# 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, 2026**

**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, 2026:

| | |
|---|---|
| Class A | 6,574,600 |
| Class B | 53,287,606 |
| Class C | 661,688 |
| Class D | 12,457 |

UNIVERSAL HEALTH SERVICES, INC.

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This Quarterly Report on Form 10-Q is for the quarter ended March 31, 2026. This Report modifies and supersedes documents filed prior to this Report. Information that we file with the Securities and Exchange Commission (the "SEC") in the future will automatically update and supersede information contained in this Report.

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

**PART I. FINANCIAL INFORMATION**

**UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES**
**CONDENSED CONSOLIDATED STATEMENTS OF INCOME**
(amounts in thousands, except per share amounts)
(unaudited)

| | Three months ended March 31, | |
|---|---|---|
| | 2026 | 2025 |
| Net revenues | $ 4,495,182 | $ 4,099,720 |
| Operating charges: | | |
| Salaries, wages and benefits | 2,088,229 | 1,951,104 |
| Other operating expenses | 1,283,928 | 1,105,752 |
| Supplies expense | 426,543 | 402,881 |
| Depreciation and amortization | 155,426 | 148,345 |
| Lease and rental expense | 38,196 | 36,813 |
| | 3,992,322 | 3,644,895 |
| Income from operations | $ 502,860 | $ 454,825 |
| Interest expense, net | 37,133 | 40,056 |
| Other (income) expense, net | (3,389) | (5,659) |
| Income before income taxes | $ 469,116 | $ 420,428 |
| Provision for income taxes | 110,438 | 98,800 |
| Net income | 358,678 | 321,628 |
| Less: Net income (loss) attributable to noncontrolling interests | 9,996 | 4,948 |
| Net income attributable to UHS | $ 348,682 | $ 316,680 |
| | | |
| Basic earnings per share attributable to UHS | $ 5.71 | $ 4.87 |
| Diluted earnings per share attributable to UHS | $ 5.65 | $ 4.80 |
| | | |
| Weighted average number of common shares - basic | 61,071 | 64,970 |
| Add: Other share equivalents | 597 | 1,067 |
| Weighted average number of common shares and equivalents - diluted | 61,668 | 66,037 |

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, | |
|---|---|---|
| | 2026 | 2025 |
| Net income | $ 358,678 | $ 321,628 |
| Other comprehensive income (loss): | | |
| Foreign currency translation adjustment | (8,283) | 14,901 |
| Other comprehensive income (loss) before tax | (8,283) | 14,901 |
| Income tax expense (benefit) related to items of other comprehensive income (loss) | 420 | (408) |
| Total other comprehensive (loss) income, net of tax | (8,703) | 15,309 |
| Comprehensive income | 349,975 | 336,937 |
| Less: Comprehensive income (loss) attributable to noncontrolling interests | 9,996 | 4,948 |
| Comprehensive income attributable to UHS | $ 339,979 | $ 331,989 |

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, 2026 | December 31, 2025 |
|---|---|---|
| Assets | | |
| Current assets: | | |
| Cash and cash equivalents | $ 119,028 | $ 137,797 |
| Accounts receivable, net | 2,745,090 | 2,602,434 |
| Supplies | 229,415 | 232,110 |
| Other current assets | 406,168 | 435,574 |
| Total current assets | 3,499,701 | 3,407,915 |
| | | |
| Property and equipment | 13,609,793 | 13,489,811 |
| Less: accumulated depreciation | (6,546,146) | (6,481,714) |
| | 7,063,647 | 7,008,097 |
| Other assets: | | |
| Goodwill | 3,980,656 | 3,990,213 |
| Deferred income taxes | 68,339 | 70,517 |
| Right of use assets-operating leases | 375,316 | 374,239 |
| Deferred charges | 9,234 | 9,272 |
| Other | 684,249 | 667,340 |
| Total Assets | $ 15,681,142 | $ 15,527,593 |
| | | |
| Liabilities and Stockholders' Equity | | |
| Current liabilities: | | |
| Current maturities of long-term debt | $ 756,240 | $ 748,158 |
| Accounts payable and other liabilities | 2,356,343 | 2,416,276 |
| Operating lease liabilities | 72,904 | 73,237 |
| Federal and state taxes | 58,591 | 1,930 |
| Total current liabilities | 3,244,078 | 3,239,601 |
| | | |
| Other noncurrent liabilities | 532,678 | 527,827 |
| Operating lease liabilities noncurrent | 344,555 | 340,715 |
| Deferred income taxes | 3,234 | 5,649 |
| Long-term debt | 3,952,118 | 4,004,393 |
| | | |
| Redeemable noncontrolling interests | 73,380 | 70,620 |
| | | |
| Equity: | | |
| UHS common stockholders' equity | 7,464,857 | 7,275,792 |
| Noncontrolling interest | 66,242 | 62,996 |
| Total equity | 7,531,099 | 7,338,788 |
| Total Liabilities and Stockholders' Equity | $ 15,681,142 | $ 15,527,593 |

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, 2026**
(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, 2026 | $ 70,620 | $ 66 | $ 538 | $ 7 | $ 0 | $ (765,357) | $ 7,992,755 | $ 47,783 | $ 7,275,792 | $ 62,996 | $ 7,338,788 |
| Common Stock | | | | | | | | | | | |
| Issued/(converted) | — | — | 6 | — | — | — | 3,932 | — | 3,938 | — | 3,938 |
| Repurchased, including excise tax | — | — | (9) | — | — | — | (164,492) | — | (164,501) | — | (164,501) |
| Restricted share-based compensation expense | — | — | — | — | — | — | 17,380 | — | 17,380 | — | 17,380 |
| Dividends paid and accrued | — | — | — | — | — | (12,551) | — | — | (12,551) | — | (12,551) |
| Stock option expense | — | — | — | — | — | — | 4,820 | — | 4,820 | — | 4,820 |
| Distributions to noncontrolling interests | (1,927) | — | — | — | — | — | — | — | — | (5,985) | (5,985) |
| Purchase (sale) of ownership interests by (from) minority members | 2,806 | — | — | — | — | — | — | — | — | 1,116 | 1,116 |
| Comprehensive income: | | | | | | | | | | | |
| Net income (loss) to UHS / noncontrolling interests | 1,881 | — | — | — | — | — | 348,682 | — | 348,682 | 8,115 | 356,797 |
| Foreign currency translation adjustments, net of income tax | — | — | — | — | — | — | — | (8,703) | (8,703) | — | (8,703) |
| Subtotal - comprehensive income (loss) | 1,881 | — | — | — | — | — | 348,682 | (8,703) | 339,979 | 8,115 | 348,094 |
| Balance, March 31, 2026 | $ 73,380 | $ 66 | $ 535 | $ 7 | $ 0 | $ (777,908) | $ 8,203,077 | $ 39,080 | $ 7,464,857 | $ 66,242 | $ 7,531,099 |

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, 2025**
(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, 2025 | $ 13,293 | $ 66 | $ 577 | $ 7 | $ 0 | $ (713,705) | $ 7,372,061 | $ 7,201 | $ 6,666,207 | $ 83,316 | $ 6,749,523 |
| Common Stock | | | | | | | | | | | |
| Issued/(converted) | — | — | 7 | — | — | — | 3,829 | — | 3,836 | — | 3,836 |
| Repurchased, including excise tax | — | — | (12) | — | — | — | (224,440) | — | (224,452) | — | (224,452) |
| Restricted share-based compensation expense | — | — | — | — | — | — | 11,842 | — | 11,842 | — | 11,842 |
| Dividends paid and accrued | — | — | — | — | — | (13,255) | | — | (13,255) | — | (13,255) |
| Stock option expense | — | — | — | — | — | — | 9,437 | — | 9,437 | — | 9,437 |
| Distributions to noncontrolling interests | — | — | — | — | — | — | — | — | — | (5,912) | (5,912) |
| Purchase (sale) of ownership interests by (from) minority members | — | — | — | — | — | — | — | — | — | 4,485 | 4,485 |
| Comprehensive income: | | | | | | | | | | | |
| Net income (loss) to UHS / noncontrolling interests | 31 | — | — | — | — | — | 316,680 | — | 316,680 | 4,917 | 321,597 |
| Foreign currency translation adjustments, net of income tax | — | — | — | — | — | — | — | 15,309 | 15,309 | — | 15,309 |
| Subtotal - comprehensive income (loss) | 31 | — | — | — | — | — | 316,680 | 15,309 | 331,989 | 4,917 | 336,906 |
| Balance, March 31, 2025 | $ 13,324 | $ 66 | $ 572 | $ 7 | $ 0 | $ (726,960) | $ 7,489,409 | $ 22,510 | $ 6,785,604 | $ 86,806 | $ 6,872,410 |

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, | |
|---|---|---|
| | 2026 | 2025 |
| **Cash Flows from Operating Activities:** | | |
| Net income | $ 358,678 | $ 321,628 |
| *Adjustments to reconcile net income to net cash provided by operating activities:* | | |
| Depreciation & amortization | 155,426 | 148,345 |
| Stock-based compensation expense | 22,504 | 21,595 |
| Gain on sales of assets and businesses | (5,046) | - |
| *Changes in assets & liabilities, net of effects from acquisitions and dispositions:* | | |
| Accounts receivable | (123,862) | (218,374) |
| Accrued interest | 10,992 | 11,086 |
| Accrued and deferred income taxes | 104,772 | 88,641 |
| Other working capital accounts | (122,911) | (42,824) |
| Other assets and deferred charges | (12,257) | (489) |
| Other, net | (221) | 3,811 |
| Accrued insurance expense, net of commercial premiums paid | 62,568 | 47,334 |
| Payments made in settlement of self-insurance claims, net of commercial insurance reimbursements | (49,015) | (20,705) |
| Net cash provided by operating activities | 401,628 | 360,048 |
| **Cash Flows from Investing Activities:** | | |
| Property and equipment additions | (217,157) | (239,026) |
| Proceeds received from sales of assets and businesses | 14,304 | - |
| Acquisition of businesses and property | (4,857) | (8,314) |
| Inflows (outflows) from foreign exchange contracts that hedge our net U.K. investment | 14,716 | (23,695) |
| Costs incurred for purchase and development of enterprise resource planning application | (4,613) | - |
| Decrease (increase) in capital reserves of commercial insurance subsidiary | 28 | (264) |
| Net cash used in investing activities | (197,579) | (271,299) |
| **Cash Flows from Financing Activities:** | | |
| Repayments of long-term debt | (44,731) | (9,113) |
| Additional borrowings | 40 | 152,454 |
| Repurchase of common shares | (163,849) | (223,385) |
| Dividends paid | (12,974) | (13,534) |
| Issuance of common stock | 3,782 | 3,658 |
| Profit distributions to noncontrolling interests | (7,912) | (5,912) |
| Purchase of ownership interests by minority members, net | 3,750 | 4,412 |
| Net cash used in financing activities | (221,894) | (91,420) |
| Effect of exchange rate changes on cash and cash equivalents | (924) | 1,645 |
| Decrease in cash, cash equivalents and restricted cash | (18,769) | (1,026) |
| Cash, cash equivalents and restricted cash, beginning of period | 271,322 | 224,752 |
| Cash, cash equivalents and restricted cash, end of period | $ 252,553 | $ 223,726 |
| **Supplemental Disclosures of Cash Flow Information:** | | |
| Interest paid | $ 25,119 | $ 27,718 |
| Income taxes paid, net of refunds | $ 8,276 | $ 5,638 |
| Noncash purchases of property and equipment | $ 70,246 | $ 116,196 |

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, 2026. 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, 2025 as filed with the SEC on February 25, 2026.

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

***Relationship with Universal Health Realty Income Trust:***

At March 31, 2026, 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 2026 at the same rate in place for 2025, 2024 and 2023, providing for an advisory 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 condensed consolidated statements of income, of approximately $1.4 million during each of the three-month periods ended March, 2026 and 2025.

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, 2026 and 2025, and is included in other income (expense), net, on the accompanying condensed consolidated statements of income for each period. We received dividends from the Trust amounting to $587,000 and $579,000 during the three-month periods ended March 31, 2026 and 2025, respectively. The carrying value of our investment in the Trust was $4.1 million and $4.4 million at March 31, 2026 and December 31, 2025, respectively, and is included in other assets in the accompanying condensed consolidated balance sheets. The market value of our investment in the Trust was $31.9 million at March 31, 2026 and $30.9 million at December 31, 2025, based on the closing price of the Trust's stock on the respective dates.

The Trust commenced operations in 1986 by purchasing certain hospital properties from us and immediately leasing the properties back to our respective subsidiaries. The base rents are paid monthly and the bonus rents, which effective 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.

The Trust commenced operations in 1986 by purchasing certain hospital properties from us and immediately leasing the properties back to our respective subsidiaries. The base rents are paid monthly and the bonus rents, which effective 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: (i) 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; (ii) two wholly-owned subsidiaries of ours transferred to the Trust, at their respective fair-market values, the real estate assets of 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), and Canyon Creek Behavioral Health ("Canyon Creek"), located in Temple, Texas, and; (iii) we received approximately $4.1 million in cash from the Trust.

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 sheets at March 31, 2026 and December 31, 2025 reflect financial liabilities, which are included in debt, of approximately $69 million and $70 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 rent payable to the Trust in connection with the leases on McAllen Medical Center, Wellington Regional Medical Center, Aiken Regional Medical Center and Canyon Creek Behavioral Health was approximately $5.6 million and $5.4 million during the three-month periods ended March 31, 2026 and 2025, respectively.

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 $2.9 million, $2.9 million and $2.8 million during 2026, 2025 and 2024, 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, 2026:

| 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 | $ 6,975,000 | December, 2026 | 5 | (b) |
| Aiken Regional Medical Center/Aurora Pavilion Behavioral Health Services | $ 4,257,000 | December, 2033 | 35 | (c) |
| Canyon Creek Behavioral Health | $ 1,925,000 | December, 2033 | 35 | (c) |
| Clive Behavioral Health Hospital | $ 2,930,000 | 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). On each January 1st through 2026, the annual rent will increase by 2.5% on a cumulative and compounded basis.

(c) We have seven 5-year renewal options at fair market value lease rates (2034 through 2068). On each January 1st 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 ("FED") owned by the Trust or by limited liability companies in which the Trust holds 95% to 100% of the ownership interest. The current lease terms on these two FEDs, which are located in Weslaco and Mission, Texas, are scheduled to end on January 31, 2030. Pursuant to terms of the leases, the lease rates are scheduled to increase 2% per year through the end of the lease

terms. Our subsidiaries have four, 5-year renewal options remaining on each of these FEDs, with the first three renewal options (covering the years 2030 through 2044) providing for 2% annual increases to the lease rates, and the remaining two, 5-year renewal options (covering the years 2045 through 2054) providing for lease rates at the then fair market value. These leases are cross-defaulted with one another and our subsidiaries have the option to purchase the leased properties upon the expiration of each five-year extended term at the fair market value at that time.

In October, 2025, a ground lease and a master flex lease were executed between a wholly-owned subsidiary of ours and the Trust. On this land, the Trust intends to develop, construct and own the real property of the Miller Medical Plaza, a MOB located in Palm Beach Gardens, Florida. This multi-tenant MOB, consisting of 80,000 rentable square feet, is scheduled to be completed during the fourth quarter of 2026. The MOB will be located on the campus of the Alan B. Miller Medical Center, a newly constructed acute care hospital owned and operated by a wholly-owned subsidiary of ours, which is scheduled to be completed and opened during the second quarter of 2026. The 10-year master flex lease agreement, which is subject to reduction based on the execution of third-party leases with the Trust, was executed for approximately 75% of the rentable square feet of the MOB. The Trust has engaged a wholly-owned subsidiary of UHS to act as project manager, and construction of the MOB commenced in February, 2026.

***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 million, net, in premium payments during 2026 and 2025.

Marc D. Miller, our President and Chief Executive Officer and member of our Board of Directors, was a member of the Board of Directors of Premier, Inc. ("Premier") from 2015 until Premier was sold in November, 2025, as discussed below. In conjunction with our GPO agreement with Premier, we had previously received shares of restricted stock of Premier which vested ratably over a seven-year period (2014 through 2020). During 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 elected to retain a portion of the previously vested shares of Premier, the carrying value of which was adjusted for changes in the market value of Premier, which were included in other assets on our consolidated balance sheets. In September, 2025, Premier entered into an agreement and plan of merger providing for the acquisition of Premier by Patient Square Capital. In November, 2025 we received approximately $63 million for our remaining shares of Premier. Included in Other (income) expense, net, in our condensed consolidated statements of income, were losses recorded to adjust for changes in the market value of our shares of Premier amounting to $4.3 million during the first quarter of 2025. Additionally, we received cash dividends from Premier amounting to $469,000 during the three-month period ended March 31, 2025, which is 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 Of Counsel to 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.

***Other Investments:***

At various times from July, 2023 to November, 2025, we invested in non-marketable securities of a healthcare generative artificial intelligence company, in which we hold a small minority ownership percentage. As of March 31, 2026 and December 31, 2025 the current market value of these non-marketable securities was approximately $115 million and is included in other assets on our condensed consolidated balance sheets.

**(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.

Generally accepted accounting principles require that noncontrolling interests be classified as equity and we have presented noncontrolling interests in total equity. However, since certain of our noncontrolling interests have redemption rights outside of our control, those noncontrolling interests are classified outside of permanent equity.

As of March 31, 2026, outside owners held noncontrolling, minority ownership interests of: (i) approximately 7% in an acute care facility located in Texas; (ii) 49%, 49%, 30%, 20%, 25%, and 48% in six behavioral health care facilities located in Arizona, Pennsylvania, Ohio, Washington, Missouri, and Iowa, respectively, (iii) 26% and 49% in two behavioral health care facilities located in Michigan and; (iv) approximately 5% in an acute care facility and 49% in a surgery center, located in Nevada. The noncontrolling interest and redeemable noncontrolling interest balances of $66 million and $73 million, respectively, as of March 31, 2026, consist primarily of the third-party ownership interests in these hospitals.

In connection with certain of the behavioral health care facilities mentioned above, the outside owners have "put options" to potentially put their entire ownership interest to us either in the future upon the occurrence of certain triggering events (as specified in the agreements), or at the present time. If exercised, the put option requires us to purchase the minority member's interest at fair market value. Amounts recorded as redeemable noncontrolling interests on our condensed consolidated balance sheet as of March 31, 2026 and December 31, 2025 reflect the estimated fair market value of the minority ownership interests that contain such put options.

The minority owners of a 20% interest in a behavioral health care facility located in Pennsylvania had previously exercised their put option and we purchased their ownership interest in April, 2025.

**(4) Treasury**

***Credit Facilities and Outstanding Debt Securities***

On April 22, 2026, we entered into the Eleventh Amendment and Increased Facility Activation Notice (the "Eleventh Amendment") to our credit agreement ("Credit Agreement"), dated as of November 15, 2010, and as amended and restated at various times from March, 2011 to September, 2024, among UHS, as borrower, the several banks and other financial institutions or entities from time to time parties thereto, as lenders, and JPMorgan Chase Bank, N.A., as administrative agent.

