarantor
UHS of Lancaster, LLC	Pennsylvania	Guarantor
UHS of Laurel Heights, L.P.	Delaware	Guarantor
UHS of Madera, Inc.	Delaware	Guarantor
UHS of New Orleans, LLC	Louisiana	Guarantor
UHS of Oklahoma, LLC	Oklahoma	Guarantor
UHS of Parkwood, Inc.	Delaware	Guarantor
UHS of Peachford, L.P.	Delaware	Guarantor
UHS of Pennsylvania, Inc.	Pennsylvania	Guarantor
UHS of Phoenix, LLC	Delaware	Guarantor
UHS of Provo Canyon, Inc.	Delaware	Guarantor
UHS of Puerto Rico, Inc.	Delaware	Guarantor
UHS of Ridge, LLC	Delaware	Guarantor

Name of Subsidiary	Jurisdiction of Organization	Obligor Type
UHS of River Parishes, Inc.	Louisiana	Guarantor
UHS of Rockford, LLC	Delaware	Guarantor
UHS of Salt Lake City, L.L.C.	Delaware	Guarantor
UHS of Savannah, L.L.C.	Delaware	Guarantor
UHS of Spring Mountain, Inc.	Delaware	Guarantor
UHS of Springwoods, L.L.C.	Delaware	Guarantor
UHS of Summitridge, L.L.C.	Delaware	Guarantor
UHS of Texoma, Inc.	Delaware	Guarantor
UHS of Timberlawn, Inc.	Texas	Guarantor
UHS of Timpanogos, Inc.	Delaware	Guarantor
UHS of Tucson, LLC	Delaware	Guarantor
UHS of Westwood Pembroke, Inc.	Massachusetts	Guarantor
UHS of Wyoming, Inc.	Delaware	Guarantor
UHS Oklahoma City LLC	Oklahoma	Guarantor
UHS Sahara, Inc.	Delaware	Guarantor
UHS Sub III, LLC	Delaware	Guarantor
UHS-Corona, Inc.	Delaware	Guarantor
UHSD, L.L.C.	Nevada	Guarantor
UHSL, L.L.C.	Nevada	Guarantor
United Healthcare of Hardin, Inc.	Tennessee	Guarantor
Universal Health Services Of Palmdale, Inc.	Delaware	Guarantor
Universal Health Services Of Rancho Springs, Inc.	California	Guarantor
University Behavioral Health of El Paso, LLC	Delaware	Guarantor
University Behavioral, LLC	Florida	Guarantor
Valle Vista Hospital Partners, LLC	Tennessee	Guarantor
Valle Vista, LLC	Delaware	Guarantor
Valley Health System LLC	Delaware	Guarantor
Valley Hospital Medical Center, Inc.	Nevada	Guarantor
Wekiva Springs Center, LLC	Delaware	Guarantor
Wellington Regional Medical Center, LLC	Florida	Guarantor
Wellstone Regional Hospital Acquisition, LLC	Indiana	Guarantor
Willow Springs, LLC	Delaware	Guarantor

Name of Subsidiary	Jurisdiction of Organization	Obligor Type
Windmoor Healthcare Inc.	Florida	Guarantor
Windmoor Healthcare Of Pinellas Park, Inc.	Delaware	Guarantor
Wisconsin Avenue Psychiatric Center, Inc.	Delaware	Guarantor
Zeus Endeavors, LLC	Florida	Guarantor

Pledged Security Collateral

As of November 8, 2022, the obligations under the UHS Senior Secured Notes were secured by pledges of the equity of the following affiliates of the Company.

Name of Issuer	Issuer Jurisdiction of Organization	Percent of Interest Owned	Percent of Interest Pledged
2012 W. University Properties, LLC	Delaware	100	100
2026 W. University Properties, LLC	Delaware	100	100
ABS LINCS KY, LLC	Virginia	100	100
ABS LINCS SC, Inc.	South Carolina	100	100
ABS LINCS TN, Inc.	Virginia	100	100
ABS LINCS VA, Inc.	Virginia	100	100
Aiken Regional Medical Centers, LLC	South Carolina	100	100
Alabama Clinical Schools, Inc.	Alabama	100	100
Alliance Health Center, Inc.	Mississippi	100	100
Alternative Behavioral Services, Inc.	Virginia	100	100
Ambulatory Surgery Center of Temecula Valley, Inc.	California	100	100
ASC of Aiken, Inc.	Delaware	100	100
ASC of East New Orleans, Inc.	Delaware	100	100
ASC of Las Vegas, Inc.	Nevada	100	100
ASC of Midwest City, Inc.	Oklahoma	100	100
ASC of Puerto Rico, Inc.	Delaware	100	100
ASC of Wellington, Inc.	Florida	100	100
Ascend Health Corporation	Delaware	100	100
Atlantic Shores Hospital, LLC	Delaware	100	100
Auburn Regional Medical Center, Inc.	Washington	100	100
AZ Holding 4, LLC	Arizona	100	100
Beach 77 LP	Delaware	99	99
Behavioral Educational Services, Inc.	Delaware	100	100
Behavioral Health Connections, Inc.	Texas	100	100
Behavioral Health Management, LLC	Delaware	100	100
Behavioral Health Realty, LLC	Delaware	100	100
Behavioral Healthcare LLC	Delaware	100	100
Benchmark Behavioral Health System, Inc.	Utah	100	100
BHC Alhambra Hospital, Inc.	Tennessee	100	100
BH AZ Master, LLC	Arizona	51	51
BHC Fairfax Hospital, Inc.	Tennessee	100	100
BHC Fox Run Hospital, Inc.	Tennessee	100	100
BHC Fremont Hospital, Inc.	Tennessee	100	100

Name of Issuer	Issuer Jurisdiction of Organization	Percent of Interest Owned	Percent of Interest Pledged
BHC Health Services of Nevada, Inc.	Nevada	100	100
BHC Heritage Oaks Hospital, Inc.	Tennessee	100	100
BHC Holdings, Inc.	Delaware	100	100
BHC Intermountain Hospital, Inc.	Tennessee	100	100
BHC Management Services of Streamwood, LLC	Delaware	100	100
BHC Mesilla Valley Hospital, LLC	Delaware	100	100
BHC Montevista Hospital, Inc.	Nevada	100	100
BHC Northwest Psychiatric Hospital, LLC	Delaware	100	100
BHC of Indiana, General Partnership	Tennessee	100	100
BHC Pinnacle Pointe Hospital, LLC	Tennessee	100	100
BHC Properties, LLC	Tennessee	100	100
BHC Sierra Vista Hospital, Inc.	Tennessee	100	100
BHC Streamwood Hospital, Inc.	Tennessee	100	100
Bloomington Meadows, General Partnership	Tennessee	100	100
Brentwood Acquisition, Inc.	Tennessee	100	100
Brentwood Acquisition-Shreveport, Inc.	Delaware	100	100
Brynn Marr Hospital, Inc.	North Carolina	100	100
Calvary Center, Inc.	Delaware	100	100
Canyon Ridge Hospital, Inc.	California	100	100
Canyon Ridge Real Estate, LLC	Delaware	100	100
CAT Realty, LLC	Delaware	100	100
Cape Girardeau Behavioral Health, LLC	Missouri	75	75
CAT Seattle, LLC	Delaware	100	100
CCS/Lansing, Inc.	Michigan	100	100
Cedar Springs Hospital, Inc.	Delaware	100	100
Central Montgomery Medical Center, L.L.C.	Pennsylvania	100	100
Chalmette Medical Center, Inc.	Louisiana	100	100
Children’s Comprehensive Services, Inc.	Tennessee	100	100
Clive Behavioral Health, LLC	Delaware	52	52
Columbus Hospital Partners, LLC	Tennessee	100	100
Columbus Hospital, LLC	Delaware	100	100
Coral Shores Behavioral Health, LLC	Delaware	100	100
Cornerstone Hospital Management, LLC	Texas	58.3	58.3
Cornerstone Regional Hospital, LP	Texas	50.2	50.2
Crossings Healthcare Solutions, Inc.		100	100
Cumberland Hospital Partners, LLC	Delaware	100	100
Cumberland Hospital, LLC	Virginia	100	100
Cypress Creek Real Estate, L.P.	Delaware	99	99
Del Amo Hospital, Inc.	California	100	100
DHP 2131 K St, LLC	Delaware	100	100
Diamond Grove Center, LLC	Delaware	100	100
District Hospital Partners, L.P.	District of Columbia	100	100
Doctors’ Hospital of Shreveport, Inc.	Louisiana	100	100
DVH Hospital Alliance LLC	Delaware	100	100
Edinburg Ambulatory Surgical Center, Inc.	Texas	100	100
Edinburg Holdings, Inc.	Delaware	100	100
Edinburg MOB Properties, LLC	Florida	100	100