The Eleventh Amendment, among other things, increased our borrowing capacity by an aggregate of $900 million as follows: (i) increased the borrowing capacity of the revolving credit facility by $200 million to $1.5 billion (from $1.3 billion previously); (ii) increased the existing tranche term loan A by $300 million to $1.455 billion (from $1.155 billion previously), and; (iii) initiated a new $400 million delayed draw term loan A which is expected to be drawn upon the closing of our acquisition of Talkspace, Inc. as discussed in *Note 6 - Commitments and Contingencies.* The maturity date for our Credit Agreement, which is scheduled for September 26, 2029, remained unchanged. As of March 31, 2026, we had approximately $373 million of borrowings outstanding pursuant to the revolving credit facility.

Prior to the Eleventh Amendment, the tranche term loan A in effect as of March 31, 2026 (outstanding balance of $1.155 billion as of that date), provides for installment payments of $7.5 million per quarter through September 30, 2026, and $15.0 million per quarter commencing on December 31, 2026 through June 30, 2029. The unpaid principal balance at June 30, 2029 (scheduled to be $975.0 million) is payable on the September 26, 2029 scheduled maturity date of the Credit Agreement.

Pursuant to the terms of the Eleventh Amendment, which became effective in April, 2026:

- *Increased tranche term loan A ($300 million)*: Installment payments are scheduled to be $1.875 million per quarter commencing on September 30, 2026 through June 30, 2028, and $3.75 million per quarter commencing on September 30, 2028 through June 30, 2029. The unpaid principal balance at June 30, 2029 (scheduled to be $270.0 million) is payable on the September 26, 2029 scheduled maturity date of the Credit Agreement.
- *Delayed draw term loan A ($400 million)*: Once drawn, the $400 million principal balance will be payable on the September 26, 2029 scheduled maturity date of the Credit Agreement.

Revolving credit and tranche term loan A borrowings under the Credit Agreement, prior to the Eleventh Amendment, 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 greater of the federal funds effective rate and the overnight bank funding rate, plus 0.5% and (c) one month term SOFR rate plus 1.1%, 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 term 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, 2026, the applicable margins were 0.25% for ABR-based loans and 1.25% for SOFR-based loans under the revolving credit and term loan A facilities. The Eleventh Amendment provides for the removal of the .10% credit spread adjustment from existing and increased revolving credit and tranche term loan A borrowings. 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, if sold to a receivables facility pursuant to the Credit Agreement, 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, 2026 and December 31, 2025.

As of March 31, 2026, we had combined aggregate principal of $3.0 billion from the following senior secured notes:

- $700 million of aggregate principal amount of 1.65% senior secured notes due in September, 2026 ("2026 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.
- $500 million of aggregate principal amount of 4.625% senior secured notes due in October, 2029 ("2029 Notes") which were issued on September 26, 2024. Interest on the 2029 Notes is payable on April 15th and October 15th, commencing April 15, 2025 until the maturity date of October 15, 2029.
- $800 million of aggregate principal amount of 2.65% senior secured notes due in October, 2030 ("2030 Notes") which were issued on September 21, 2020. Interest on the 2030 Notes is payable on April 15th and October 15th, until the maturity date of October 15, 2030.
- $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 2032 Notes is payable on January 15th and July 15th until the maturity date of January 15, 2032.
- $500 million of aggregate principal amount of 5.050% senior secured notes due in October, 2034 ("2034 Notes") which were issued on September 26, 2024. Interest on the 2034 Notes is payable on April 15th and October 15th, commencing on April 15, 2025 until the maturity date of October 15, 2034.

The 2026, 2029, 2030, 2032 and 2034 Notes (collectively "All the Notes") are guaranteed (the “Guarantees”) on a senior secured basis by all of our existing and future direct and indirect subsidiaries that guarantee our Credit Agreement, other first lien obligations, or any junior lien obligations (the "Subsidiary Guarantors"). All 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 a Company-related receivables facility (as defined in the Indentures pursuant to which All the Notes were issued (the “Indentures”), and certain other excluded assets). The Company’s obligations with respect to All 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. However, the liens on the collateral securing All the Notes and the Guarantees will be released if: (i) All 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 All 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 All 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 average outstanding borrowings and the average effective interest rate, which includes amortization of deferred financing costs and original issue discount, under our revolving credit, term loan A and senior notes, were approximately $4.60 billion and 4.0%, respectively, during the first quarter of 2026, and $4.28 billion and 4.1%, respectively, during the first quarter of 2025.

In connection with an asset purchase and sale agreement, and related lease agreements, completed with Universal Health Realty Income Trust ("Trust") in December 2021, our consolidated balance sheets at March 31, 2026 and December 31, 2025 reflect financial liabilities, which are included in debt, of approximately $69 million and $70 million, respectively. In connection with that transaction, as a result of our purchase option within the lease agreements related to two of our facilities, the asset purchase and sale transaction was 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.

At March 31, 2026, the carrying value and fair value of our debt were approximately $4.7 billion and $4.5 billion, respectively. At December 31, 2025, the carrying value and fair value of our debt were approximately $4.8 billion and $4.6 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.

The aggregate scheduled maturities of our $4.7 billion total debt outstanding as of March 31, 2026, are as follows: (i) $756 million due during the next 12 months; (ii) $71 million due during months 13 to 24; (iii) $72 million due during months 25 to 36; (iv) $1.87 billion due during months 37 to 48; (v) $808 million due during months 49 to 60, and; (vi) $1.13 billion due in greater than 60 months.

***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 inflows of $15 million and net cash outflows of $24 million during the three-month periods ended March 31, 2026 and 2025, respectively.

***Derivatives Hedging Relationships:***

The following table presents the effects of our foreign currency forward exchange contracts on our results of operations for the three-month periods ended March 31, 2026 and 2025 (in thousands):

| | Gain/(Loss) recognized in AOCI | |
|---|---|---|
| | Three months ended | |
| | March 31, 2026 | March 31, 2025 |
| Net Investment Hedge relationships | | |
| Foreign currency forward exchange contracts | $ 16,772 | $ (24,925) |

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, 2026 | March 31, 2025 | December 31, 2025 |
|---|---|---|---|
| Cash and cash equivalents | $ 119,028 | $ 126,753 | $ 137,797 |
| Restricted cash (a) | 133,525 | 96,973 | 133,525 |
| Total cash, cash equivalents and restricted cash | $ 252,553 | $ 223,726 | $ 271,322 |

(a) Restricted cash is included in other assets on the accompanying condensed consolidated balance sheets and consists of statutorily required capital reserves related to our commercial insurance subsidiary.

The fair value of our restricted cash was computed based upon quotes received from financial institutions. We consider these to be “level 1” in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with financial securities.

**(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, 2026 | Balance Sheet Location | Basis of Fair Value Measurement Level 1 | Level 2 | Level 3 |
|---|---|---|---|---|---|
| Assets: | | | | | |
| Money market mutual funds | $ 151,016 | Other noncurrent assets | $ 151,016 | | |
| Certificates of deposit | 2,200 | Other noncurrent assets | | 2,200 | |
| Non-marketable securities | 115,248 | Other noncurrent assets | | | 115,248 |
| Deferred compensation assets | 53,175 | Other noncurrent assets | 53,175 | | |
| Foreign currency forward exchange contracts | 893 | Other current assets | | 893 | |
| | $ 322,532 | | $ 204,191 | $ 3,093 | $ 115,248 |
| Liabilities: | | | | | |
| Deferred compensation liability | 53,175 | Other noncurrent liabilities | 53,175 | | |
| | $ 53,175 | | $ 53,175 | $ - | $ - |

| (in thousands) | Balance at December 31, 2025 | Balance Sheet Location | Basis of Fair Value Measurement Level 1 | Level 2 | Level 3 |
|---|---|---|---|---|---|
| Assets: | | | | | |
| Money market mutual funds | $ 150,948 | Other noncurrent assets | $ 150,948 | | |
| Certificates of deposit | 2,200 | Other noncurrent assets | | 2,200 | |
| Non-marketable securities | 115,248 | Other noncurrent assets | | | 115,248 |
| Deferred compensation assets | 55,160 | Other noncurrent assets | 55,160 | | |
| Foreign currency forward exchange contracts | 1,163 | Other current assets | | 1,163 | |
| | $ 324,719 | | $ 206,108 | $ 3,363 | $ 115,248 |
| Liabilities: | | | | | |
| Deferred compensation liability | 55,160 | Other noncurrent liabilities | 55,160 | | |
| | $ 55,160 | | $ 55,160 | $ - | $ - |

The fair value of our money market mutual funds and certificates of deposit 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 foreign currency exchange contracts is valued using quoted forward exchange rates and spot rates at the reporting date. The fair value of the non-marketable securities that we hold are accounted for under the measurement alternative. Under the measurement alternative, the carrying value is measured at cost, less any impairment, plus or minus changes resulting from observable price changes in orderly transactions for identical or similar investments of the same issuer. Adjustments are determined primarily based on a market approach as of the transaction date and are recorded in other (income) expense, net.

**(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 2026, 2025, 2024, 2023, 2022 and 2021; (ii) $10 million and $3 million per occurrence, respectively, in 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. For each of the years indicated above, through February 2025, for claims involving multiple plaintiffs, a single self-insured retention may apply, as stipulated in and subject to the terms and conditions of the applicable commercial policies, for claims qualifying as group related integrated occurrences and/or medical incidents. As of March 1, 2025, the single self-insured retention no longer applies in connection with claims made by multiple plaintiffs against our behavioral health care facilities.

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 $120 million in 2026; $110 million in 2025; $175 million in 2024; $165 million in 2023; $162 million in 2022; $155 million in 2021 and $250 million during each of 2014 through 2020. Effective March, 2025, our commercial insurance coverage contains less favorable terms than previous years including coverage exclusions for incidents involving sexual molestation or abuse, higher premiums and lower aggregate limitations.

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 £20 million of professional liability coverage and £25 million of general liability coverage.

The commercial insurance limits indicated above for each policy year may have been reduced due to payment of covered claims or suits, subject to the policy terms and conditions.

As of March 31, 2026, the total net accrual for our self-insured professional and general liability claims was $460 million, of which $130 million was included in current liabilities. As of December 31, 2025, the total net accrual for our self-insured professional and general liability claims was $449 million, of which $125 million was included in current liabilities.

All professional and general liability insurance we purchase is subject to policy limitations. 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 and jury verdicts, estimates of incurred but not reported claims based on historical experience, and estimates of amounts recoverable under our commercial insurance policies. All relevant information, including our own historical experience, applicable per occurrence and aggregate self-insured retentions, and limitations and exclusions pursuant to our commercial insurance policies, is used in estimating our expected liability for self-insured claims. While we continuously monitor these factors, our ultimate liability for professional and general liability claims could change materially from our current estimates due to inherent uncertainties involved in making this estimate. Given our significant exposure to 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, and/or reductions in the amount of commercial coverage available to us, will not have a material adverse effect on our future results of operations.

As of March 31, 2026, the total accrual for our workers' compensation liability claims was $155 million, $66 million of which was included in current liabilities. As of December 31, 2025, the total accrual for our workers' compensation liability claims was $152 million, $64 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.

As disclosed below in Legal Proceedings, Cumberland Hospital for Children and Adolescents ("Cumberland"), an indirect subsidiary of the Company, is a defendant in multi-plaintiff lawsuits filed in the Circuit Court for Richmond, Virginia (the "Cumberland Litigation"), relating to allegations of inappropriate sexual contact during medical examinations by Dr. Daniel Davidow, an independent contractor and the former medical director for Cumberland. The Company and UHS of Delaware, Inc., our administrative services subsidiary ("UHS Delaware"), were also named as co-defendants in the Cumberland Litigation. Plaintiffs have asserted claims of negligence, assault and battery (against Dr. Davidow), false imprisonment, violations of the Virginia Consumer Protection Act ("VCPA"), and vicarious liability for Dr. Davidow's conduct against Cumberland, the Company, and UHS Delaware. The Company and UHS Delaware were dismissed from the action during the trial of the first three plaintiffs, which occurred in September, 2024. On September 27, 2024, a jury entered a verdict finding Dr. Davidow and Cumberland liable and awarded these three plaintiffs

combined compensatory damages of $60 million for all liability theories, an additional combined $180 million in trebled damages for violation of the VCPA, and an additional combined $120 million in punitive damages. Cumberland filed post-trial motions challenging this verdict, including the amounts awarded in the verdict. Based upon Virginia law, the Court reduced the punitive damage amount to a combined maximum of $1.05 million ($350,000 per plaintiff). Cumberland has filed a notice of appeal on the remaining verdict. Plaintiffs have separately filed a notice of appeal seeking to challenge the dismissal of the Company and UHS Delaware during trial, and the Court's order reducing the punitive damages award against Cumberland. These appeals were recently dismissed by the appellate court without prejudice as premature because the judgments in favor of the first three plaintiffs are neither final nor enforceable at this time.

There are approximately 43 additional plaintiffs making similar allegations with claims pending in the Cumberland Litigation. The Company and UHS Delaware remain defendants with respect to the remaining plaintiffs. We expect that the trials for the remaining plaintiffs, as well as any additional plaintiffs, will be scheduled at various times over the next several years. The next trial is tentatively planned to commence in August, 2026. On April 24, 2026, Cumberland, UHS Delaware, and the Company filed a Petition for Interlocutory Appeal that seeks reversal of the court's Trial Scheduling Order and a stay pending discretionary review by the Court of Appeals of Virginia.

We can make no assurances regarding the ultimate financial exposure, timing, substance or outcome of the Cumberland matter (which related to occurrences in the 2020 policy year), or the amount of damages that may be ultimately held recoverable after post-judgment proceedings and appeals. As of March 31, 2026, without reduction for any potential amounts related to the Cumberland matter, the Company and its subsidiaries have aggregate insurance coverage of approximately $143 million remaining under commercial policies for matters applicable to the 2020 policy year (in excess of the applicable self-insured retention amounts of $10 million per single occurrence/$25 million for multi-plaintiff matters for professional liability claims and $3 million per occurrence for general liability claims). In the event the resolution of the Cumberland matter exhausts all or a significant portion of our/our subsidiaries' remaining commercial insurance coverage related to the 2020 policy year, or the Cumberland matter causes the posting of large bonds or other collateral during the appeal processes, our future results of operations and capital resources would be materially adversely impacted.

We have received lawsuits in various jurisdictions on behalf of numerous former patients spanning decades claiming to be the victims of sexual assaults while patients at our facilities. Many of these lawsuits have been brought in conjunction with various states extending their statute of limitations to allow alleged victims of sexual assaults or abuse to file claims many years after the alleged incidents occurred. We are uncertain as to potential liability in connection with these matters.

***Property Insurance***

We have commercial property insurance policies for our properties, covering the period of June 1, 2025 to June 1, 2026, providing property and business interruption coverage for losses in excess of $15 million per occurrence or per location (as applicable based upon the event) up to a $1 billion annual policy limitation for certain catastrophic events or perils. These commercial policies provide for coverage of up to $250 million of annual aggregate coverage for losses resulting from windstorm damage at all facilities except those in Puerto Rico where $100 million of annual aggregate coverage is provided. 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 and Alaska; (ii) $100 million limitation for our facilities in New Madrid Seismic Zone, Pacific Northwest Seismic Zone, South Carolina, Utah and certain counties in Nevada; (iii) $40 million limitation for our facilities located in Puerto Rico, and; (iv) $250 million limitation for 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.

These commercial property policies are subject to a deductible of: (i) $5 million per location for damage resulting from earthquake, wind, hail and flood, and; (ii) $5 million per occurrence for all other events. For per location or per occurrence losses in excess of the applicable deductible, we are self-insured, through our wholly-owned captive insurance company, for up to $10 million of annual aggregate losses. Should the $10 million self-insured annual aggregate limitation be exhausted during the policy year, we have commercial reinsurance coverage for the next $30 million of annual aggregate losses in excess of the applicable deductible. In the event the $30 million of commercial reinsurance coverage is also exhausted, we are self-insured for all per location or per occurrence losses up to $25 million, including the $5 million deductible.

As of January 1, 2026, property insurance for our behavioral health facilities located in the U.K. are provided on an all-risk basis up to a £2.7 billion, with a coverage cap per location of £150 million for any one occurrence, that includes coverage for real and personal property as well as business interruption losses.

***Commitment to Develop, Lease and Operate an Acute Care Hospital in Washington, D.C.***

During 2020, we entered into various agreements with the District of Columbia (the "District") related to the development, leasing and operation of an acute care hospital and certain other facilities/structures on land owned by the District ("District Facilities"). Pursuant

to the agreements, on behalf of the District, we served as manager for development and construction of the District Facilities, which were funded entirely by the District. The District Facilities had an aggregate cost of approximately $417 million, substantially all of which has been incurred as of March 31, 2026. Construction of the acute care hospital (Cedar Hill Regional Medical Center) was completed and the hospital opened on April 15, 2025.

We are leasing the District Facilities for a nominal rental amount for a period of 75 years and are obligated to operate the District Facilities during the lease term. We have certain lease termination rights in connection with the District Facilities beginning on the tenth anniversary of the lease commencement date for various and decreasing amounts as provided for in the agreements. Additionally, any time after the 10th anniversary of the lease term, we have a right to purchase the District Facilities for a price equal to the greater of fair market value of the District Facilities or the amount necessary to defease the bonds issued by the District to fund the construction of the District Facilities. The lease agreement also entitles the District to participation rent should certain specified earnings before interest, taxes, depreciation and amortization thresholds be achieved by the acute care hospital.

Additionally, we have committed to expend no less than $75 million (approximately $22 million of which has been incurred as of March 31, 2026), over a projected 12-year period, in healthcare infrastructure including expenditures related to the District Facilities as well as other healthcare related expenditures in certain specified areas of Washington, D.C. Pursuant to the agreements, the District is entitled to certain termination fees and other amounts as specified in the agreements in the event we, within certain specified periods of time, cease to operate the acute care hospital or there is a transfer of control of us or our subsidiary operating the hospital.

***Acquisition of Talkspace, Inc****.*

On March 9, 2026, we announced that we entered into a definitive agreement to acquire Talkspace, Inc. ("Talkspace") for $5.25 per share, or approximately $835 million in the aggregate. Talkspace is a virtual behavioral healthcare company, with a network of approximately 6,000 licensed professionals that serve all 50 states, Washington, D.C., and Puerto Rico. We intend to finance the acquisition of Talkspace with additional borrowings pursuant to our Credit Agreement, as amended in April, 2026, as discussed in *Note 4 - Treasury, Credit Facilities and Outstanding Debt Securities.* The transaction is expected to close during the third quarter of 2026 and is subject to approval by Talkspace's stockholders, satisfaction of regulatory approvals and other customary closing conditions.

***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 original Patient Protection and Affordable Care Act, as amended by the Health and Education Reconciliation Act, has added additional obligations on healthcare providers to report and refund overpayments by government healthcare programs and authorizes the suspension of Medicare and Medicaid payments "pending an investigation of a credible allegation of fraud." We monitor our business and have

developed an ethics and compliance program with respect to these complex laws, rules and regulations. Although we believe our policies, procedures and practices comply with government regulations, there is no assurance that we will not be faced with the sanctions referenced above which include fines, penalties and/or substantial damages, repayment obligations, payment suspensions, licensure revocation, and expulsion from government healthcare programs. Even if we were to ultimately prevail in any action brought against us or our facilities or in responding to any inquiry, such action or inquiry could have a material adverse effect on us.

Certain legal matters are described below:

*K.E.E., et al., Plaintiffs v. Cumberland Hospital, LLC d/b/a Cumberland Hospital for Children and Adolescents, et al. (and related lawsuits)*

Cumberland Hospital for Children and Adolescents ("Cumberland"), an indirect subsidiary of the Company, is a defendant in multi-plaintiff lawsuits filed in the Circuit Court for Richmond, Virginia (the "Cumberland Litigation"), relating to allegations of inappropriate sexual contact during medical examinations by Dr. Daniel Davidow, an independent contractor and the former medical director for Cumberland. The Company and UHS of Delaware, Inc., our administrative services subsidiary ("UHS Delaware"), were also named as co-defendants in the Cumberland Litigation. Plaintiffs have asserted claims of negligence, assault and battery (against Dr. Davidow), false imprisonment, violations of the Virginia Consumer Protection Act ("VCPA"), and vicarious liability for Dr. Davidow's conduct against Cumberland, the Company, and UHS Delaware. All defendants have denied liability.

The claims asserted by three of the plaintiffs in the Cumberland Litigation were consolidated for trial in September of 2024. The Company and UHS Delaware were dismissed from the action during trial. On September 27, 2024, a jury entered a verdict finding Dr. Davidow and Cumberland liable and awarded these three plaintiffs combined compensatory damages of $60 million for all liability theories, an additional combined $180 million in trebled damages for violation of the VCPA, and an additional combined $120 million in punitive damages. Cumberland filed post-trial motions challenging this verdict. Based upon Virginia law, the Court reduced the punitive damage amount to a combined maximum of $1.05 million ($350,000 per plaintiff). Cumberland has filed a notice of appeal on the remaining verdict. Plaintiffs have separately filed a notice of appeal seeking to challenge the dismissal of the Company and UHS Delaware during trial, and the Court's order reducing the punitive damages award against Cumberland. These appeals were recently dismissed by the appellate court without prejudice as premature because the judgments in favor of the first three plaintiffs are neither final nor enforceable at this time.

There are approximately 43 additional plaintiffs making similar allegations with claims pending in the Cumberland Litigation. The Company and UHS Delaware remain defendants with respect to the remaining plaintiffs. We expect that the trials for the remaining plaintiffs, as well as any additional plaintiffs, will be scheduled at various times over the next several years. The next trial is tentatively planned to commence in August, 2026. On April 24, 2026, Cumberland, UHS Delaware, and the Company filed a Petition for Interlocutory Appeal that seeks reversal of the court's Trial Scheduling Order and a stay pending discretionary review by the Court of Appeals of Virginia.

In the event the resolution of the Cumberland matter exhausts all or a significant portion of our/our subsidiaries' remaining commercial insurance coverage related to the 2020 policy year, or the Cumberland matter causes the posting of large bonds or other collateral during the appeal processes, our future results of operations and capital resources would be materially adversely impacted.

*St. Mary's Medical Group, Inc. et. al. v. Pinnacle Medical Group, Northern Nevada, et. al.*

UHS of Delaware, Inc., the wholly-owned administrative services subsidiary of the Company is a defendant in a lawsuit filed in Washoe County, Nevada, along with Pinnacle Management Group NV, LLC ("Pinnacle Medical Group", in which a subsidiary of the Company holds a 50% interest) and several individuals. The Company was previously dismissed from the lawsuit. The lawsuit contains allegations of intentional interference with contractual relationships and prospective economic advantage resulting from the departure of several physicians and advance practice providers from St. Mary's Medical Group in Reno, Nevada, who joined Pinnacle Medical Group in 2021.

A trial of this matter was concluded on September 26, 2025, with a verdict rendered against UHS of Delaware, Inc. and the other defendants for approximately $4.7 million in compensatory damages. The jury also awarded punitive damages against UHS of Delaware, Inc. of $500 million and lesser amounts against some of the other defendants. Based upon Nevada statutory law, we expect the punitive damages to be reduced to a maximum of approximately $14 million. UHS of Delaware, Inc. and the other defendants filed post-trial motions. In March 2026, the trial court granted a motion for a new trial based upon juror misconduct.

Although we are uncertain as to the ultimate financial exposure related to this matter and we can make no assurance regarding its outcome on appeal or a new trial, or the amount of damages that may be recoverable after appeals or a new trial, during the third quarter of 2025, we recorded an $18 million legal reserve in connection with this matter.

*Laurel Ridge Treatment Center*

In April 2026, Laurel Ridge Treatment Center ("Laurel Ridge"), a 330-bed, behavioral health care facility located in San Antonio, Texas, received notice from the Centers for Medicare and Medicaid Services (CMS) that it was terminating Laurel Ridge's Medicare provider agreement effective April 30, 2026. Laurel Ridge filed an administrative appeal contesting the decision and also filed a

lawsuit in federal court for the Western District of Texas seeking a temporary restraining order to prevent the termination from taking effect pending completion of the administrative appeal process. The Court denied the request for the temporary restraining order. As such, Laurel Ridge has been terminated from the Medicare and Medicaid program. The facility intends to re-apply for Medicare/Medicaid certification and will remain open during the reapplication process although there is no assurance that recertification will be granted. During the reapplication process, we expect to incur operating losses and cash flow deficits. During the year ended December 31, 2025, Laurel Ridge's income before income taxes was approximately $23 million.

*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**

We operate in two reportable segments: Acute Care Hospital Services and Behavioral Health Care Services. Our chief operating decision making ("CODM") group is comprised of our President and Chief Executive Officer and each of our respective division Presidents for our Acute Care Hospital Services and Behavioral Health Care Services. 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 primary profitability measurement utilized by the President and Chief Executive Officer as well as the Presidents of each operating segment is segment income before income taxes. Segment income before income taxes is utilized by the CODM group during the annual budgeting process and during their reviews of our monthly operating results to monitor each segment's operating results as compared to prior periods, and the respective operating budgets.

The expenses included in our non-segment operating expenses below include centralized services including, but not limited to, information technology, purchasing, reimbursement, accounting and finance, taxation, legal, advertising and design and construction. 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, 2025. We do not present asset information for our segments as this information is not used to allocate resources.

Note: prior year amounts related to certain facilities previously included in our Behavioral Health Care Services' results have been reclassified into our Acute Care Hospital Services' results as of January 1, 2025 to conform with current year presentation.

| Three Months Ended March 31, 2026 | Acute Care Hospital Services | Behavioral Health Care Services (c) | Total |
|---|---|---|---|
| | | (amounts in thousands) | |
| Net revenue from reportable segments | $ 2,610,136 | $ 1,882,152 | $ 4,492,288 |
| *Reconciliation of Net Revenue* | | | |
| Non-segment revenue | | | 2,894 |
| Total Net Revenue | | | $ 4,495,182 |
| Salaries, wages and benefits | $ 972,846 | $ 1,001,094 | |
| Other segment item operating expenses (a) | 1,254,357 | 462,200 | |
| Depreciation and amortization expense | 96,318 | 56,634 | |
| Interest (income) expense, net | 986 | 1,272 | |
| Other (income) expense, net | (2,132) | (883) | |
| Reportable segment income before income taxes | $ 287,761 | $ 361,835 | $ 649,596 |
| *Reconciliation of non-segment revenue/expenses to consolidated income before income taxes* | | | |
| Non-segment revenue | | | 2,894 |
| Non-segment operating expenses (b) | | | 148,873 |
| Non-segment interest expense, net | | | 34,875 |
| Non-segment other (income) expense, net | | | (374) |
| Income before income taxes | | | $ 469,116 |

| Three Months Ended March 31, 2025 | Acute Care Hospital Services | Behavioral Health Care Services (c) | Total |
|---|---|---|---|
| | | (amounts in thousands) | |
| Net revenue from reportable segments | $ 2,357,814 | $ 1,739,064 | $ 4,096,878 |
| *Reconciliation of Net Revenue* | | | |
| Non-segment revenue | | | 2,842 |
| Total Net Revenue | | | $ 4,099,720 |
| Salaries, wages and benefits | $ 915,524 | $ 923,366 | |
| Other segment item operating expenses (a) | 1,090,698 | 428,774 | |
| Depreciation and amortization expense | 94,903 | 51,152 | |
| Interest expense, net | 2,262 | 1,075 | |
| Other expense (income), net | (8,267) | (825) | |
| Reportable segment income before income taxes | $ 262,694 | $ 335,522 | $ 598,216 |
| *Reconciliation of non-segment revenue/expenses to consolidated income before income taxes* | | | |
| Non-segment revenue | | | 2,842 |
| Non-segment operating expenses (b) | | | 140,478 |
| Non-segment interest expense, net | | | 36,719 |
| Non-segment other (income) expense, net | | | 3,433 |
| Income before income taxes | | | $ 420,428 |

(a) Other segment operating expenses for each period includes other operating expenses, supplies expense and lease and rental expense.

(b) Non-segment operating expenses for each period includes salaries, wages and benefits, other operating expenses, supplies expense and lease and rental expense.

(c) Includes net revenues generated from our behavioral health care facilities located in the U.K. amounting to approximately $261 million and $227 million for the three-month periods ended March 31, 2026 and 2025, respectively

**(8) Earnings Per Share Data 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, | |
|---|---|---|
| | 2026 | 2025 |
| Net income attributable to UHS – basic and diluted | $ 348,682 | $ 316,680 |
| Weighted average number of common shares - basic | 61,071 | 64,970 |
| Net effect of dilutive stock options and grants based on the treasury stock method | 597 | 1,067 |
| Weighted average number of common shares and equivalents - diluted | 61,668 | 66,037 |
| Earnings per basic share attributable to UHS: | $ 5.71 | $ 4.87 |
| Earnings per diluted share attributable to UHS: | $ 5.65 | $ 4.80 |

The “Net effect of dilutive stock options and grants based on the treasury stock method” for all periods presented above, excludes certain outstanding stock options applicable to each period since the effect would have been anti-dilutive. There were no excluded weighted-average stock options for the three-months ended March 31, 2026 and 7,500 for the three-months ended March 31, 2025. All classes of our common stock have the same dividend rights.

**Stock-Based Compensation:**

During the three-month periods ended March, 2026 and 2025, pre-tax compensation costs of $4.8 million and $9.4 million, respectively, was recognized related to outstanding stock options. In addition, during the three-month periods ended March 31, 2026 and 2025, pre-tax compensation costs of approximately $17.4 million and $11.8 million, respectively, was recognized related to restricted stock awards, restricted stock units and performance based restricted stock units.

As of March, 2026 there was approximately $232.1 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 2.9 years. There were an aggregate of 569,836 restricted units, net of cancellations, granted during the first three months of 2026 under the 2020 Stock Incentive Plan, including 62,749 performance based restricted stock units, with a weighted-average grant date fair value of $185.17 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 $22.5 million and $21.6 million during the three-month periods ended March 31, 2026 and 2025, respectively.

**(9) Dispositions and Acquisitions**

***Three-month period ended March 31 2026:***

***Acquisitions:***

During the first three months of 2026, we spent $5 million on the acquisition of businesses and property.

***Divestitures:***

During the first three months of 2026, we received $14 million from the sales of assets and businesses.

***Three-month period ended March 31 2025:***

***Acquisitions:***

During the first three months of 2025, we spent $8 million on the acquisition of businesses and property.

***Divestitures:***

During the first three months of 2025, there were no divestitures.

**(10) Dividends**

We declared and paid dividends of $13.0 million, or $.20 per share, during the first quarter of 2026 and $13.5 million, or $.20 per share, during the first quarter of 2025.

**(11) Income Taxes**

Our effective income tax rates were 23.5% during each of the three-month periods ended March 31, 2026 and 2025.

As of January 1, 2026, 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, 2026, 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, 2026, we have less than $1 million of accrued interest and penalties. The U.S. federal statute of limitations remains open for 2022 and subsequent years. Foreign and U.S. state and local jurisdictions have statutes of limitations generally ranging from 3 to 4 years.
We operate in multiple jurisdictions with varying tax laws. We are subject to audits by any of these taxing authorities. We believe that adequate accruals have been provided for federal, foreign and state taxes.

**(12) Revenue Recognition**

We recognize revenue when services/goods have been provided to patients/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, 2026 and 2025 (in thousands):

Note: prior year amounts related to certain facilities previously included in our Behavioral Health Care Services' results have been reclassified into our Acute Care Hospital Services' results as of January 1, 2025 to conform with current year presentation.

| | For the three months ended March 31, 2026 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Acute Care | | Behavioral Health | | Other | | Total | |
| Medicare | $ 400,503 | 15% | $ 81,174 | 4% | | | $ 481,677 | 11% |
| Managed Medicare | 447,999 | 17% | 102,101 | 5% | | | 550,100 | 12% |
| Medicaid | 370,297 | 14% | 339,603 | 18% | | | 709,900 | 16% |
| Managed Medicaid | 171,825 | 7% | 474,777 | 25% | | | 646,602 | 14% |
| Managed Care (HMO and PPOs) | 793,426 | 30% | 407,072 | 22% | | | 1,200,498 | 27% |
| UK Revenue | 0 | 0% | 261,212 | 14% | | | 261,212 | 6% |
| Other patient revenue and adjustments, net | 170,240 | 7% | 159,104 | 8% | | | 329,344 | 7% |
| Other non-patient revenue | 255,846 | 10% | 57,109 | 3% | 2,894 | | 315,849 | 7% |
| Total Net Revenue | $ 2,610,136 | 100% | $ 1,882,152 | 100% | $ 2,894 | | $ 4,495,182 | 100% |

| | For the three months ended March 31, 2025 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Acute Care | | Behavioral Health | | Other | | Total | |
| Medicare | $ 392,093 | 17% | $ 75,946 | 4% | | | $ 468,039 | 11% |
| Managed Medicare | 421,134 | 18% | 99,165 | 6% | | | 520,299 | 13% |
| Medicaid | 252,765 | 11% | 274,143 | 16% | | | 526,908 | 13% |
| Managed Medicaid | 161,719 | 7% | 441,110 | 25% | | | 602,829 | 15% |
| Managed Care (HMO and PPOs) | 781,586 | 33% | 403,215 | 23% | | | 1,184,801 | 29% |
| UK Revenue | 0 | 0% | 227,068 | 13% | | | 227,068 | 6% |
| Other patient revenue and adjustments, net | 149,364 | 6% | 160,709 | 9% | | | 310,073 | 8% |
| Other non-patient revenue | 199,153 | 8% | 57,708 | 3% | 2,842 | | 259,703 | 6% |
| Total Net Revenue | $ 2,357,814 | 100% | $ 1,739,064 | 100% | $ 2,842 | | $ 4,099,720 | 100% |

**(13) Lease Accounting**

We follow FASB ASU 2016-02 ("Topic 842") "Leases." Under Topic 842, lessees are required to recognize assets and liabilities on the balance sheets for most leases and provide enhanced disclosures. Leases will be classified as either finance or operating.

We have elected the policy exemption that allows lessees to choose to not separate lease and non-lease components by class of underlying asset and are applying this expedient to all relevant asset classes.

We determine if an arrangement is or contains a lease at inception of the contract. Our right-of-use assets represent our right to use the underlying assets for the lease term and our lease liabilities represent our obligation to make lease payments arising from the leases. Right-of-use assets and lease liabilities are recognized at commencement date based on the present value of lease payments over the lease term. We use the implicit rate noted within the contract if known or determinable. If the implicit rate is not readily available, we use our estimated incremental borrowing rate, which is derived using a collateralized borrowing rate for the same currency and term as the associated lease. A right-of-use asset and lease liability is not recognized for leases with an initial term of 12 months or less and we recognize lease expense for these leases on a straight-line basis over the lease term within lease and rental expense.

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 hospital terms expiring in 2026, two expiring in 2033, and one expiring in 2040 (see Note 2 for additional disclosure). We also lease the real property of certain facilities.

Supplemental cash flow information related to leases for the three-month periods ended March 31, 2026 and 2025 are as follows (in thousands):

| | Three months ended March 31, | |
|---|---|---|
| | 2026 | 2025 |
| Cash paid for amounts included in the measurement of lease liabilities: | | |
| Operating cash flows from operating leases | $ 35,812 | $ 34,005 |
| Operating cash flows from finance leases | $ 866 | $ 889 |
| Financing cash flows from finance leases | $ 558 | $ 588 |
| | | |
| Right-of-use assets obtained in exchange for lease obligations: | | |
| Operating leases | $ 21,511 | $ 11,960 |
| Finance leases | $ - | $ 1,327 |

**(14) Recent Accounting Standards**

In November 2025, the FASB issued ASU 2025-09, “Derivatives and Hedging (Topic 815), Hedging Accounting Improvements. ASU 2025-09 intends to more closely align hedge accounting with the economics of an entity's risk management activities. This ASU is effective for fiscal years beginning after December 15, 2026, including interim periods within those fiscal years. We are currently evaluating the impact this new standard will have on the consolidated financial statements.

In November 2024, the FASB issued ASU 2024-03, “Income Statement-Reporting Comprehensive Income-Expense Disaggregation Disclosures (subtopic 220-40)". ASU 2024-03 requires disclosures, in the notes to financial statements, of specified information about certain costs and expenses. This ASU is effective for fiscal years beginning after December 15, 2026, and interim periods within those fiscal years beginning after December 15, 2027. We are currently evaluating the impact this new standard will have on the related disclosures in the consolidated financial statements.

From time to time, new accounting guidance is issued by the FASB or other standard setting bodies that is adopted by us as of the effective date or, in some cases where early adoption is permitted, in advance of the effective date. We have assessed the recently issued guidance that is not yet effective and, unless otherwise indicated above, we believe 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

As of March 31, 2026, we owned and/or operated 375 inpatient facilities and 168 outpatient and other facilities located in 40 states, Washington, D.C., the United Kingdom and Puerto Rico.

Our facilities include the following:

***Acute care facilities located in the U.S.:***

- 29 inpatient acute care hospitals;
- 35 free-standing emergency departments, and;
- 13 outpatient centers & 1 surgical hospital.

***Behavioral health care facilities (346 inpatient facilities and 119 outpatient facilities):***

***Located in the U.S.:***

- 182 inpatient behavioral health care facilities, and;
- 110 outpatient behavioral health care facilities.

***Located in the U.K.:***

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

***Located in Puerto Rico:***

- 3 inpatient behavioral health care facilities.
- 7 outpatient behavioral health care facilities.

Net revenues from our acute care hospitals, outpatient facilities and commercial health insurer accounted for 58% of our consolidated net revenues during each of the three-month periods ended March 31, 2026 and 2025. Net revenues from our behavioral health care facilities and commercial health insurer accounted for 42% of our consolidated net revenues during each of the three-month periods ended March 31, 2026 and 2025.

Our behavioral health care facilities located in the U.K. generated net revenues of approximately $261 million and $227 million during the three-month periods ended March 31, 2026 and 2025, respectively. Total assets at our U.K. behavioral health care facilities were approximately $1.522 billion as of March 31, 2026 and $1.531 billion as of December 31, 2025.