Name of Issuer	Issuer Jurisdiction of Organization	Percent of Interest Owned	Percent of Interest Pledged
Emerald Coast Behavioral Hospital, LLC	Delaware	100	100
Everglades Holdings, LLC	Delaware	100	100
Fannin Management Services, LLC	Texas	100	100
First Hospital Corporation of Virginia Beach	Virginia	100	100
Forest View Psychiatric Hospital, Inc.	Michigan	100	100
Fort Duncan Medical Center, Inc.	Delaware	100	100
Fort Duncan Medical Center, L.P.	Delaware	99	99
Fort Lauderdale Hospital, Inc.	Florida	100	100
Foundations Recovery Network, LLC	Tennessee	100	100
Friends Behavioral Health System, LP	Pennsylvania	79.92	79.92
Friends GP, LLC	Pennsylvania	80	80
FRN, Inc.	Delaware	100	100
Frontline Behavioral Health, Inc.	Delaware	100	100
Frontline Children's Hospital, L.L.C.	Delaware	100	100
Frontline Hospital, LLC	Delaware	100	100
Frontline Residential Treatment Center, LLC	Delaware	100	100
Garfield Park Hospital, LLC	Illinois	100	100
Glen Oaks Hospital, Inc.	Texas	100	100
Great Plains Hospital, Inc.	Missouri	100	100
Gulf Coast Treatment Center, Inc.	Florida	100	100
Gulph Mills Associates, LLC	Pennsylvania	100	100
H. C. Corporation	Alabama	100	100
H. C. Partnership	Alabama	100	100
Harbor Point Behavioral Health Center, Inc.	Virginia	100	100
Havenwyck Hospital Inc.	Michigan	100	100
HHC Augusta, Inc.	Georgia	100	100
HHC Berkeley, Inc.	South Carolina	100	100
HHC Delaware, Inc.	Delaware	100	100
HHC Indiana, Inc.	Indiana	100	100
HHC Kingwood Investment, LLC	Delaware	100	100
HHC Oconee, Inc.	South Carolina	100	100
HHC Ohio, Inc.	Ohio	100	100
HHC Pennsylvania, LLC	Delaware	100	100
HHC Poplar Springs, LLC	Virginia	100	100
HHC River Park, Inc.	West Virginia	100	100
HHC South Carolina, Inc.	South Carolina	100	100
HHC St. Simons, Inc.	Georgia	100	100
Hickory Trail Hospital, L.P.	Delaware	99	99
High Plains Behavioral Health, L.P.	Delaware	99	99
Holly Hill Hospital, LLC	Tennessee	100	100
Holly Hill Real Estate, LLC	North Carolina	100	100
Horizon Health Austin, Inc.	Texas	100	100
Horizon Health Corporation	Delaware	100	100
Horizon Health Hospital Services, LLC	Delaware	100	100
Horizon Health Physical Rehabilitation Services, LLC	Delaware	100	100
Horizon Mental Health Management, LLC	Texas	100	100
HRI Clinics, Inc.	Massachusetts	100	100
HRI Hospital, Inc.	Massachusetts	100	100