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, 2025, 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 in *Part 1, Item 1A. Risk Factors* and *Part II, 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, 2025 and in *Part II, Item 1A. Risk Factors and Part I, 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 are difficult to predict and many of which are outside of our control. Many factors, including those set forth herein in *Item 1A. Risk Factors* in our Annual Report on Form 10-K for the year ended December 31, 2025, and other important factors disclosed in this Quarterly Report, and from time to time in our other filings with the SEC, could cause actual performance or results to differ materially from those expressed in the statements. Such factors include, among other things, the following:

- 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 Nevada, California, Texas, Washington, D.C., Illinois, Pennsylvania, Kentucky, Ohio, Virginia, Massachusetts, Michigan, Mississippi, Florida and Tennessee. Most of these programs are approved on a year-to-year basis and there is no assurance that these revenues will continue at their current rates or at all. 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;
- legislation adopted on July 4, 2025 (the One Big Beautiful Bill Act), attaches work and community service requirements to eligibility for Medicaid benefits that will have the effect of limiting Medicaid enrollment and expenditure. That legislation also places limits on provider fees used to increase federal Medicaid funding to states. The legislation prohibits states not previously having expanded Medicaid eligibility to 138% of federal poverty level from increasing the rate of current provider fees which fund certain state supplemental payments or increasing the base of the fee to a class or items of services that the fee did not previously cover. That current provider fee threshold will remain at 6%. For states having expanded Medicaid eligibility under the legislation, the provider fee threshold will be reduced by 0.5% annually between federal fiscal years 2028 and 2032 with the resulting threshold ultimately becoming 3.5%. Under current law, and based on our current expectations, we estimate that, commencing with the 2028 state fiscal years, our aggregate annual net benefit will be reduced, on an annually increasing and relatively pro rata basis, by approximately $432 million to $480 million by 2032. The legislation also eliminates certain insurance exchange premium tax credits beyond 2025 and exchange enrollment is expected to be adversely impacted. On January 8, 2026, the U.S. House of Representatives passed H.R.1834 to extend for three years the enhanced premium tax credits ("EPTCs") that expired on December 31, 2025. As of early May 2026, no legislation extending the EPTCs has been enacted, and there can be no assurance regarding the timing or outcome of future legislative action. We cannot predict whether these subsidies will ultimately be adopted in federal fiscal year 2026. All of these factors, which could have a material unfavorable impact on our results of operations, may be expected to reduce our revenue and likely increase the level of uncompensated care provided by our facilities;
- there are additional legislative changes that are likely to result in major changes in the health care delivery system on a national or state level, including changes in the structure and administration of, and funding for, federal and state agencies and programs. For example, Congress has reduced to $0 the penalty for failing to maintain health coverage that was part of the original Patient Protection and Affordable Care Act, as amended by the Health and Education Reconciliation Act (collectively, the “ACA") as part of the Tax Cuts and Jobs Act. The Biden administration had 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 Inflation Reduction Act of 2022 (“IRA”) was passed on August 16, 2022, which among other things, allows for the Centers for Medicare and Medicaid Services ("CMS") to negotiate prices for certain single-source drugs reimbursed under Medicare Part B and Part D. The American Rescue Plan Act’s expansion of subsidies to purchase coverage through an ACA exchange, which the IRA continued through 2025, has increased exchange enrollment. These enhanced subsidies expired on December 31, 2025;
- there have been numerous political and legal efforts to expand, repeal, replace or modify the ACA since its enactment, some of which have been successful, in part, in modifying the ACA, as well as court challenges to the constitutionality of the legislation. The U.S. Supreme 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 ACA. The legislation faced its most recent challenge when the Supreme Court, in the June 2025 *Kennedy v. Braidwood Management* decision, opined in favor of ACA HIV preventive care coverage. The impacts of this decision cannot be predicted. Any future efforts to challenge, replace or replace the ACA or expand or substantially amend its provision is unknown. See below in *Sources of Revenues and Health Care Reform* for additional disclosure;

- additional 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;
- 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 the past, staffing shortages have, 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. Additionally, California is in the process of implementing staffing standards specific to acute psychiatric hospitals and requirements to determine appropriate staffing based on patient acuity and care needs, which are expected to take effect on June 1, 2026. This can further increase our costs and limit our revenue if we are required to limit the number of patients at our California facilities;
- we have experienced inflationary pressures, primarily in personnel costs, although those pressures have moderated more recently. 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 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;
- in our acute care segment, we have experienced a significant increase in hospital based physician related expenses, especially in the areas of emergency room care, anesthesiology and radiology. We have implemented various initiatives to mitigate the increased expense, to the degree possible, which has moderated the rate of increase. However, significant increases in these physician related expenses could have a material unfavorable impact on our future results of operations;
- the increase in interest rates during the past few years has 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 increased borrowing rates have adversely impacted our results of operations, financial condition and cash flows. We cannot predict future changes to interest rates, however, significant increases in our borrowing rates could have a material unfavorable impact on our future results of operations. Our $700 million, 1.65% senior notes ("2026 Notes") mature on September 1, 2026. Market interest rates have increased significantly since the 2026 Notes were issued in 2021. We expect that we will refinance the 2026 Notes at significantly higher interest rates which will significantly increase our interest expense thereby decreasing our net income attributable to UHS;
- significant tariffs or other restrictions, if imposed on our imported pharmaceutical ingredients, medical devices, medical equipment and their ingredients and components, could escalate costs of medications, medical devices and medical equipment and disrupt our supply chains. While we continue to evaluate the potential impact of the new tariffs on our business, given the uncertainty regarding the scope and duration of any new tariffs, as well as the potential for additional tariffs or trade barriers by the U.S. and the impacted foreign countries, we can provide no assurance that any strategies we implement to mitigate the impact of such tariffs or other trade actions will be successful. Therefore, changes in laws or policies governing the terms of foreign trade, and in particular, increased trade restrictions, tariffs or taxes on imports from where our products or materials are made (either directly or through our suppliers) could have an impact on our competitive position, business operations and financial results;
- as of early May 2026, Congress has enacted appropriations legislation funding most federal agencies for fiscal year 2026, following a lapse in appropriations affecting certain Department of Homeland Security operations that began on February 14, 2026 and was resolved on April 30, 2026. In the past several years political disputes concerning authorization of a federal budget have led to shutdown of substantial portions of the federal government and other federal budget authorization delays have occurred. Federal budget delays and federal government shutdowns are unpredictable and may occur in the future. We cannot predict whether or not there will be future appropriations legislation avoiding a federal government shutdown, however, our operating cash flows and results of operations could be materially unfavorably impacted by the federal government shutdown;
- as part of the Consolidated Appropriations Act of 2021 (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 CAA 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 rules to implement the legislation. The rules have limited the ability of our hospital-based physicians to receive payments for services at usually higher out-of-network rates in certain circumstances, and, as a result, have caused us to increase subsidies to these physicians or to replace their services at a higher cost;

- in June 2024, the U.S. Supreme Court issued its decision in *Loper Bright Enters. v. Raimondo* and *Relentless, Inc. v. Department of Commerce*, which modified the regulatory interpretation standard established 40 years ago by *Chevron v. National Resources Defense Council*. *Chevron* doctrine generally required courts to defer to federal agencies in their interpretation of federal statutes when a statute was silent or ambiguous with respect to a specific issue. In *Loper Bright*, the Supreme Court held that courts are no longer required to grant such deference, though they may consider an agency's statutory interpretation. As it is highly regulated, the health care industry could be significantly impacted by the *Loper Bright* decision, particularly in the areas of Medicare reimbursement, decision making by the Food & Drug Administration and health care fraud and abuse compliance, where parties may no longer be able to rely on federal agencies' policies, rules and guidance;
- our ability to enter into managed care provider agreements on acceptable terms and the ability of our competitors to do the same;
- the impact of a shift of care from inpatient to lower cost outpatient settings and controls designed to reduce inpatient services;
- our ability to achieve operating and financial targets, develop and execute plans to offset to the extent possible impacts from the recent regulatory changes, including the enactment of the One Big Beautiful Bill Act and the expiration of EPTCs, and tariffs, attain expected levels of patient volumes and revenues, and control the costs of providing services;
- the outcome of known and unknown litigation, government investigations, inquiries, false claims act allegations, and liabilities and other claims asserted against us and other matters, and the effects of adverse publicity relating to such matters, as disclosed in *Note 6 to the Condensed Consolidated Financial Statements - Commitments and Contingencies,* including, but not limited to, the jury verdict returned against Cumberland Hospital for Children and Adolescents located in New Kent, Virginia, an indirect subsidiary of ours, and the verdict in the Pinnacle litigation in Washoe County, Nevada, against certain subsidiaries of ours;
- effective March, 2025, our excess commercial insurance coverage for professional and general liability claims contains less favorable terms than previous years including coverage exclusions for incidents involving sexual molestation or abuse, higher premiums and lower aggregate limitations;
- 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, or any third-party security systems that we rely on, 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 violations of applicable privacy and other laws, significant penalties or fines, litigation, loss of customers, significant damage to our reputation and business, and other liability or losses. We may also incur additional costs related to cybersecurity risk management and remediation. There can be no assurance that we or our service providers, if applicable, will not suffer losses relating to cyber-attacks or other information security breaches in the future or that our insurance coverage will be adequate to cover all the costs resulting from such events;
- our ability to implement technology and other programs to drive efficiencies, and improve patient outcomes and experiences, and the risks associated with the use of technologies by us or our services providers;
- on March 9, 2026, we announced that we entered into a definitive agreement to acquire Talkspace, Inc. ("Talkspace") for $5.25 per share, or approximately $835 million in the aggregate. The transaction is expected to close during the third quarter of 2026 and is subject to approval by Talkspace's stockholders, satisfaction of regulatory approvals and other customary closing conditions. The acquisition is subject to numerous risks and uncertainties including uncertainty as to whether the parties will be able to complete the merger on the terms set forth in the merger agreement; uncertainty

regarding the timing of the receipt of required regulatory approvals for the merger and the possibility that the parties may be required to accept conditions that could reduce or eliminate the anticipated benefits of the merger as a condition to obtaining the outcome of any legal proceedings that may be instituted against the parties or others following announcement of the transactions contemplated by the merger agreement; challenges, disruptions and costs of closing, integrating the business and achieving anticipated synergies, or that such synergies will take longer to realize than expected; failure to retain key employees of Talkspace during the period prior to closing or thereafter; failure to retain a significant portion of Talkspace's providers or relationships with payors, risks that the merger and other transactions contemplated by the merger agreement disrupt current plans and operations that may harm the parties' businesses or divert management's attention from the parties' ongoing business operations; and the amount of any costs, fees, expenses, impairments and charges related to the merger including costs and use of capital related to financing the merger;

- 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, flash floods, wildfires and climate change;
- 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. Current legislation has 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;
- uninsured and self-pay patients treated at our facilities unfavorably impact our ability to satisfactorily and timely collect our self-pay patient accounts;
- changes in our business strategies or development plans;
- 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, 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 2025 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**

***Clinical Staffing, Inflation, Future Medicaid Reductions and Tariffs:***

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 the past, staffing shortages have, 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. We have also experienced general inflationary cost increases related to certain of our other operating expenses. Many of these factors, which had a material unfavorable impact on our results of operations in prior years, have moderated more recently. However, we cannot predict future inflationary increases, which if significant, could have a material unfavorable impact on our future results of operations.

We have experienced inflationary pressures, primarily in personnel costs, although those pressures have moderated more recently. 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 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.

Legislation adopted on July 4, 2025 attaches work and community service requirements to eligibility for Medicaid benefits that will have the effect of limiting Medicaid enrollment and expenditures and the legislation also places limits on provider taxes used to increase federal Medicaid funding to states. In addition, insurance exchange subsidies expired on December 31, 2025 which could unfavorably impact insurance exchange enrollment. As these provisions become effective over the next several years, they may be expected to reduce our revenues and likely increase the level of uncompensated care provided by our facilities. Please see *Sources of Revenue* below for additional disclosure related to Medicaid supplemental payment programs in various states in which we operate.

Significant tariffs or other restrictions, if imposed on our imported pharmaceutical ingredients, medical devices, medical equipment and their ingredients and components, could escalate costs of medications, medical devices and medical equipment and disrupt our supply chains. While we continue to evaluate the potential impact of the new tariffs on our business, given the uncertainty regarding the scope and duration of any new tariffs, as well as the potential for additional tariffs or trade barriers by the U.S. and the impacted foreign countries, we can provide no assurance that any strategies we implement to mitigate the impact of such tariffs or other trade actions will be successful. Therefore, changes in laws or policies governing the terms of foreign trade, and in particular, increased trade restrictions, tariffs or taxes on imports from where our products or materials are made (either directly or through our suppliers) could have an impact on our competitive position, business operations and financial results.

Although our ability to pass on increased costs associated with providing healthcare to Medicare and Medicaid patients is limited, as discussed above, we have been requesting and 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, 2026 and 2025:***

The following table summarizes our results of operations and is used in the discussion below for the three-month periods ended March 31, 2026 and 2025 (dollar amounts in thousands):

| | Three months ended March 31, 2026 | | Three months ended March 31, 2025 | |
|---|---|---|---|---|
| | Amount | % of Net Revenues | Amount | % of Net Revenues |
| Net revenues | $ 4,495,182 | 100.0% | $ 4,099,720 | 100.0% |
| Operating charges: | | | | |
| Salaries, wages and benefits | 2,088,229 | 46.5% | 1,951,104 | 47.6% |
| Other operating expenses | 1,283,928 | 28.6% | 1,105,752 | 27.0% |
| Supplies expense | 426,543 | 9.5% | 402,881 | 9.8% |
| Depreciation and amortization | 155,426 | 3.5% | 148,345 | 3.6% |
| Lease and rental expense | 38,196 | 0.8% | 36,813 | 0.9% |
| Subtotal-operating expenses | 3,992,322 | 88.8% | 3,644,895 | 88.9% |
| Income from operations | 502,860 | 11.2% | 454,825 | 11.1% |
| Interest expense, net | 37,133 | 0.8% | 40,056 | 1.0% |
| Other (income) expense, net | (3,389) | (0.1)% | (5,659) | (0.1)% |
| Income before income taxes | 469,116 | 10.4% | 420,428 | 10.3% |
| Provision for income taxes | 110,438 | 2.5% | 98,800 | 2.4% |
| Net income | 358,678 | 8.0% | 321,628 | 7.8% |
| Less: Income (loss) attributable to noncontrolling interests | 9,996 | 0.2% | 4,948 | 0.1% |
| Net income attributable to UHS | $ 348,682 | 7.8% | $ 316,680 | 7.7% |

Net revenues increased by 9.6%, or $395 million, to $4.495 billion during the three-month period ended March 31, 2026, as compared to $4.100 billion during the first quarter of 2025. The net increase was primarily attributable to: (i) a $313 million, or 7.9%, 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) an other combined net increase of $82 million, consisting of a $48 million increase in provider tax assessments (which had no impact on income before income taxes since the amounts offset between net revenues and other operating expenses) and other combined net increase of $34 million consisting primarily of the net revenues generated during the first quarter of 2026 at a newly constructed acute care hospital located in Washington, D.C. (Cedar Hill Regional Medical Center which opened during the second quarter of 2025).

Income before income taxes (before income attributable to noncontrolling interests) increased by $49 million, or 12%, to $469 million during the three-month period ended March 31, 2026 as compared to $420 million during the first quarter of 2025. The net increase was due to:

- an increase of $25 million at our acute care facilities, as discussed below in *Acute Care Hospital Services*;
- an increase of $26 million at our behavioral health care facilities, as discussed below in *Behavioral Health Care Services,* and;
- a $2 million other combined net decrease.

Net income attributable to UHS increased by $32 million, or 10%, to $349 million during the three-month period ended March 31, 2026, as compared to $317 million during the first quarter of 2025. This increase was primarily attributable to:

- a $49 million increase in income before income taxes, as discussed above;
- a $5 million decrease due to an increase in income attributable to noncontrolling interests, and;
- a decrease of $12 million resulting from an increase in the provision for income taxes resulting primarily from the increase in the provision for income taxes resulting from the $44 million increase in income before income taxes ($49 million increase in income before income taxes net of a $5 million increase in income attributable to noncontrolling interests).

***Acute Care Hospital Services***

The following table sets forth certain operating statistics for our acute care hospital services for the three-month periods ended March 31, 2026 and 2025.

| | Same Facility Basis Three Months Ended | | All Three Months Ended | |
|---|---|---|---|---|
| | March 31, 2026 | March 31, 2025 | March 31, 2026 | March 31, 2025 |
| Average licensed beds | 7,023 | 6,994 | 7,165 | 6,994 |
| Average available beds | 6,851 | 6,822 | 6,993 | 6,822 |
| Patient days | 425,835 | 429,030 | 431,073 | 429,030 |
| Average daily census | 4,731.5 | 4,767.0 | 4,789.7 | 4,767.0 |
| Occupancy-licensed beds | 67.4% | 68.2% | 66.8% | 68.2% |
| Occupancy-available beds | 69.1% | 69.9% | 68.5% | 69.9% |
| Admissions | 86,780 | 88,090 | 87,889 | 88,090 |
| Length of stay | 4.9 | 4.9 | 4.9 | 4.9 |

**Acute Care Hospital Services-Same Facility Basis**

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-Summary of 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. Prior year amounts related to certain facilities previously included in our Behavioral Health Care Services' results have been reclassified into our Acute Care Hospital Services' results as of January 1, 2025 to conform with current year presentation. 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, 2026 and 2025 (dollar amounts in thousands):

| | Three months ended March 31, 2026 | | Three months ended March 31, 2025 | |
|---|---|---|---|---|
| | Amount | % of Net Revenues | Amount | % of Net Revenues |
| Net revenues | $ 2,470,045 | 100.0% | $ 2,281,831 | 100.0% |
| Operating charges: | | | | |
| Salaries, wages and benefits | 952,835 | 38.6% | 913,829 | 40.0% |
| Other operating expenses | 728,152 | 29.5% | 638,599 | 28.0% |
| Supplies expense | 365,497 | 14.8% | 348,824 | 15.3% |
| Depreciation and amortization | 95,681 | 3.9% | 94,901 | 4.2% |
| Lease and rental expense | 26,738 | 1.1% | 25,344 | 1.1% |
| Subtotal-operating expenses | 2,168,903 | 87.8% | 2,021,497 | 88.6% |
| Income from operations | 301,142 | 12.2% | 260,334 | 11.4% |
| Interest expense, net | 986 | 0.0% | 2,262 | 0.1% |
| Other (income) expense, net | (2,555) | (0.1)% | (8,572) | (0.4)% |
| Income before income taxes | $ 302,711 | 12.3% | $ 266,644 | 11.7% |

***Three-month periods ended March 31, 2026 and 2025:***

During the three-month period ended March 31, 2026, as compared to the comparable prior year quarter, net revenues from our acute care hospital services, on a Same Facility basis, increased by $188 million or 8.2%.

Income before income taxes (and before income attributable to noncontrolling interests) increased by $36 million, or 14%, amounting to $303 million, or 12.3% of net revenues during the first quarter of 2026, as compared to $267 million, or 11.7% of net revenues during the first quarter of 2025.

During the three-month period ended March 31, 2026, net revenue per adjusted admission increased by 6.3% while net revenue per adjusted patient day increased 5.5%, as compared to the comparable quarter of 2025. During the three-month period ended March 31, 2026, as compared to the comparable prior year quarter, inpatient admissions to our acute care hospitals decreased by 1.5% while adjusted admissions (adjusted for outpatient activity) were unchanged. Patient days at these facilities decreased by 0.7% and adjusted patient days increased by 0.8% during the three-month period ended March 31, 2026, as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities was 4.9 days during each of the three-month periods ended March 31, 2026 and 2025, respectively. The occupancy rate, based on the average available beds at these facilities, was 69% and 70% during the three-month periods ended March 31, 2026 and 2025, respectively.

On a Same Facility basis, during the three-month period ended March 31, 2026, as compared to the comparable quarter of 2025, salaries, wages and benefits expense increased by $39 million, or 4.3%. As a percentage of net revenues, salaries, wages and benefits expense decreased to 38.6% during the first quarter of 2026 as compared to 40.0% during the first quarter of 2025.

Other operating expenses increased by $90 million, or 14.0%, during the first quarter of 2026, as compared to the comparable quarter of 2025. Operating expenses incurred by our commercial health insurer, consisting primarily of medical costs, increased by $45 million, or 27.6% (due to an increase in membership), during the first quarter of 2026, as compared to the comparable quarter of 2025. Excluding the operating costs of our commercial insurer from each period, other operating expenses increased by $45 million, or 9.3%. Contributing to the increased operating expenses during the first quarter of 2026, as compared to the comparable quarter of 2025, was a $20 million, or 12.3%, aggregate increase in physician expenses incurred at certain hospitals. As a percentage of net revenues, other operating expenses increased to 29.5% during the first quarter of 2026, as compared to 28.0% during the comparable quarter of 2025.

Supplies expense increased by $17 million, or 4.8%, during the first quarter of 2026, as compared to the first quarter of 2025. As a percentage of net revenues, supplies expense decreased to 14.8% during the three-month period ended March 31, 2026, as compared to 15.3% during the first quarter of 2025.

**All Acute Care Hospital Services**

The following table summarizes the results of operations for all our acute care operations during the three-month periods ended March 31, 2026 and 2025. 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 the results of recently acquired and/or opened facilities and businesses. Dollar amounts below are reflected in thousands.

| | Three months ended March 31, 2026 | | Three months ended March 31, 2025 | |
|---|---|---|---|---|
| | Amount | % of Net Revenues | Amount | % of Net Revenues |
| Net revenues | $ 2,610,136 | 100.0% | $ 2,357,814 | 100.0% |
| Operating charges: | | | | |
| Salaries, wages and benefits | 972,846 | 37.3% | 915,524 | 38.8% |
| Other operating expenses | 859,847 | 32.9% | 716,662 | 30.4% |
| Supplies expense | 367,938 | 14.1% | 348,692 | 14.8% |
| Depreciation and amortization | 96,318 | 3.7% | 94,903 | 4.0% |
| Lease and rental expense | 26,572 | 1.0% | 25,344 | 1.1% |
| Subtotal-operating expenses | 2,323,521 | 89.0% | 2,101,125 | 89.1% |
| Income from operations | 286,615 | 11.0% | 256,689 | 10.9% |
| Interest expense, net | 986 | 0.0% | 2,262 | 0.1% |
| Other (income) expense, net | (2,132) | (0.1)% | (8,267) | (0.4)% |
| Income before income taxes | $ 287,761 | 11.0% | $ 262,694 | 11.1% |

***Three-month periods ended March 31, 2026 and 2025:***

During the three-month period ended March 31, 2026, as compared to the comparable prior year quarter, net revenues from our acute care hospital services increased by $252 million, or 10.7%, due to: (i) the $188 million, or 8.2% increase in Same Facility revenues, as discussed above, and; (ii) an other combined net increase of $64 million consisting of increased provider tax assessments and the net revenues generated during the first quarter of 2026 at a newly constructed acute care hospital located in Washington, D.C. (Cedar Hill Regional Medical Center which opened during the second quarter of 2025).

Income before income taxes increased by $25 million, or 10%, to $288 million, or 11.0% of net revenues during the first quarter of 2026, as compared to $263 million, or 11.1% of net revenues during the comparable quarter of 2025. The increase resulted primarily

from: (i) the $36 million, or 14%, increase in income before income taxes from our acute care hospital services, on a Same Facility basis, as discussed above, partially offset by; (ii) an $11 million increase in the aggregate pre-tax losses incurred during the first quarter of 2026, as compared to the first quarter of 2025, at the recently completed and opened Cedar Hill Regional Medical Center located in Washington, D.C., as well as the new acute care hospital being constructed in Palm Beach Gardens, FL (Alan B. Miller Medical Center) that is scheduled to be completed and opened during the second quarter of 2026.

During the three-month period ended March 31, 2026, as compared to the comparable quarter of 2025, salaries, wages and benefits expense increased by $57 million, or 6.3%. The increase was due primarily to the above-mentioned $39 million, or 4.3%, increase related to our acute care hospital services, on a Same Facility basis, as well as the salaries, wages and benefits expense incurred at the two above-mentioned newly constructed acute care hospitals.

Other operating expenses increased by $143 million, or 20.0%, during the first quarter of 2026, as compared to the comparable quarter of 2025. The increase was due primarily to: (i) the $90 million above-mentioned increase related to our acute care hospital services, on a Same Facility basis; (ii) a $35 million increase in provider tax assessments, and; (iii) a combined increase of $18 million consisting primarily of the operating expenses incurred at Cedar Hill Regional Medical Center.

Supplies expense increased by $19 million, or 5.5%, during the first quarter of 2026, as compared to the comparable quarter of 2025. The increase was due to the above-mentioned $17 million increase related to our acute care hospital services, on a Same Facility basis, as well as the supplies expense incurred during the first quarter of 2026 at Cedar Hill Regional Medical Center.

**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, 2026 and 2025:

*Uncompensated care:*

| Amounts in millions | Three Months Ended | | | |
|---|---|---|---|---|
| | March 31, 2026 | % | March 31, 2025 | % |
| Charity care | $ 116 | 10% | $ 269 | 28% |
| Uninsured discounts | 997 | 90% | 677 | 72% |
| Total uncompensated care | $ 1,113 | 100% | $ 946 | 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.

| Amounts in millions | Three Months Ended | |
|---|---|---|
| | March 31, 2026 | March 31, 2025 |
| Estimated cost of providing charity care | $ 10 | $ 23 |
| Estimated cost of providing uninsured discounts | 82 | 58 |
| Estimated cost of providing uncompensated care | $ 92 | $ 81 |

***Behavioral Health Care Services***

The following table sets forth certain operating statistics for our behavioral health care services for the three-month periods ended March 31, 2026 and 2025.

| | Same Facility Basis Three Months Ended | | All Three Months Ended | |
|---|---|---|---|---|
| | March 31, 2026 | March 31, 2025 | March 31, 2026 | March 31, 2025 |
| Average licensed beds | 24,016 | 23,856 | 24,570 | 24,083 |
| Average available beds | 23,916 | 23,756 | 24,470 | 23,983 |
| Patient days | 1,593,351 | 1,570,599 | 1,619,586 | 1,588,545 |
| Average daily census | 17,703.9 | 17,451.1 | 17,995.4 | 17,650.5 |
| Occupancy-licensed beds | 73.7% | 73.2% | 73.2% | 73.3% |
| Occupancy-available beds | 74.0% | 73.5% | 73.5% | 73.6% |
| Admissions | 116,268 | 115,049 | 117,491 | 116,350 |
| Length of stay | 13.7 | 13.7 | 13.8 | 13.7 |

**Behavioral Health Care Services-Same Facility Basis**

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-Summary of 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. Prior year amounts related to certain facilities previously included in our Behavioral Health Care Services' results have been reclassified into our Acute Care Hospital Services' results as of January 1, 2025 to conform with current year presentation. 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, 2026 and 2025 (dollar amounts in thousands):

| | Three months ended March 31, 2026 | | Three months ended March 31, 2025 | |
|---|---|---|---|---|
| | Amount | % of Net Revenues | Amount | % of Net Revenues |
| Net revenues | $ 1,818,676 | 100.0% | $ 1,694,160 | 100.0% |
| Operating charges: | | | | |
| Salaries, wages and benefits | 993,038 | 54.6% | 919,790 | 54.3% |
| Other operating expenses | 334,423 | 18.4% | 319,600 | 18.9% |
| Supplies expense | 58,456 | 3.2% | 54,995 | 3.2% |
| Depreciation and amortization | 55,156 | 3.0% | 50,879 | 3.0% |
| Lease and rental expense | 11,305 | 0.6% | 10,878 | 0.6% |
| Subtotal-operating expenses | 1,452,378 | 79.9% | 1,356,142 | 80.0% |
| Income from operations | 366,298 | 20.1% | 338,018 | 20.0% |
| Interest expense, net | 1,192 | 0.1% | 1,075 | 0.1% |
| Other (income) expense, net | (883) | (0.0)% | (825) | (0.0)% |
| Income before income taxes | $ 365,989 | 20.1% | $ 337,768 | 19.9% |

***Three-month periods ended March 31, 2026 and 2025:***

During the three-month period ended March 31, 2026, as compared to the comparable prior year quarter, net revenues from our behavioral health services, on a Same Facility basis, increased by $125 million or 7.3%.

Income before income taxes increased by $28 million, or 8%, amounting to $366 million or 20.1% of net revenues during the first quarter of 2026, as compared to $338 million or 19.9% of net revenues during the first quarter of 2025.

During the three-month period ended March 31, 2026, net revenue per adjusted admission increased by 6.2% while net revenue per adjusted patient day increased by 5.8%, as compared to the comparable quarter of 2025. During the three-month period ended March 31, 2026, as compared to the comparable prior year quarter, inpatient admissions and adjusted admissions to our behavioral health care hospitals increased by 1.1% and 1.2%, respectively. Patient days at these facilities increased by 1.4% and adjusted patient days increased by 1.6% during the three-month period ended March 31, 2026, as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities was 13.7 days during each of the three-month periods ended March 31, 2026 and 2025. The occupancy rate, based on the average available beds at these facilities, was 74% during each of the three-month periods ended March 31, 2026 and 2025.

On a Same Facility basis during the three-month period ended March 31, 2026, as compared to the comparable quarter of 2025, salaries, wages and benefits expense increased by $73 million or 8.0%. The increase during the first quarter of 2026, as compared to the comparable quarter of 2025, was due to a 5.2% increase in salaries, wages and benefits expense per average full time equivalent employee, as well as a 2.7% increase in the average number of full-time equivalent employees. As a percentage of net revenues during each quarter, salaries, wages and benefits expense increased to 54.6% during the first quarter of 2026 as compared to 54.3% during the first quarter of 2025.

Other operating expenses increased by $15 million, or 4.6%, during the first quarter of 2026, as compared to the comparable quarter of 2025. As a percentage of net revenues during each quarter, other operating expenses decreased to 18.4% during the first quarter of 2026, as compared to 18.9% during the first quarter of 2025.

Supplies expense increased by $3 million, or 6.3%, during the first quarter of 2026, as compared to the comparable quarter of 2025. As a percentage of net revenues during each quarter, supplies expense remained unchanged at 3.2% during each of the three-month periods ended March 31, 2026 and 2025.

**All Behavioral Health Care Services**

The following table summarizes the results of operations for all our behavioral health care services during the three-month periods ended March 31, 2026 and 2025. 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. Dollar amounts below are reflected in thousands.

| | Three months ended March 31, 2026 | | Three months ended March 31, 2025 | |
|---|---|---|---|---|
| | Amount | % of Net Revenues | Amount | % of Net Revenues |
| Net revenues | $ 1,882,152 | 100.0% | $ 1,739,064 | 100.0% |
| Operating charges: | | | | |
| Salaries, wages and benefits | 1,001,094 | 53.2% | 923,366 | 53.1% |
| Other operating expenses | 391,898 | 20.8% | 362,262 | 20.8% |
| Supplies expense | 58,787 | 3.1% | 55,148 | 3.2% |
| Depreciation and amortization | 56,634 | 3.0% | 51,152 | 2.9% |
| Lease and rental expense | 11,515 | 0.6% | 11,364 | 0.7% |
| Subtotal-operating expenses | 1,519,928 | 80.8% | 1,403,292 | 80.7% |
| Income from operations | 362,224 | 19.2% | 335,772 | 19.3% |
| Interest expense, net | 1,272 | 0.1% | 1,075 | 0.1% |
| Other (income) expense, net | (883) | (0.0)% | (825) | (0.0)% |
| Income before income taxes | $ 361,835 | 19.2% | 335,522 | 19.3% |

***Three-month periods ended March 31, 2026 and 2025:***

During the three-month period ended March 31, 2026, as compared to the comparable prior year quarter, net revenues generated from our behavioral health services increased by $143 million, or 8.2%. The increase was primarily attributable to the above-mentioned $125 million, or 7.3%, increase in net revenues at our behavioral health facilities, on a Same Facility basis.

Income before income taxes increased by $26 million, or 7.8%, to $362 million or 19.2% of net revenues during the first quarter of 2026, as compared to $336 million or 19.3% of net revenues during the first quarter of 2025. The increase in income before income taxes at our behavioral health facilities during the first quarter of 2026, as compared to the comparable quarter of 2025, was primarily attributable to the $28 million, or 8.4% increase in income before income taxes generated at our behavioral health facilities, on a Same Facility basis.

During the three-month period ended March 31, 2026, as compared to the comparable quarter of 2025, salaries, wages and benefits expense increased by $78 million or 8.4%. The increase was due primarily to the above-mentioned $73 million increase related to our behavioral health facilities, on a Same Facility basis.

Other operating expenses increased by $30 million, or 8.2%, during the first quarter of 2026, as compared to the comparable quarter of 2025. The increase was due primarily to the above-mentioned $15 million increase related to our behavioral health facilities, on a Same Facility basis, as well as a $13 million increase in provider tax assessments.

Supplies expense increased by $4 million, or 6.6%, during the first quarter of 2026, as compared to the comparable quarter of 2025, due primarily to the above-mentioned increase related to our behavioral health facilities, on a Same Facility basis.

**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.

**Sources of Revenues and Health Care Reform:** Given increasing budget deficits, the federal government and many states are currently considering additional ways to limit increases in levels of Medicare and Medicaid funding, which could also adversely affect future payments received by our hospitals. In addition, the uncertainty and fiscal pressures placed upon the federal government as a result of, among other things, economic recovery stimulus packages, responses to natural disasters, and the federal and state budget deficits in general may affect the availability of government funds to provide additional relief in the future. Changes resulting from the outcome of the 2024 elections may include increased reliance on Medicare Advantage programs, work requirements for Medicaid waiver program eligibility, increased focus on hospital outpatient site neutral payment policies, and similar initiatives that may reduce the availability of funding for federal healthcare programs or make eligibility for benefits more difficult. ACA adopted on July 4, 2025, commonly known as the One Big Beautiful Bill Act (“OBBBA”), will have the effect of substantially decreasing federal funding for state Medicaid Programs. Any significant reduction in federal Medicaid funding to states would likely result in states reducing Medicaid payments to us which would have a material adverse effect on us. We are unable to predict the effect of future policy changes on our operations.

In 2010, the Patient Protection and Affordable Care Act, as amended by the Health and Education Reconciliation Act (collectively, the “ACA”) was enacted and its two primary goals were to provide for increased access to coverage for healthcare and to reduce healthcare-related expenses. The ACA revised 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 ACA provides for reductions to Medicaid DSH payments which are now scheduled to begin in federal fiscal year 2028.

A 2012 U.S. Supreme Court ruling limited the federal government’s ability to expand health insurance coverage by holding unconstitutional sections of the ACA 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 withdrew certain previously issued section 1115 demonstrations aligned with these policies, but Georgia has imposed work and community engagement requirements under a Medicaid demonstration program that launched July 1, 2023. President Trump, who favored work and community engagement requirements in his first administration, sought and obtained legislation under the OBBBA that applies such requirements to a significant percentage of Medicaid program beneficiaries. We anticipate this change will lead to reductions in Medicaid coverage and likely increases in uncompensated care.

On December 14, 2018, a Texas Federal District Court deemed the ACA 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 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 ACA unconstitutional. The Court also held that because the individual mandate is “essential” to the ACA and is inseverable from the rest of the law, the entire ACA 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 ACA’s individual mandate and the entirety of the ACA itself. As a result, the ACA will continue to be law, and the Department of Health and Human Services ("HHS") and its respective agencies will continue to enforce regulations implementing the law. However, on September 7, 2022, the ACA 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 decision was ultimately appealed to the U.S. Supreme Court, which in its June 2025 *Kennedy v. Braidwood Management* decision, opined in favor of HIV preventive care coverage. The impact of this decision on us cannot be predicted.

The ACA also contained provisions aimed at reducing fraud and abuse in healthcare. The ACA 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 ACA 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 ACA provides that a healthcare provider that retains an overpayment in excess of 60 days is subject to the federal civil False Claims Act. In December, 2024, CMS changed the standard for identification of an overpayment and now requires the report and return of an overpayment if a provider or supplier has actual knowledge of the existence of an overpayment or acts in reckless disregard or deliberate ignorance of an overpayment. The ACA also expanded 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 ACA 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 ACA 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. A repeal of the ACA, in whole or in relevant part, may result in physicians being able to expand ownership interest in hospitals.

In addition to legislative changes, the ACA can be significantly impacted by executive branch actions. The Biden administration had 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 American Rescue Plan Act of 2021's expansion of subsidies to purchase coverage through an exchange contributed to increased exchange enrollment in 2021. The Inflation Reduction Act (IRA)'s extension of subsidies through 2025 increased exchange enrollment in years subsequent to 2021. These enhanced subsidies expired on December 31, 2025. It remains unclear what portions of the ACA 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. Extension of these subsidies is currently the subject of Congressional debate as part of the federal budget negotiation, and we cannot predict whether these subsidies will ultimately be adopted in federal fiscal year 2026.

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 Recognition*.

**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, 2026, CMS published its IPPS 2027 proposed payment rule which provides for a 3.2% 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 ACA are considered (including a 0.8% productivity

adjustment offset), without consideration for the required Medicare DSH payments changes and increase to the Medicare Outlier threshold, the overall increase in IPPS payments is approximately 1.1%. Including DSH payments, an increase to the Medicare Outlier threshold and certain other adjustments, we estimate our overall increase from the proposed IPPS 2027 rule (covering the period of October 1, 2026 through September 30, 2027) will approximate 0.3%.

In July, 2025, CMS published its IPPS 2026 final payment rule which provides for a 3.3% 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 ACA are considered (including a -0.7% productivity adjustment offset), without consideration for the required Medicare DSH payments changes and increase to the Medicare Outlier threshold, the overall increase in IPPS payments is approximately 1.0%. Instead of applying a state-level rural floor budget neutrality adjustment to the wage index, the final rule has applied a uniform, national budget neutrality adjustment to the FY 2026 wage index for the rural floor. Nevada will be subject to a 5.0% reduction in the wage index adjustment as a result of a decrease in the wage index rural floor in that state. Including DSH payments, a decrease to the Medicare Outlier threshold and certain other adjustments, we estimate our overall increase from the final IPPS 2026 rule (covering the period of October 1, 2025 through September 30, 2026) will approximate 2.7%.