Name of Issuer	Issuer Jurisdiction of Organization	Percent of Interest Owned	Percent of Interest Pledged
HSA Hill Crest Corporation	Alabama	100	100
Hughes Center, LLC	Virginia	100	100
Independence Amarillo, LLC	Delaware	100	100
Independence Denison, LLC	Delaware	100	100
Independence Laredo, LLC	Delaware	100	100
Independence McAllen, LLC	Delaware	100	100
Independence Wellington, LLC	Delaware	100	100
Independence Physician Management, LLC	Delaware	100	100
Indiana Psychiatric Institutes, LLC	Delaware	100	100
InfoScriber Corporation	Delaware	100	100
Island 77 LLC	Delaware	100	100
KEYS Group Holdings LLC	Delaware	100	100
Keystone Charlotte LLC	North Carolina	100	100
Keystone Continuum, LLC	Tennessee	100	100
Keystone Education and Youth Services, LLC	Tennessee	100	100
Keystone Marion, LLC	Virginia	100	100
Keystone Memphis, LLC	Tennessee	100	100
Keystone NPS LLC	California	100	100
Keystone Newport News, LLC	Virginia	100	100
Keystone Richland Center LLC	Ohio	100	100
Keystone WSNC, L.L.C.	North Carolina	100	100
Keystone/CCS Partners LLC	Delaware	100	100
Kids Behavioral Health of Utah, Inc.	Utah	100	100
Kingwood Pines Hospital, LLC	Texas	100	100
KMI Acquisition, LLC	Delaware	100	100
KOP Limited	South Carolina	100	100
La Amistad Residential Treatment Center, LLC	Florida	100	100
Lancaster Behavioral Health Hospital, LLC	Pennsylvania	50	50
Lancaster Hospital Corporation	California	100	100
Laredo ASC, Inc.	Texas	100	100
Laredo Holdings, Inc.	Delaware	100	100
Laredo Regional, Inc.	Delaware	100	100
Laredo Regional Medical Center, LP	Delaware	80.14	80.14
Laurel Oaks Behavioral Health Center, Inc.	Delaware	100	100
Lebanon Hospital Partners, LLC	Tennessee	100	100
Liberty Point Behavioral Healthcare, LLC	Delaware	100	100
Manatee Memorial Hospital, L.P.	Delaware	100	100
Mayhill Behavioral Health, LLC	Texas	100	100
Mayhill Behavioral Properties, LLC	Texas	100	100
McAllen Holdings, Inc.	Delaware	100	100
McAllen Hospitals, L.P.	Delaware	100	100
McAllen Medical Center, Inc.	Delaware	100	100
Mental Health Outcomes, LLC	Delaware	100	100
Meridell Achievement Center, Inc.	Texas	100	100
Merion Building Management, Inc.	Delaware	100	100
Mesilla Valley Hospital, Inc.	New Mexico	100	100
Michigan BH JV, LLC	Michigan	74	74
Michigan Healthcare Staffing, LLC	Michigan	100	100

Name of Issuer	Issuer Jurisdiction of Organization	Percent of Interest Owned	Percent of Interest Pledged
Michigan Psychiatric Services, Inc.	Michigan	100	100
Millwood Hospital, L.P.	Texas	99	99
Milwaukee Behavioral Health, LLC	Wisconsin	100	100
Nashville Rehab, LLC	Tennessee	100	100
Neuro Institute of Austin, L.P.	Texas	99	99
NEWCO Oregon, Inc.	Delaware	100	100
North Spring Behavioral Healthcare, Inc.	Tennessee	100	100
Northern Indiana Partners, LLC	Tennessee	100	100
Northern Nevada Diagnostic Imaging-Spanish Springs, L.L.C	Nevada	100	100
Northwest Texas Healthcare System, Inc.	Texas	100	100
NWTHS Management, LLC	Texas	100	100
Oak Plains Academy of Tennessee, Inc.	Tennessee	100	100
Ocala Behavioral Health, LLC	Delaware	100	100
Oregon Psychiatric Realty, LLC	Delaware	100	100
Palm Point Behavioral Health, LLC	Florida	100	100
Palmetto Behavioral Health Holdings, LLC	Delaware	100	100
Palmetto Behavioral Health Solutions, LLC	South Carolina	100	100
Palmetto Behavioral Health System, L.L.C.	South Carolina	100	100
Palmetto Lowcountry Behavioral Health, L.L.C.	South Carolina	100	100
Palmetto Pee Dee Behavioral Health, L.L.C.	South Carolina	100	100
Park Healthcare Company	Tennessee	100	100
Pasteur Healthcare Properties, LLC	Delaware	100	100
Peak Behavioral Health Services, LLC	Delaware	100	100
Pendleton Methodist Hospital, L.L.C.	Delaware	100	100
Pennsylvania Clinical Schools, Inc.	Pennsylvania	100	100
PR Holding II, Inc.	Puerto Rico	100	100
Premier Behavioral Solutions of Florida, Inc.	Delaware	100	100
Premier Behavioral Solutions, Inc.	Delaware	100	100
Pride Institute, Inc.	Minnesota	100	100
PSJ Acquisition, LLC	North Dakota	100	100
Psychiatric Realty, LLC	Delaware	100	100
Psychiatric Solutions, Inc.	Delaware	100	100
Psychiatric Solutions Hospitals, LLC	Delaware	100	100
Psychiatric Solutions of Virginia, Inc.	Tennessee	100	100
PsychManagement Group, Inc.	West Virginia	100	100
Radiation Oncology Center of Aiken, LLC	South Carolina	95	95
Ramsay Managed Care, LLC	Delaware	100	100
Ramsay Youth Services of Georgia, Inc.	Delaware	100	100
Red Rock Solutions, LLC	Delaware	100	100
Relational Therapy Clinic, Inc.	Louisiana	100	100
Ridge Outpatient Counseling, L.L.C.	Kentucky	100	100
River Crest Hospital, Inc.	Texas	100	100
River Oaks, Inc.	Louisiana	100	100
Riveredge Hospital Holdings, Inc.	Delaware	100	100
Riveredge Hospital, Inc.	Illinois	100	100
Riveredge Real Estate, Inc.	Illinois	100	100