In August, 2024, CMS published its IPPS 2025 final payment rule which provides for a 2.9% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments, and adjustments mandated by the ACA 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 1.8%. Including DSH payments, an increase to the Medicare Outlier threshold and certain other adjustments, we estimate our overall increase from the final IPPS 2025 rule (covering the period of October 1, 2024 through September 30, 2025) will approximate 1.2%.

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, 2026, CMS published its Psych PPS proposed rule for the federal fiscal year 2027. Under this proposed rule, payments to our behavioral health care hospitals and units from the market basket update are estimated to increase by 2.3% compared to federal fiscal year 2026. This amount includes the effect of the 3.1% net market basket update which reflects the offset of a 0.8% productivity adjustment. When all of the final patient level adjustments described below as well as proposed wage index values are considered, we estimate that Psych PPS payments will increase by 2.0% in FFY 2027.

In August, 2025, CMS published its Psych PPS final rule for the federal fiscal year 2026. Under this final rule, payments to our behavioral health care hospitals and units from the market basket update are estimated to increase by 2.5% compared to federal fiscal year 2025. This amount includes the effect of the 3.2% net market basket update which reflects the offset of a 0.7% productivity adjustment. When all of the final patient level adjustments described below as well as proposed wage index values are considered, we estimate that Psych PPS payments will increase by 1.7% in FFY 2026.

In July, 2024, CMS published its Psych PPS final rule for the federal fiscal year 2025. Under this final rule, payments to our behavioral health care hospitals and units from the market basket update are estimated to increase by 2.8% compared to federal fiscal year 2024. This amount includes the effect of the 3.3% net market basket update which reflects the offset of a 0.5% productivity adjustment. When all of the final patient level adjustments described below as well as proposed wage index values are considered, we estimate that Psych PPS payments will increase by 2.1% in FFY 2025.

In addition to the market basket update noted above, CMS made the following changes:

- Revisions to the methodology for determining the payment rates under the Inpatient Psychiatric Facility ("IPF") PPS for psychiatric hospitals and psychiatric units based on a review of the data and information collected in prior years in accordance with section 1886(s)(5)(A) of the Social Security Act, as added by the Consolidated Appropriations Act of 2023 ("CAA of 2023"). CMS finalized revisions to the IPF patient-level adjustment factors. The patient-level adjustments include Medicare Severity Diagnosis Related Groups (MS–DRGs) assignment of the patient's principal diagnosis, selected comorbidities, patient age, and the variable per diem adjustments;
- Implement these revisions in a budget-neutral manner (that is, estimated payments to IPFs for FFY 2025 would be the same with or without the final revisions), and;
- Clarified the criteria regarding all-inclusive cost reporting. This clarification requires our behavioral health care hospitals, which are currently utilizing an all-inclusive charging practice, to modify both their billing practices and information technology applications by June 1, 2025 to ensure compliance with future regulations. We are in compliance with this CMS billing requirement.

This final rule also includes two requests for information on future revisions to the IPF PPS facility-level adjustment factors and development of the new standardized IPF Patient Assessment Instrument, required by the CAA of 2023, which IPFs participating in the IPF Quality Reporting Program will be required to report for Rate Year 2028.

In November, 2025, CMS issued its OPPS final rule for 2026. The hospital market basket increase is 3.3% and the productivity adjustment reduction is 0.7% for a net market basket increase of 2.6%. When other statutorily required adjustments (including a 0.5% reduction for the 340B remedy discussed below) and hospital patient service mix are considered, we estimate that our overall Medicare OPPS update for 2026 will aggregate to a net increase of 2.0%

Some key changes in the 2026 OPPS final rule include:

*340B Remedy Recoupment:*

CMS anticipates shortening the 340B Remedy recoupment transition from the previously established 16-year schedule beginning 2027; however the revised duration has not yet been determined. A 2023 CMS final rule had implemented a negative OPPS recoupment adjustment of 0.5 percent for approximately 16 years to offset $7.8 billion paid to hospitals for non-drug OPPS payments between 2018 and 2022 – following the US Supreme Court decision overturning the Trump Administration's 340B reduction policy. CMS will maintain the annual offset of 0.5 percent in CY 2026 with a plan to increase the reduction amount above the 0.5% in CY 2027 and with an unspecified reduction to remain in effect until the estimated payment reduction reaches $7.8 billion.

*Eliminating the Inpatient Only (IPO) List:*

CMS will phase out the IPO list over a 3-year period, beginning with removing 285 mostly musculoskeletal procedures for CY 2026. Procedures removed from the IPO list would be exempted from certain medical review activities related to the two-midnight policy for CY 2026 and subsequent years until CMS determines the service or procedure is more commonly performed in the Medicare population in the outpatient setting. For CY 2026, the Company expects the impact to be immaterial. For CY's 2027 and later, the estimated potential financial impact to the Company cannot be determined until future CMS rulemaking process related to changes in the IPO list occurs.

On November 2, 2023, in light of the Supreme Court's decision in *American Hospital Association v. Becerra* (142 S. Ct. 1896 (2022)) and the district court's remand to the agency, CMS issued a final rule outlining the remedy for the 340B-acquired drug payment policy for calendar years 2018-2022. CMS published the final rule to remedy the payment rates the Court held were invalid aspects of their past policy and will affect nearly all hospitals paid under the OPPS. As part of the final remedy, CMS will make an adjustment to the update factor to maintain budget neutrality as required by statute. CMS finalized the 340B policy for calendar year 2018 in 2017 in a budget neutral manner that included increasing payments for non-drug items and services; this payment increase was in effect from calendar years 2018 through 2022. CMS estimates that hospitals were paid $7.8 billion more for non-drug items and services during this time period than they would have been paid in the absence of the 340B payment policy. Because CMS is now making additional payments to affected 340B covered entity hospitals to pay them what they would have been paid had the 340B policy never been implemented, CMS will make a corresponding offset to maintain budget neutrality as if the 340B payment policy had never been in effect. To carry out this required $7.8 billion budget neutrality adjustment, CMS will reduce future non-drug item and service payments by adjusting the OPPS conversion factor by minus 0.5% starting in calendar year 2026 and continuing for an estimated 16

years. However, as discussed above and as noted in the 2026 OPPS final rule, CMS is likely to shorten the recovery period of the $7.8 billion to less than 17 years starting in calendar year 2027 to a currently unspecified reduction to non-drug item and service payments.

In November, 2024, CMS issued its OPPS final rule for 2025. The hospital market basket increase is 3.4% and the productivity adjustment reduction is 0.5% for a net market basket increase of 2.9%. When other statutorily required adjustments and hospital patient service mix are considered, including a 14.2% increase to the partial hospitalization rate, we estimate that our overall Medicare OPPS update for 2025 will aggregate to a net increase of 3.6%.

In November, 2023, CMS issued its OPPS final rule for 2024. The hospital market basket increase is 3.3% and the productivity adjustment reduction is 0.2% for a net market basket increase of 3.1%. When other statutorily required adjustments and hospital patient service mix are considered, we estimate that our overall Medicare OPPS update for 2024 will aggregate to a net increase of 9.7%. This percentage reflects the impact resulting from rural floor changes to the Medicare wage index adjustment factor where certain states, such as California and Nevada, will materially benefit from this change.

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: hospitals to make public: (1) their standard changes (both gross charges and payer-specific negotiated charges) for all items and services online in a machine-readable format, and; (2) 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. In November, 2023, CMS finalized multiple provisions, effective as of January 1, 2024, focused on increasing hospital price transparency and compliance enforcement including but not limited to: (1) standard charges data would be posted online using a CMS template, instead of using the hospital’s own form/format; (2) all standard charge information would be encoded with a specified set of data elements (e.g., hospital name, license number, payer/plan name, description of service and billing codes, among others); (3) other technical changes related to increasing consumers’ automated accessibility to hospital standard charges, and; (4) certifications regarding accuracy of standard charge data and related compliance warning notices from CMS and requiring accessibility to health system leadership regarding transparency noncompliance.

In September, 2024, the Departments of Labor, Health and Human Services and the Treasury published final rules that:

- Mandate that insurers analyze the outcomes of their coverage to ensure there's equivalent access to mental health care, including provider networks, prior authorization rates and payment for out-of-network providers, and take action to get in compliance;
- Establish when health plans can’t use prior authorization or other tactics to make it more difficult to access mental health and substance use treatment, and;
- Require additional insurers to comply with the 2008 Mental Health Parity and Addiction Equity Act.

While these rules will likely improve patient access to inpatient and outpatient mental health services, we are unable to estimate the related potential impact on our results of operations.

*Medicare Advantage Payment Annual Update:*

In April, 2026, CMS released the calendar year 2027 ("CY 2027") rate announcement for the MA that finalizes the payment policies for this program. Payments from the government to MA plans are expected to increase on average by 2.48% from 2026 to 2027 excluding the CMS estimate of Medicare Advantage risk score trend. This change represents an increase of 2.39% since the CY 2027 announcement, which is largely attributable to a favorable change in risk model adjustment factor percentage.

In April, 2025, the CMS released the calendar year 2026 ("CY 2026") rate announcement for the MA that finalizes the payment policies for this program. Payments from the government to MA plans are expected to increase on average by 5.06% from 2025 to 2026 excluding the CMS estimate of Medicare Advantage risk score trend. This change represents an increase of 2.83% since the CY 2026 announcement, which is largely attributable to an increase in the effective growth rate.

**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 Nevada, California, Texas, Washington,

D.C., Illinois, Pennsylvania, Kentucky, Ohio, Virginia, Massachusetts, Michigan, Mississippi, Florida and Tennessee. We also receive Medicaid disproportionate share hospital payments in certain states including, most significantly, Texas. Many of these programs have a Medicaid supplemental payment component that are subject to approval on a year-to-year basis and there is no assurance that these supplemental payment revenues will continue at their current rates or at all. 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 ACA 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 ACA 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 ACA 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.

***Summary of Various State Medicaid Supplemental Payment Programs:***

As noted elsewhere herein, the OBBBA has specific legislative language that will reduce Medicaid supplemental payments as well as limit Provider Taxes used by states to finance the non-federal share of Medicaid supplemental payments. The following table summarizes the revenues, healthcare provider taxes (“Provider Taxes”) and net benefit related to each of the below-mentioned Medicaid supplemental programs for the three-month periods ended March 31, 2026 and 2025. The Provider Taxes are recorded in other operating expenses on the consolidated statements of income, as included herein. The "Projected Full Year 2026" amounts reflected on the table below are, in many cases, subject to federal and potentially state approval and may be affected by any reductions or other changes in federal funding for these programs.

| | (amounts in millions) | | |
|---|---|---|---|
| | | Three Months Ended | |
| | Projected Full Year 2026 | March 31, 2026 | March 31, 2025 |
| **Texas Supplemental Payment Programs:** | | | |
| Revenues | $ 328 | $ 70 | $ 47 |
| Provider Taxes | (138) | (28) | (19) |
| Net benefit | $ 190 | $ 42 | $ 28 |
| | | | |
| **Nevada SDP:** | | | |
| Revenues | $ 458 | $ 146 | $ 87 |
| Provider Taxes | (162) | (50) | (31) |
| Net benefit | $ 296 | $ 96 | $ 56 |
| | | | |
| **Various Other State Programs:** | | | |
| Revenues | $ 1,203 | $ 305 | $ 207 |
| Provider Taxes | (368) | (86) | (67) |
| Net benefit | $ 835 | $ 219 | $ 140 |
| | | | |
| **Subtotal-Provider Tax Programs:** | | | |
| Revenues | $ 1,989 | $ 521 | $ 341 |
| Provider Taxes | (668) | (164) | (117) |
| Aggregate net benefit from Provider Tax Programs | $ 1,321 | $ 357 | $ 224 |
| | | | |
| **Texas, Nevada and South Carolina DSH/SPA Programs:** | | | |
| Revenues | $ 41 | $ 12 | $ 12 |
| Provider Taxes | 0 | 0 | 0 |
| Net benefit | $ 41 | $ 12 | $ 12 |
| | | | |
| **Total Supplemental Medicaid Programs:** | | | |
| Revenues | $ 2,030 | $ 533 | $ 353 |
| Provider Taxes | (668) | (164) | (117) |
| Aggregate net benefit from all Supplemental Programs | $ 1,362 | $ 369 | $ 236 |

***Texas Supplemental Payment Programs:***

Certain of our acute care hospitals located in various counties of Texas participate in Medicaid supplemental payment Section 1115 Waiver indigent care programs. The 1115 Waiver has been approved by CMS through September 30, 2030. 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.

***CHIRP (including QIF)***

On July 31, 2023, CMS approved the Comprehensive Hospital Increase Reimbursement Program ("CHIRP"), with a pool of $6.5 billion, for the rate period of September 1, 2023 to August 31, 2024. On September 13, 2024, CMS approved the CHIRP program with a pool of $6.5 billion for the rate period September 1, 2024 to August 31, 2025 (with an amended CMS approval on October 1, 2024). A CHIRP preprint for the rate period September 1, 2025 to August 31, 2026 was approved by CMS in August, 2025 with a pool size of $9.2 billion. This program is estimated to increase reimbursement to our hospitals by approximately $20 million to $23 million in program year 2026.

CHIRP payments beginning with the state fiscal year 2025 rate period included modifications to promote the advancement of the quality goals and strategies the program is designed to advance.

The final modifications include:

- Creation of a new pay-for-performance incentive payment through a third component in CHIRP, the Alternate Participating Hospital Reimbursement for Improving Quality Award ("APHRIQA"). For state fiscal years beginning with SFY 2025, behavioral health hospitals and rural hospitals will not be included in the pay-for-performance program, and;
- The funds for payment of the APHRIQA component will be transitioned from the existing uniform rate increase components of the Uniform Hospital Rate Increase Percentage and the Average Commercial Incentive Award and will be paid using a scorecard that directs managed care organizations to pay providers for performance achievements on quality outcome measures. Payments will be distributed under APHRIQA on a semi-annual basis that aligns with the measurement period determined for quality metrics reporting.

CHIRP payment levels could be reduced materially if our hospitals are not able meet the required APHRIQA pay-for-performance metrics.

In connection with the Quality Incentive Fund (“QIF”), certain of our acute care hospitals located in Texas may earn incentive payments pursuant to contractual arrangements with Medicaid managed care plans. No QIF revenues were recorded during the three-month periods ended March 31, 2026 and 2025. These amounts were 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 CHIRP payments are less than targeted CHIRP payments for a specific rate year.

We estimate that these hospitals will be entitled to approximately $18 million of aggregate QIF revenues during the year ended December 31, 2026.

***UC***

Included in these provider tax programs are reimbursements received in connection with the Texas Uncompensated Care program ("UC"). The size and distribution of the UC pool are determined based on charity care costs reported to THHSC in accordance with Medicare cost report Worksheet S-10 principles.

***HARP***

The Hospital Augmented Reimbursement Program (“HARP”) provides additional funding to hospitals to help offset the cost hospitals incur while providing Medicaid services. HARP is technically a Medicaid Upper Payment Limit as payment under this program is based on a reasonable estimate of the amount that would be paid for the services under Medicare payment principles but is referred to as HARP by THHSC.

In connection with this program, included in our results of operations was approximately $5 million and $6 million recorded during the three-month periods ended March 31, 2026 and 2025, respectively.

We expect our net reimbursements pursuant to HARP to approximate $19 million during the year ended December 31, 2026.

***ATLIS***

In March 2026, the HHSC initiated plans to restart the Aligning Technology by Linking Interoperable Systems ("ATLIS") program for program year 2 covering FFY 2026. Although our acute care hospitals in Texas participated in the ATLIS program during year 1, the impact was not material to our results of operations. For year 2, the ATLIS pool will be comparable in size to the year 1 pool amounting to approximately $930 million. Participation terms for the ATLIS program in year 2 are not yet finalized so we are uncertain as to the impact on our results of operations. However, under certain participation scenarios, the ATLIS program in year 2 (FFY 2026) could have a favorable material impact on our results of operations.

***Nevada State Directed Payment Program ("SDP"):***

Beginning with the period of January 1, 2024 through December 31, 2024 CMS approved a new hospital SDP in Nevada. Payments made pursuant to this component of the Nevada SDP program, which requires annual approval by CMS, are subject to reconciliation by the Division of Health Care Financing and Policy ("DHCFP") based on actual Medicaid managed care utilization during 2024 and each year thereafter. The Nevada SDP (as revised in February, 2026) for the period of January 1, 2025 through December 31, 2025 was approved by CMS. In March 2026, CMS also approved the preprint for the period January 1, 2026 to December 31, 2026. There can be no assurance that the Medicaid managed care component of the Nevada SDP will continue for any period after December 31, 2026, or that it will not be modified.

In connection with this program, included in our results of operations was approximately $96 million and $56 million recorded during the three-month periods ended March 31, 2026 and 2025, respectively. Approximately $30 million of the amount recorded during the first quarter of 2026 relates to the period of January 1, 2025 to December 31, 2025.

We estimate that our aggregate net reimbursements pursuant to both components of the Nevada SDP program (net of related provider taxes) will approximate $296 million during the year ended December 31, 2026.

***Various Other State Programs:***

We receive substantial reimbursement from multiple states in connection with various supplemental Medicaid payment programs. The states include, but are not limited to, the state programs listed below from which we receive significant reimbursements.

***Kentucky Hospital Rate Increase Program ("HRIP")***

In early 2021, CMS approved the Kentucky Medicaid Managed Care Hospital Rate Increase Program. In February, 2026, CMS approved the program for the period of January 1, 2026 through December 31, 2026 whereby the HRIP pool size will increase from $2.4 billion to $2.8 billion.

In connection with this program, included in our results of operations was $24 million and $22 million during the three-month periods ended March 31, 2026 and 2025, respectively. We estimate that our net reimbursements pursuant to HRIP will approximate $106 million during the year ended December 31, 2026.

***California Supplemental Payments***

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, 2024 | Approved through December 31, 2024; Paid through December 31, 2024 |
| Managed Care-Pass-Through Payment | Approved through December 31, 2024 | Approved through December 31, 2023 and paid in advance through December 31, 2024 |
| Managed Care-Directed Payment | Approved through December 31, 2024 | Approved through December 31, 2023 and paid in advance through June 30, 2024 |

In connection with this program, included in our results of operations was $17 million and $16 million during the three-month periods ended March 31, 2026 and 2025, respectively. During the first quarter of 2026, the Department of Health Care Services submitted an amended final draft of the Hospital Quality Assurance Fee program 9 fee to CMS for approval for the period January 1, 2025 to December 31, 2025. This submission includes the Managed Care-Directed Payment preprint. We are unable to predict the outcome, amount or timing of any related increase that may result from this submission.

We estimate that our net reimbursements pursuant to this program will approximate $68 million during the year ended December 31, 2026.

***Mississippi Hospital Access Program***

Beginning July 1, 2023, Mississippi implemented a two part Medicaid payment program that is funded by annual hospital assessments to the state's Medicaid program. These hospital assessments are calculated using a formula provided under state law. The first part of the program, known as the Mississippi Hospital Access Program ("MHAP"), provides direct payments for hospitals that serve patients in the state's Medicaid managed care delivery system. Hospitals are reimbursed near the average commercial rate, which is the upper limit ("UPL") for Medicaid managed care reimbursements. The second part of the program supplements traditional Medicaid payment rates for hospitals providing inpatient and outpatient services up to Medicaid's regulated UPL. In June 2024, CMS approved the MHAP program component for the period July 1, 2024 to June 30, 2025. The UPL component was approved in April, 2024. In September 2025, CMS approved the MHAP program component for the period July 1, 2025 to June 30, 2026. The UPL component was approved in April 2024.

In connection with this program, included in our results of operations was approximately $12 million and $11 million recorded during the three-month periods ended March 31, 2026 and 2025, respectively.

We estimate that our net reimbursements pursuant to these supplemental payment programs will approximate $59 million during the year ended December 31, 2026.

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

The Florida DPP provides for an additional payment for Medicaid managed care contracted services which is typically recorded during the fourth quarter of each year.

In April, 2026, CMS approved the Florida DPP for the period of October 1, 2024 to September 30, 2025. The approved DPP preprint includes: (i) a request to increase the size of the program and related DPP add-on payment levels based on a percentage of average commercial rates, and; (ii) change in the provider tax structure which in the aggregate was favorable to our hospitals.

Pursuant to this recently approved program, we estimate that the annual aggregate net benefit applicable to our facilities will increase by approximately $100 million (applicable to the period of October 1, 2024 through September 30, 2025), which we expect to record during the second quarter of 2026. This $100 million incremental increase to the Florida DPP program is not yet reflected in the above Medicaid Supplemental Provider Tax table.

Excluding the $100 million increase as discussed above, we estimate that our reimbursements pursuant to this DPP will approximate $53 million during the year ended December 31, 2026 (applicable to the period of October 1, 2025 to September 30, 2026). However, the DPP program preprint for the period October 1, 2025 to September 30, 2026 is still pending the state Medicaid agency's submission for CMS approval. The state agency submitted provider tax waivers from the federal provider tax broad based requirement. We are uncertain as to whether or not CMS will approve the DPP program preprint for the period October 1, 2025 to September 30, 2026, or the ultimate amount and timing of such approval.

***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. These programs require various related legislative and regulatory approvals each year.

In connection with this program, included in our results of operations was approximately $8 million and $10 million recorded during the three-month periods ended March 31, 2026 and 2025, respectively.

We estimate that our net reimbursements pursuant to these supplemental payment programs will approximate $32 million during the year ended December 31, 2026. Approval of these programs for the period of January 1, 2026 to December 31, 2026 is under CMS' review.

***Indiana Medicaid Managed Care DPP***

The Indiana DPP provides for an additional payment for Medicaid managed care contracted services. In connection with this program, included in our results of operations was approximately $10 million and $8 million recorded during the three-month periods ended March 31, 2026 and 2025, respectively.

We estimate that our net reimbursements pursuant to this program will approximate $35 million during the year ended December 31, 2026.

***Oklahoma (Transition to Managed Care and Implementation of a Medicaid Managed Care DPP)***

The current Oklahoma Medicaid supplemental payment program in effect, prior to the planned implementation of the new DPP in 2024, is the Supplemental Hospital Offset Payment Program ("SHOPP"). The SHOPP component will remain in place for certain categories of Medicaid patients that will continue to be enrolled in the traditional Medicaid Fee for Service program.

In May, 2022, Oklahoma enacted legislation 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 90% of 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. In September, 2023, CMS approved the DPP program for the 15-month period effective as of April 1, 2024 through June 30, 2025. CMS approval of the DPP program for the period July 1, 2025 to June 30, 2026 is pending.

In connection with this program, included in our results of operations was approximately $7 million recorded during both three-month periods ended March 31, 2026 and 2025, respectively.

We estimate that our net reimbursements pursuant to these two supplemental payment programs (i.e. SHOPP and DPP) will approximate $27 million during the year ended December 31, 2026.

***South Carolina Health Access, Workforce and Quality ("HAWQ") Program***

In September 2023, CMS approved the South Carolina HAWQ Program retroactive to July 1, 2023 and subsequently approved by CMS in July, 2024 for the period of July 1, 2024 to June 30, 2025. In December 2025, CMS approved the period July 1, 2025 to June 30, 2026. This program is a Medicaid managed care directed payment program that provides for a rate enhancement to Medicaid managed care encounters. In connection with this program, included in our results of operations was approximately $7 million and $9 million recorded during the three-month periods ended March 31, 2026 and 2025, respectively.

We estimate that our net reimbursements pursuant to this program will approximate $28 million during the year ended December 31, 2026.

***Michigan Directed Payment Program ("DPP")***

In March 2024, CMS approved the Michigan Medicaid DPP retroactive to October 1, 2023 based on average commercial rates. The Michigan DPP provides for an additional payment for Medicaid managed care contracted services. In connection with this program, included in our results of operations was approximately $11 million and $7 million recorded during the three-month periods ended March 31, 2026 and 2025, respectively.

We estimate that our net reimbursements pursuant to this program will approximate $46 million during the year ended December 31, 2026. The Michigan DPP for the period of October 1, 2025 to September 30, 2026 was approved by CMS.

***Idaho Upper Payment Limit ("UPL")***

In April 2024, the Idaho Department of Health and Welfare ("IDHW") released its updated Medicaid UPL calculation for SFY 2024 (July 1, 2023 to June 30, 2024) and revised its SFY 2023 (July 1, 2022 to June 30, 2023) UPL calculation. Subject to CMS approval, the IDHW plans to continue this UPL program through SFY 2026 (July 1, 2025 to June 30, 2026). Due to the transition of to Medicaid managed care on July 1, 2024 and the end of the two year run out, the UPL program will sunset June 30, 2026. For SFY 2026, the IDHW will not replace the UPL program with a Medicaid managed care state directed payment program..

In connection with this program, included in our results of operations was approximately $4 million and $5 million recorded during the three-month periods ended March 31, 2026 and 2025, respectively.

We estimate that our net reimbursements pursuant to this program will approximate $8 million during the year ended December 31, 2026.

***Washington Safety Net Assessment Program***

On April 2, 2024, CMS approved an expanded state directed payment program in Washington whereby payments will now be based on the average commercial rates. The program was approved retroactively for the period January 1, 2024 to December 31, 2024.

In connection with this program, included in our results of operations was approximately $11 million and $12 million recorded during the three-month periods ended March 31, 2026 and 2025, respectively.

We estimate that our net reimbursements pursuant to this expanded program will approximate $42 million during the year ended December 31, 2026. The program for the period of January 1, 2025 to December 31, 2025 was approved by CMS.

***New Mexico State Directed Payment Program ("SDP")***

In November, 2024, CMS approved the New Mexico Medicaid SDP, retroactive to July 1, 2024, based on average commercial rates. The New Mexico SDP provides for an additional payment for Medicaid managed care contracted services. The program requires the submission of an annual report that demonstrates that 75% of the incremental net funds were used for the delivery of and access to healthcare services in the state.

The New Mexico SDP for the period of January 1, 2025 to December 31, 2025 was approved by CMS.

In connection with this program, included in our results of operations was approximately $10 million and $4 million recorded during the three-month periods ended March 31, 2026 and 2025, respectively.

We estimate that our net reimbursements pursuant to this program will approximate $26 million during the year ended December 31, 2026.

***Tennessee Directed Payment Program ("DPP")***

Tennessee SB1740, enacted in May, 2024, imposes an annual coverage assessment on covered hospitals for fiscal year 2024-2025. The total assessment on all covered hospitals in the aggregate will be equal to 6% of the federally recognized annual coverage assessment base. The assessment proceeds will be used to fund an increase to the state's DPP payment pool to be based on average commercial rates.

In January, 2025, CMS approved the DPP payment increase for the period July 1, 2024 to December 31, 2024, contingent upon CMS' approval of the state's 1115 Medicaid Waiver amendment. In addition, the DPP program for calendar year 2025 (January 1, 2025 to December 31, 2025) was approved by CMS in April, 2025, also contingent upon CMS' approval of the state's 1115 Medicaid Waiver amendment which was approved by CMS in June, 2025.

In connection with this program, included in our results of operations was approximately $17 million recorded during the three-month period ended March 31, 2026 and no revenue was recorded during the three-month period ended March 31, 2025

We estimate that our net reimbursements pursuant to this program will approximate $54 million during the year ended December 31, 2026.

***Washington, D.C. State Directed Payment program ("SDP")***

In September, 2025, CMS approved the SDP program for the period October 1, 2024 to September 30, 2025. This SDP program provides for an add-on to in-network Medicaid managed care paid claims.

In connection with this program, included in our results of operations was approximately $27 million recorded during the three-month period ended March 31, 2026. No revenues related to the program were recorded in the three-month period ending March 31, 2025.

We estimate that our net reimbursements pursuant to this program will approximate $107 million during the year ended December 31, 2026.

***Ohio Medicaid Managed Care DPP***

The Ohio DPP provides for an additional payment for Medicaid managed care contracted services. In connection with this program, included in our results of operations was approximately $26 million and $4 million recorded during the three-month periods ended March 31, 2026 and 2025, respectively.

We estimate that our net reimbursements pursuant to this program will approximate $50 million during the year ended December 31, 2026, approximately $16 million of which relates to the period January through December, 2025.

***Texas DSH and Nevada SPA Programs:***

***Texas DSH***

Upon meeting certain conditions and serving a disproportionately high share of Texas' low income patients, our qualifying facilities located in Texas receive additional reimbursement from the state's DSH fund. The Texas DSH program was renewed for the state's 2026 DSH fiscal year (covering the period of October 1, 2025 through September 30, 2026).

In connection with this program, included in our results of operations was approximately $8 million recorded during both the three-month periods ended March 31, 2026 and 2025.

We estimate that our aggregate net reimbursements earned pursuant to the Texas DSH program will approximate $24 million during the year ended December 31, 2026.

The ACA and subsequent federal legislation provides for a significant reduction in Medicaid disproportionate share payments beginning in federal fiscal year 2028 (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, will be reduced in the coming years. Based on the CMS final rule published in September, 2019 (as amended by the CARES Act and the CAA), beginning in fiscal year 2026, annual Medicaid DSH payments in Texas could be reduced by approximately 33% from current DSH payment levels. However, states have discretion in the allocation of their respective federal DSH allotment and we do not believe the state's allocation will result in a material decrease to DSH payment levels to our hospitals located in Texas. A series of federal continuing resolutions were passed by the federal government which provided for ongoing federal funding.

In connection with certain previous DSH and UC adverse federal court decisions, including the *Children's Hospital Association of Texas v. Azar*, 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 $33 million as of both March 31, 2026 and December 31, 2025.

***Nevada 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 2024 fiscal year covering the period of July 1, 2023 through June 30, 2024. CMS approval for the 2025 and 2026 fiscal years, which is still pending, is expected to occur.

In connection with this program, included in our results of operations was approximately $4 million recorded during both the three-month periods ended March 31, 2026 and 2025.
We estimate that our net reimbursements pursuant to this program will approximate $17 million during the year ended December 31, 2026

***Legislation Commonly Known as the One Big Beautiful Bill Act ("OBBBA")***

The OBBBA was enacted into law on July 4, 2025. This legislation includes material changes to the Medicaid program and other healthcare related programs including but not limited to:

***Medicaid State Directed Payments ("SDP")***

- In states that expanded their Medicaid programs under the ACA ("Expansion States"), the SDP payment rate is capped at 100% of Medicare.
- For states that did not expand Medicaid under the ACA ("Non-Expansion States"), the SDP rate is capped at 110% of Medicare.
- These provisions grandfathered SDP programs already in existence or pending approval from CMS. Beginning with the 2028 state fiscal years, SDP provisions pursuant to the OBBBA are being phased in whereby grandfathered payment plans will be reduced by no more than 10% annually until the applicable Medicare rate is reached.

***Limits on Provider Taxes***

- Prior law capped Provider Taxes at 6% of net patient revenue. The new law reduces the percentage of revenue that can be taxed as a Provider Tax.
- The Provider Tax provisions pursuant to the OBBBA are largely being phased in over a 5-year period.
- In Expansion States, beginning with the 2028 state fiscal years, this percentage will be reduced by 0.5% each year until it reaches 3.5%. In Non-Expansion States, the Provider Tax percentage will remain unchanged.
- Establishes new discretion for CMS to refuse waivers of Provider Tax uniformity requirement.
- In January 2026, CMS issued its Medicaid Provider Tax Rule final rule changing how state provider taxes are evaluated for compliance with federal requirements. Transition periods for state compliance with the new requirements will vary based on state specific circumstances. We are unable to determine the financial impact on our future Medicaid supplemental payments.

***Rural Health Transformation Program***

- Establishes a $50 billion rural health grant program for states between fiscal years 2026 and 2030 to be used for payments to rural health facilities. 50% of the fund will go to states equally and 50% will be allocated based on a rural formula determined by the HHS Secretary.
- In December 2025, The Centers for Medicare & Medicaid Services (CMS) announced that all 50 states will receive awards under the Rural Health Transformation Program. In 2026, states will receive first-year awards from CMS averaging $200 million within a range of $147 million to $281 million. The state of Texas received the highest award amount.
- Although certain of our hospitals that are designated by CMS as rural may be eligible for reimbursement pursuant to this fund, we are unable to predict if any of our facilities will ultimately qualify for reimbursement and are therefore unable to quantify any potential favorable impact on our future results of operations.

***Medicaid Eligibility:***

- Institutes an 80-hour a month work requirement for all Medicaid individuals ages 19-64 at least every 6 months, with some exceptions.
- Requires states to conduct eligibility redeterminations at least every 6 months for Medicaid expansion adults effective no later than January 1, 2027.
- Although we cannot predict the potential unfavorable impact on our future results of operations from these changes to Medicaid eligibility requirements, these changes could reduce the overall number of Medicaid enrollees thereby potentially decreasing our Medicaid revenues (including revenues earned pursuant to various state Medicaid supplemental payment programs) while potentially increasing the level of uncompensated care provided by our facilities.

As noted above, the OBBBA has specific legislative language that will reduce SDP payments as well as limit Provider Taxes used by states to finance the non-federal share of Medicaid supplemental payments. However, certain OBBBA provisions that would impact payment levels could be subject to some interpretation by CMS and related future federal rulemaking such as the definition of an SDP grandfathered program.

Based upon our current 2025 full year net benefit related to various state Medicaid supplemental payment programs, amounting to approximately $1.361 billion, as reflected on the table above in Summary of Various State Medicaid Supplemental Payment Programs, we estimate that, commencing with the 2028 state fiscal years, our aggregate annual net benefit will be reduced, on an annually increasing and relatively pro rata basis, by approximately $432 million to $480 million by 2032. We cannot predict, among other things, if this legislation will ultimately be implemented as enacted, or if certain states may attempt to modify their respective SDP program in response to the OBBBA legislation. Given the various uncertainties and evolving state-by-state interpretations and computations related to this legislation, our forecasted estimates are subject to change, potentially by material amounts.

***Other 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. 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 cause our estimates to differ by material amounts which 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.

We receive Medicaid SDP payments from MCOs authorized by CMS under 42 CFR § 438.6(c). Consistent with capitated rates paid by Medicaid state agencies to MCO's for managing Medicaid beneficiary lives under a risk-based arrangement, SDP program related capitated rates must also be developed by the state in accordance with actuarial soundness standards noted at 42 CFR § 438.4 and non-compliance could result in a reduction to SDP payment levels. In general, Medicaid SDP payments under 42 CFR § 438.6(c) are subject to annual CMS approval via the submission of a preprint application by a state agency which provides details of the SDP payment methodology and conformity with applicable federal regulations. CMS SDP preprint approval, and the timing of such approval, if it occurs, are not certain which can affect the both the SDP payment level and timing of SDP revenue recorded by us.

We incur 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 that are used by respective states to finance the non-federal share of SDP's (or other Medicaid supplemental payment programs). 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 supplemental payment programs. States are subject to CMS both concurrent and retrospective review for their compliance with the applicable Provider Tax regulations and related federal statute. If CMS determines Provider Taxes used by a state Medicaid program to finance the non-federal share of a SDP (or other Medicaid supplemental payment programs) are not in compliance with the applicable Provider Tax regulations and related federal statutes, our SDP payments (and other Medicaid supplemental payments) could be subject to recoupment by the respective state agency when non-compliance is determined by CMS to exist.

We believe that the SDP (and other state supplemental payment) programs are designed by each state to be in full compliance with the applicable federal regulations and federal statutes. However, we are unable to provide assurance CMS will determine on a retroactive basis that a state's SDP (or other Medicaid supplemental payment program) design and Medicaid financing structures is in full compliance with the applicable federal regulations and federal statute(s).

On April 22, 2024, CMS issued Medicaid and Children's Health Insurance Program ("CHIP") Managed Care Access, Finance, and Quality Final Rule ("Managed Care Rule"). CMS intends for the Managed Care Rule to:

- Strengthen standard for timely access to care and states' monitoring and enforcement efforts;
- Enhance quality and fiscal and program integrity standards for state directed payments ("SDPs");
- Specify the scope of in lieu of services and settings to better address health-related social needs;
- Further specify medical loss ratio requirements, and;
- Establish a quality rating system for Medicaid and CHIP managed care plans.

The SDP provisions included in the Managed Care Rule:

- Requires that provider payment levels for state directed payments for inpatient and outpatient hospital services, nursing facility services, and the professional services at an academic medical center not exceed the average commercial rate;
- Prohibits the use of post-payment reconciliation processes for state directed payments that are based on fee schedules;
- Makes explicit in regulation the existing requirement that state directed payments must comply with all federal laws concerning funding sources of the non-federal share, and;
- Requires 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. CMS concurrently released an informational bulletin regarding CMS' exercise of enforcement discretion until calendar year 2028 for existing health-care related tax programs with certain hold-harmless arrangements involving the redistribution of Medicaid payments.

***Fee-For-Service Short-Doyle Medi-Cal ("SD/MC") Hospitals Change In Payment Methodology:***

Under the California Medicaid prepaid inpatient health plan program, counties are required to ensure delivery of mental health services utilizing a system of county operated and contract providers. The California Medicaid program has adopted a new reimbursement method for inpatient psychiatric services with an effective date of December 12, 2023, incorporated a cost-based ceiling to negotiated rates. This change may require renegotiation of contracts our hospitals have had with counties, retroactive to December 12, 2023, and may also impact prospective rate negotiations. New California Medicaid rates could be materially lower than prior payment rates particularly if counties look to limit payment rates to a cost-based methodology rather than a market-based negotiated rate. We are awaiting formal guidance from California as to the manner in which this change will be implemented and whether the reimbursement method will change prospectively. Further, it is uncertain at this time whether and how counties will retroactively apply this change in method retroactively to December 12, 2023, given the previously negotiated payment terms. We are unable to predict with certainty the impact of this SPA at this time. However, under some scenarios, the adverse financial impact could be material.

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.

Future changes to the terms and conditions of the various programs outlined above could materially reduce our net benefit derived from the programs which could have a material adverse impact on our future 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 results of operations.