Name of Issuer	Issuer Jurisdiction of Organization	Percent of Interest Owned	Percent of Interest Pledged
Riverside Medical Clinic Patient Services, L.L.C.	California	100	100
Rolling Hills Hospital, LLC	Tennessee	100	100
RR Behavioral Realty LLC	Delaware	100	100
RR Recovery, LLC	Delaware	100	100
Salt Lake Behavioral Health, LLC	Delaware	100	100
Salt Lake Psychiatric Realty, LLC	Delaware	100	100
Samson Properties, LLC	Florida	100	100
Schick Shadel of Florida, LLC	Florida	100	100
Shadow Mountain Behavioral Health System, LLC	Delaware	100	100
SHC-KPH, LP	Texas	99.1	99.1
Somerset, Incorporated	California	100	100
Southeastern Hospital Corporation	Tennessee	100	100
Southside Imaging Center, LLC	South Carolina	100	100
SP Behavioral, LLC	Florida	100	100
Sparks Family Hospital, Inc.	Nevada	100	100
Spokane Behavioral Health, LLC	Washington	80	80
Spokane Valley Behavioral Health, LLC	Delaware	100	100
Springfield Hospital, Inc.	Delaware	100	100
St. Louis Behavioral Medicine Institute, Inc.	Missouri	100	100
Stonington Behavioral Health, Inc.	Delaware	100	100
Summerlin Hospital Medical Center, LP	Delaware	93.2	93.2
Summit Oaks Hospital, Inc.	New Jersey	100	100
Sunstone Behavioral Health, LLC	Tennessee	100	100
TBD Acquisition, LLC	Delaware	100	100
TBD Acquisition II, LLC	Delaware	100	100
TBJ Behavioral Center, LLC	Delaware	100	100
Temecula Valley Hospital, Inc.	California	100	100
Temple Behavioral Healthcare Hospital, Inc.	Texas	100	100
Tennessee Clinical Schools, LLC	Tennessee	100	100
Texas Cypress Creek Hospital, L.P.	Texas	99	99
Texas Hospital Holdings, Inc.	Delaware	100	100
Texas Hospital Holdings, LLC	Texas	100	100
Texas Laurel Ridge Hospital, L.P.	Texas	99	99
Texas Oaks Psychiatric Hospital, L.P.	Texas	99	99
Texas San Marcos Treatment Center, L.P.	Texas	99	99
Texas West Oaks Hospital, L.P.	Texas	99	99
The Arbour, Inc.	Massachusetts	100	100
The Bridgeway, LLC	Arkansas	100	100
The National Deaf Academy, LLC	Florida	100	100
Three Rivers Behavioral Health, LLC	South Carolina	100	100
Three Rivers Healthcare Group, LLC	South Carolina	100	100
Three Rivers Residential Treatment/Midlands Campus, Inc.	South Carolina	100	100
Three Rivers SPE Holding, LLC	South Carolina	100	100
Toledo Holding Co., LLC	Delaware	100	100
Turning Point Care Center, LLC	Georgia	100	100
Two Rivers Psychiatric Hospital, Inc.	Delaware	100	100

Name of Issuer	Issuer Jurisdiction of Organization	Percent of Interest Owned	Percent of Interest Pledged
UBH of Phoenix, LLC	Delaware	100	100
UBH of Phoenix Realty, LLC	Delaware	100	100
UBH of Oregon, LLC	Delaware	100	100
UHP LP	Delaware	100	100
UHS Advisory, Inc.	Delaware	100	100
UHS BH Telepsych, LLC	Delaware	100	100
UHS Building Solutions, Inc.	Delaware	100	100
UHS Capitol Acquisition, LLC	Delaware	100	100
UHS Children Services, Inc.	Delaware	100	100
UHS Funding, LLC	Delaware	100	100
UHS Good Samaritan, L.L.C.	Delaware	100	100
UHS Holding Company, Inc.	Nevada	100	100
UHS International, Inc.	Delaware	100	100
UHS Kentucky Holdings, L.L.C.	Delaware	100	100
UHS Midwest Behavioral Health, LLC	Delaware	100	100
UHS Midwest Center for Youth and Families, LLC	Indiana	100	100
UHS Oklahoma City LLC	Oklahoma	100	100
UHS Receivables Corp.	Delaware	100	100
UHS Sahara, Inc.	Delaware	100	100
UHS Surgical Hospital of Texoma, LLC	Texas	100	100
UHS of Anchor, L.P.	Delaware	100	100
UHS of Benton Day School and Treatment Program, Inc.	Delaware	100	100
UHS of Benton, LLC	Delaware	100	100
UHS of Bowling Green, LLC	Delaware	100	100
UHS of Centennial Peaks, L.L.C.	Delaware	100	100
UHS of Cornerstone Holdings, Inc.	Delaware	100	100
UHS of Cornerstone, Inc.	Delaware	100	100
UHS of D.C., Inc.	Delaware	100	100
UHS of Delaware, Inc.	Delaware	100	100
UHS of Denver, Inc.	Delaware	100	100
UHS of Dover, L.L.C.	Delaware	100	100
UHS of Doylestown, L.L.C.	Delaware	100	100
UHS of Fairmount, Inc.	Delaware	100	100
UHS of Fuller, Inc.	Massachusetts	100	100
UHS of GB, Inc.	Delaware	100	100
UHS of Georgia Holdings, Inc.	Delaware	100	100
UHS of Georgia, Inc.	Delaware	100	100
UHS of Greenville, LLC	Delaware	100	100
UHS of Hampton Learning Center, Inc.	New Jersey	100	100
UHS of Hampton, Inc.	New Jersey	100	100
UHS of Hartgrove, Inc.	Illinois	100	100
UHS of Indiana, Inc.	Indiana	100	100
UHS of Kootenai River, Inc.	Delaware	100	100
UHS of Lakeside, LLC	Delaware	100	100
UHS of Lancaster, LLC	Pennsylvania	100	100
UHS of Laurel Heights, L.P.	Delaware	100	100
UHS of Madera, Inc.	Delaware	100	100

Name of Issuer	Issuer Jurisdiction of Organization	Percent of Interest Owned	Percent of Interest Pledged
UHS of New Orleans, LLC	Louisiana	100	100
UHS of No. Nevada, LLC	Nevada	100	100
UHS of Oklahoma Receivables, L.L.C	Delaware	100	100
UHS of Oklahoma, LLC	Oklahoma	100	100
UHS of Parkwood, Inc.	Delaware	100	100
UHS of Peachford, L.P.	Delaware	100	100
UHS of Pennsylvania, Inc.	Pennsylvania	100	100
UHS of Phoenix, LLC	Delaware	100	100
UHS of Provo Canyon, Inc.	Delaware	100	100
UHS of Puerto Rico, Inc.	Delaware	100	100
UHS of Ridge, LLC	Delaware	100	100
UHS of River Parishes, Inc.	Louisiana	100	100
UHS of Rockford, LLC	Delaware	100	100
UHS of Salt Lake City, L.L.C.	Delaware	100	100
UHS of Savannah, L.L.C.	Delaware	100	100
UHS of Spring Mountain, Inc.	Delaware	100	100
UHS of Springwoods, L.L.C.	Delaware	100	100
UHS of SummitRidge, L.L.C.	Delaware	100	100
UHS of Sutton, Inc.	Delaware	100	100
UHS of Talbot, L.P.	Delaware	100	100
UHS of Texoma, Inc.	Delaware	100	100
UHS of Timberlawn, Inc.	Texas	100	100
UHS of Timpanogos, Inc.	Delaware	100	100
UHS of Tuscon, LLC	Delaware	100	100
UHS of Westwood Pembroke, Inc.	Massachusetts	100	100
UHS of Wyoming, Inc.	Delaware	100	100
UHS-Corona, Inc.	Delaware	100	100
UHS-Lakeland Medical Center, L.L.C.	Delaware	100	100
UHS Sub III, LLC	Delaware	100	100
UHSD, L.L.C	Nevada	100	100
UHSF, L.L.C	Delaware	100	100
UHSL, L.L.C	Nevada	100	100
UK Acquisition No. 6, Ltd	United Kingdom	100	65
United Healthcare of Hardin, Inc.	Tennessee	100	100
Universal Community Behavioral Health, Inc.	Pennsylvania	100	100
Universal HMO, Inc.	Nevada	100	100
Universal Health Network, Inc.	Nevada	100	100
Universal Health Recovery Centers, Inc.	Pennsylvania	100	100
Universal Health Services of Cedar Hill, Inc.	Texas	100	100
Universal Health Services of Palmdale, Inc.	Delaware	100	100
Universal Health Services of Rancho Springs, Inc.	California	100	100
Universal Treatment Centers, Inc.	Delaware	100	100
University Behavioral, LLC	Florida	100	100
University Behavioral Health of El Paso, LLC	Delaware	100	100
Valle Vista Hospital Partners, LLC	Tennessee	100	100
Valle Vista, LLC	Delaware	100	100
Valley Health System LLC	Delaware	100	100
Valley Hospital Medical Center, Inc.	Nevada	100	100

Name of Issuer	Issuer Jurisdiction of Organization	Percent of Interest Owned	Percent of Interest Pledged
Virgin Islands Behavioral Services, Inc.	Virginia	100	100
Vista Diagnostic Center, L.L.C.	Nevada	100	100
Wekiva Springs Center, LLC	Delaware	100	100
Wellington Physician Alliances, Inc.	Florida	100	100
Wellington Regional Medical Center, LLC	Florida	100	100
Wellstone Holdings, LLC	Delaware	100	100
Wellstone Regional Hospital Acquisition, LLC	Indiana	98	98
West Church Partnership	Illinois	100	100
West Oaks Real Estate, L.P.	Texas	99	99
Westside Outpatient Center, LLC	Florida	50	50
Willow Springs, LLC	Delaware	100	100
Windmoor Healthcare Inc.	Florida	100	100
Windmoor Healthcare of Pinellas Park, Inc.	Delaware	100	100
Wisconsin Avenue Psychiatric Center, Inc.	Delaware	100	100
Zeus Endeavors, LLC	Florida	100	100

Exhibit 31.1

CERTIFICATION—Chief Executive Officer

I, Marc D. Miller, certify that:

1. I have reviewed this quarterly report on Form 10-Q of Universal Health Services, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report, based on such evaluation; and

d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: May 8, 2023

/s/ Marc D. Miller

Marc D. Miller

Chief Executive Officer

Exhibit 31.2

CERTIFICATION—Chief Financial Officer

I, Steve Filton, certify that:

1. I have reviewed this quarterly report on Form 10-Q of Universal Health Services, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report, based on such evaluation; and

d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: May 8, 2023

/s/ Steve Filton

Steve Filton
Executive Vice President and
Chief Financial Officer

Exhibit 32.1

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report of Universal Health Services, Inc. (the "Company") on Form 10-Q for the quarter ended March 31, 2023, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Marc D. Miller, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, and to the best of my knowledge, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company at the end of, and for the period covered by, the Report.

/s/ Marc D. Miller
Marc D. Miller
Chief Executive Officer
May 8, 2023

A signed original of this written statement required by Section 906 has been provided to Universal Health Services, Inc. and will be retained and furnished to the Securities and Exchange Commission or its staff upon request.

Exhibit 32.2

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report of Universal Health Services, Inc. (the "Company") on Form 10-Q for the quarter ended March 31, 2023, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Steve Filton, Executive Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, and to the best of my knowledge, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company at the end of, and for the period covered by, the Report.

/s/ Steve Filton
Steve Filton
Executive Vice President and
Chief Financial Officer
May 8, 2023

A signed original of this written statement required by Section 906 has been provided to Universal Health Services, Inc. and will be retained and furnished to the Securities and Exchange Commission or its staff upon request.