**HITECH Act:** In July 2010, HHS published final regulations implementing the health information technology 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 ("IDR") 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 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 by the IDR entity and providing additional factors the IDR entity should consider when choosing between two competing offers. CMS regulations and guidance implementing the IDR process has been subject to a significant amount of provider-initiated litigation. As a result, portions of those regulations and guidance materials have been vacated by a federal district court, causing CMS to, on several occasions, pause and resume IDR process operations, causing significant delay in the processing of claims. On October 27, 2023, HHS, the Department of Labor, the Department of the Treasury, and OPM issued a proposed rule intended to improve the functioning of the federal IDR process. Additionally, arguments made by the plaintiffs in such litigation have included allegations that CMS's regulations and guidance materials are favorable to payers. We cannot predict the impact of the proposed rule on our operations at this time.

**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 ACA.

***Medicaid Federal DSH Allotment:***

The ACA (amended by subsequent federal legislation) requires annual aggregate reductions in federal Medicaid DSH allotment. In FFY 2028, DSH payments are scheduled to be reduced by $8 billion.

***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 ACA required HHS to implement a value-based purchasing program for inpatient hospital services which became effective on October 1, 2012. The ACA 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 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. In FFY 2024, as part of the FFY 2024 IPPS final rule, CMS removed the budget neutral policy that was in place in FFY 2022 and FFY 2023.

***Hospital Acquired Conditions:***

The ACA 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 suppressed all nine measures in the HAC Reduction Program for the FY 2023 program year and eliminated the HAC reduction program’s one percent payment penalty. In FFY 2024, as part of the FFY 2024 IPPS final rule, CMS eliminated the suppression of the applicable HAC measures and as a result reinstated the HAC reduction program.

***Readmission Reduction Program:***

In the ACA, 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% reduction. As part of the FFY 2023 IPPS final rule discussed above, CMS modified all of the condition-specific readmission measures to include an adjustment for patient history of COVID-19 for FFY 2024.

***Accountable Care Organizations:***

The ACA 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 also developed and implemented more advanced ACO payment models that require ACOs to assume greater risk for attributed beneficiaries. Through various subsidiaries, we participate in ACOs in many of our acute care hospital markets.

***Infectious Disease Outbreaks, Pandemics, or Other Public Health Emergencies or Crisis:***

Our business and financial results may be harmed by an international, national or localized outbreak of a highly contagious or epidemic disease, including but not limited to, COVID-19 or similar corona viruses, Ebola or Zika. Such outbreaks may stress the capacity of all or a part of our health care facilities, could result in an abnormally high demand for health care services which may require that resources be diverted from one part of operations to another, or disrupt the supply chain for equipment and supplies necessary for operations. In addition, unaffected individuals may decide to defer elective procedures or otherwise avoid medical treatment, resulting in reduced patient volumes and operating revenues.

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 $37 million and $40 million for the three-month periods ended March 31, 2026 and 2025 (amounts in thousands):

| | Three Months Ended March 31, 2026 | Three Months Ended March 31, 2025 |
|---|---|---|
| Revolving credit facility (a.) | $ 5,902 | $ 1,794 |
| Tranche A term loan, 2029 (a.) | 14,636 | 17,192 |
| $800 million, 2.65% Senior Notes due 2030 | 5,356 | 5,356 |
| $700 million, 1.65% Senior Notes due 2026 | 2,932 | 2,932 |
| $500 million, 2.65% Senior Notes due 2032 | 3,345 | 3,345 |
| $500 million, 4.625% Senior Notes due 2029 | 5,792 | 5,792 |
| $500 million, 5.050% Senior Notes due 2034 | 6,352 | 6,352 |
| Subtotal-revolving credit, term loan A and Senior Notes | 44,315 | 42,763 |
| Amortization of financing fees | 1,251 | 1,252 |
| Other combined interest expense | 1,961 | 3,031 |
| Capitalized interest on major projects | (10,303) | (6,583) |
| Interest income | (91) | (407) |
| Interest expense, net | $ 37,133 | $ 40,056 |

(a.) Interest on outstanding borrowings pursuant to our Credit Agreement, as discussed herein.

Interest expense decreased by $3 million, or 7%, during the three-month period ended March 31, 2026, as compared to the three-month period ended March 31, 2025. The decrease was due to: (i) a net $2 million increase in aggregate interest expense on our revolving credit, term loan A and senior notes resulting from a decrease in our aggregate average cost of borrowings pursuant to these facilities (3.84% during the first quarter of 2026 as compared to 3.98% during the comparable quarter of 2025), as well as an increase in the aggregate average outstanding borrowings pursuant to these facilities ($4.60 billion during the first quarter of 2026 as compared to $4.28 billion during the first quarter of 2025); (ii) a $4 million decrease resulting from an increase in capitalized interest on major projects, and; (iii) a net $1 million decrease in other combined interest expense.

The average effective interest rates, including amortization of deferred financing costs and original issue discount, on borrowings outstanding under our revolving credit, term loan A and senior notes, which amounted to approximately $4.60 billion and $4.28 billion during the first quarters of 2026 and 2025, respectively, were 4.0% and 4.1% during the three-month periods ended March 31, 2026 and 2025, 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, 2026 and 2025 (dollar amounts in thousands):

| | Three months ended | |
|---|---|---|
| | March 31, 2026 | March 31, 2025 |
| Provision for income taxes | $ 110,438 | $ 98,800 |
| Income before income taxes | 469,116 | 420,428 |
| Effective tax rate | 23.5% | 23.5% |

The provision for income taxes increased $12 million during the first quarter of 2026, as compared to the comparable quarter of 2025, due primarily to an increase in the provision for income taxes resulting from the $44 million increase in income before income taxes ($49 million increase in income before income taxes net of a $5 million increase in income attributable to noncontrolling interests).

**Liquidity**

**Net cash provided by operating activities**

Net cash provided by operating activities was $402 million during the three-month period ended March 31, 2026 and $360 million during the first three months of 2025. The net increase of $42 million was attributable to the following:

- a favorable change of $40 million resulting from an increase in net income plus/minus depreciation and amortization expense, stock-based compensation expense and gains on sales of assets and businesses;
- a favorable change of $95 million in accounts receivable (due, in part, to delays experienced during the first quarter of 2025 in receipt of funds in connection with certain Medicaid supplemental payment programs in various states);
- an unfavorable change of $80 million in other working capital accounts due primarily to the timing of accounts payable disbursements, and;
- $13 million of other combined net unfavorable changes.

***Days sales outstanding ("DSO"):*** Our DSO are calculated by dividing our net revenue by the number of days in the 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 55 days and 53 days at March 31, 2026 and 2025, respectively.

**Net cash used in investing activities**

During the first three months of 2026, we used $198 million of net cash in investing activities as follows:

- $217 million spent on capital expenditures including costs related to a new acute care hospital being constructed in Florida, and capital expenditures for equipment, renovations and new projects at existing facilities;
- $15 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;
- $14 million received from the sales of assets and businesses;
- $5 million spent on the acquisition of businesses and property, and;
- $5 million paid in connection with the purchase and development of an enterprise resource planning application.

During the first three months of 2025, we used $271 million of net cash in investing activities as follows:

- $239 million spent on capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities;
- $24 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;
- $8 million spent on the acquisition of businesses and property.

**Net cash used in financing activities**

During the first three months of 2026, we used $222 million of net cash in financing activities as follows:

- spent $164 million to repurchase shares of our Class B Common Stock in connection with: (i) open market purchases pursuant to our stock repurchase program ($127 million), and; (ii) income tax withholding obligations related to stock-based compensation programs ($37 million);
- spent $45 million on net repayments of debt as follows: (i) $36 million related to our revolving credit facility; (ii) $7 million related to our tranche A term loan facility, and; (iii) $2 million related to other debt facilities;
- spent $13 million to pay quarterly cash dividends of $.20 per share;
- spent $8 million to pay profit distributions related to noncontrolling interests in majority owned businesses;
- received $4 million from the sale of ownership interests to minority members, and;
- generated $4 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 2025, we used $91 million of net cash in financing activities as follows:

- spent $223 million to repurchase shares of our Class B Common Stock in connection with: (i) open market purchases pursuant to our stock repurchase program ($181 million), and; (ii) income tax withholding obligations related to stock-based compensation programs ($42 million);
- generated $152 million of additional borrowings as follows: (i) $148 million pursuant to our revolving credit facility, and; (ii) $4 million related to other debt facilities;
- spent $14 million to pay quarterly cash dividends of $.20 per share;
- spent $9 million on net repayments of debt as follows: (i) $7 million related to our tranche A term loan facility, and; (ii) $2 million related to other debt facilities;
- spent $6 million to pay profit distributions related to noncontrolling interests in majority owned businesses;
- received $4 million from the sale of ownership interests to minority members, and;
- generated $4 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

**Expected capital expenditures during remainder of 2026**

During the full year of 2026, we expect to spend approximately $950 million to $1.1 billion 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 2026 we spent approximately $217 million on capital expenditures and expect to spend approximately $733 million to $883 million during the remainder of 2026.

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.

On March 9, 2026, we announced that we entered into a definitive agreement to acquire Talkspace, Inc. ("Talkspace") for $5.25 per share, or approximately $835 million in the aggregate. Talkspace is a virtual behavioral healthcare company, with a network of approximately 6,000 licensed professionals that serve all 50 states, Washington, D.C., and Puerto Rico. We intend to finance the acquisition of Talkspace with additional borrowings pursuant to our Credit Agreement, as amended in April, 2026, as discussed in *Note 4 – Treasury - Credit Facilities and Outstanding Debt Securities.* The transaction is expected to close during the third quarter of 2026 and is subject to approval by Talkspace's stockholders, satisfaction of regulatory approvals and other customary closing conditions.

**Capital Resources**

***Credit Facilities and Outstanding Debt Securities***

On April 22, 2026, we entered into the Eleventh Amendment and Increased Facility Activation Notice (the "Eleventh Amendment") to our credit agreement ("Credit Agreement"), dated as of November 15, 2010, and as amended and restated at various times from March, 2011 to September, 2024, among UHS, as borrower, the several banks and other financial institutions or entities from time to time parties thereto, as lenders, and JPMorgan Chase Bank, N.A., as administrative agent.

The Eleventh Amendment, among other things, increased our borrowing capacity by an aggregate of $900 million as follows: (i) increased the borrowing capacity of the revolving credit facility by $200 million to $1.5 billion (from $1.3 billion previously); (ii) increased the existing tranche term loan A by $300 million to $1.455 billion (from $1.155 billion previously), and; (iii) initiated a new $400 million delayed draw term loan A which is expected to be drawn upon the closing of our acquisition of Talkspace, Inc. The maturity date for our Credit Agreement, which is scheduled for September 26, 2029, remained unchanged. As of March 31, 2026, we had approximately $373 million of borrowings outstanding pursuant to the revolving credit facility.

Prior to the Eleventh Amendment, the tranche term loan A in effect as of March 31, 2026 (outstanding balance of $1.155 billion as of that date), provides for installment payments of $7.5 million per quarter through September 30, 2026, and $15.0 million per quarter commencing on December 31, 2026 through June 30, 2029. The unpaid principal balance at June 30, 2029 (scheduled to be $975.0 million) is payable on the September 26, 2029 scheduled maturity date of the Credit Agreement.

Pursuant to the terms of the Eleventh Amendment, which became effective in April, 2026:

- *Increased tranche term loan A ($300 million)*: Installment payments are scheduled to be $1.875 million per quarter commencing on September 30, 2026 through June 30, 2028, and $3.75 million per quarter commencing on September 30, 2028 through June 30, 2029. The unpaid principal balance at June 30, 2029 (scheduled to be $270.0 million) is payable on the September 26, 2029 scheduled maturity date of the Credit Agreement.

- *Delayed draw term loan A ($400 million)*: Once drawn, the $400 million principal balance will be payable on the September 26, 2029 scheduled maturity date of the Credit Agreement.

Revolving credit and tranche term loan A borrowings under the Credit Agreement, prior to the Eleventh Amendment, 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 greater of the federal funds effective rate and the overnight bank funding rate, plus 0.5% and (c) one month term SOFR rate plus 1.1%, 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 term 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, 2026, the applicable margins were 0.25% for ABR-based loans and 1.25% for SOFR-based loans under the revolving credit and term loan A facilities. The Eleventh Amendment provides for the removal of the .10% credit spread adjustment from existing and increased credit and tranche term loan A borrowings. 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, if sold to a receivables facility pursuant to the Credit Agreement, 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, 2026 and December 31, 2025.

As of March 31, 2026, we had combined aggregate principal of $3.0 billion from the following senior secured notes:

- $700 million of aggregate principal amount of 1.65% senior secured notes due in September, 2026 ("2026 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.
- $500 million of aggregate principal amount of 4.625% senior secured notes due in October, 2029 ("2029 Notes") which were issued on September 26, 2024. Interest on the 2029 Notes is payable on April 15th and October 15th, commencing April 15, 2025 until the maturity date of October 15, 2029.
- $800 million of aggregate principal amount of 2.65% senior secured notes due in October, 2030 ("2030 Notes") which were issued on September 21, 2020. Interest on the 2030 Notes is payable on April 15th and October 15th, until the maturity date of October 15, 2030.
- $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 2032 Notes is payable on January 15th and July 15th until the maturity date of January 15, 2032.
- $500 million of aggregate principal amount of 5.050% senior secured notes due in October, 2034 ("2034 Notes") which were issued on September 26, 2024. Interest on the 2034 Notes is payable on April 15th and October 15th, commencing on April 15, 2025 until the maturity date of October 15, 2034.

The 2026, 2029, 2030, 2032 and 2034 Notes (collectively "All the Notes") are guaranteed (the "Guarantees") on a senior secured basis by all of our existing and future direct and indirect subsidiaries that guarantee our Credit Agreement, other first lien obligations, or any junior lien obligations (the "Subsidiary Guarantors"). All 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 a Company-related receivables facility (as defined in the Indentures pursuant to which All the Notes were issued (the "Indentures"), and certain other excluded assets). The Company's obligations with respect to All 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. However, the liens on the collateral securing All the Notes and the Guarantees will be released if: (i) All 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 All 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 All 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.

In connection with an asset purchase and sale agreement, and related lease agreements, completed with Universal Health Realty Income Trust ("Trust") in December 2021, our consolidated balance sheets at March 31, 2026 and December 31, 2025 reflect financial liabilities, which are included in debt, of approximately $69 million and $70 million, respectively. In connection with that transaction,

as a result of our purchase option within the lease agreements related to two of our facilities, the asset purchase and sale transaction was 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.

At March 31, 2026, the carrying value and fair value of our debt were approximately $4.7 billion and $4.5 billion, respectively. At December 31, 2025, the carrying value and fair value of our debt were approximately $4.8 billion and $4.6 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 39% and 40% as of March 31, 2026 and December 31, 2025, respectively.

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 $1.5 billion revolving credit facility (as amended in April, 2026, as discussed above), which had $373 million of borrowings outstanding as of March 31, 2026, 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, 2026, we had combined aggregate principal of $3.0 billion from All the Notes:

- $700 million of aggregate principal amount of the 2026 Notes;
- $500 million of aggregate principal amount of the 2029 Notes;
- $800 million of aggregate principal amount of the 2030 Notes;
- $500 million of aggregate principal amount of the 2032 Notes, and;
- $500 million of aggregate principal amount of the 2034 Notes.

All the Notes are fully and unconditionally guaranteed pursuant to the Guarantees on a senior secured basis by the Subsidiary Guarantors. All 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 All the Notes were issued ), and certain other excluded assets). The Company’s obligations with respect to All 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. However, the liens on the collateral securing All the Notes and the Guarantees will be released if: (i) All 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 All 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 All 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.

All 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 All 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 All the Notes may not produce proceeds in an amount sufficient to pay any amounts due on All 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 All 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 All the Notes, subject to collateral arrangements, the holders of that debt will be entitled to share

ratably with holders of All the Notes 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 All the Notes.

Federal and state fraudulent transfer and conveyance statutes may apply to the issuance of All 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, All 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 All 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 All 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, 2026 | December 31, 2025 |
|---|---|---|
| Current assets | $ 2,846,780 | $ 2,746,857 |
| Noncurrent assets (1) | 9,503,036 | 9,453,432 |
| Current liabilities | 2,851,937 | 2,837,781 |
| Noncurrent liabilities | 4,784,092 | 4,828,865 |
| Due to non-guarantors | 1,235,385 | 1,235,522 |

(1) Includes goodwill of $3.262 billion as of March 31, 2026 and December 31, 2025.

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, 2026 | Twelve Months Ended December 31, 2025 |
|---|---|---|
| Net revenues | $ 3,546,372 | $ 13,798,773 |
| Operating charges | 3,086,039 | 12,012,189 |
| Interest expense, net | 36,796 | 206,845 |
| Other (income) expense, net | (3,694) | (134,903) |
| Net income | $ 314,706 | $ 1,302,496 |

**Affiliates Whose Securities Collateralize the Senior Secured Notes**

All 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 All 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 All the Notes, subject to the terms of the Security Agreement relating to All 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 All 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 All the Notes may not produce proceeds in an amount sufficient to pay any amounts due on All the Notes.

The security agreement relating to All 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, 2026 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, 2025 we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds which totaled $182 million consisting of: (i) $163 million related to our self-insurance programs, and; (ii) $19 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, 2026. 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, 2025.

## Item 4. Controls and Procedures

As of March 31, 2026, 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 during the first quarter of 2026 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 to the Condensed Consolidated Financial Statements-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

The following is an update to the risk factors set forth in our Annual Report on Form 10-K for the fiscal year ended December 31, 2025. Other than the following update, there have been no material changes to the risk factors previously disclosed under the heading "Risk Factors" in our Annual Report on Form 10-K for the fiscal year ended December 31, 2025. You should carefully consider the risk factors contained in our Annual Report on Form 10-K, our Quarterly Reports on Form 10-Q and our other filings made with the Securities and Exchange Commission.

***The success of our acquisition of Talkspace, Inc. is subject to numerous risks and uncertainties.***

On March 9, 2026, we announced that we entered into a definitive agreement to acquire Talkspace, Inc. ("Talkspace") for $5.25 per share, or approximately $835 million in the aggregate. Talkspace is a virtual behavioral healthcare company, with a network of approximately 6,000 licensed professionals that serve all 50 states, Washington, D.C., and Puerto Rico. We intend to finance the acquisition of Talkspace with additional borrowings pursuant to our Credit Agreement, as amended in April, 2026, as discussed in *Note 4 to Condensed Consolidated Financial Statements – Treasury - Credit Facilities and Outstanding Debt Securities.* The transaction is expected to close during the third quarter of 2026 and is subject to approval by Talkspace's stockholders, satisfaction of regulatory approvals and other customary closing conditions.

The acquisition is subject to numerous risks and uncertainties including the occurrence of any event, change or other circumstances that could give rise to the termination of the merger agreement or the failure to satisfy the closing conditions; the possibility that the consummation of the proposed acquisition is delayed or does not occur, including the failure of Talkspace's stockholders to approve the proposed merger; uncertainty as to whether the parties will be able to complete the merger on the terms set forth in the merger agreement; uncertainty regarding the timing of the receipt of required regulatory approvals for the merger and the possibility that the parties may be required to accept conditions that could reduce or eliminate the anticipated benefits of the merger as a condition to obtaining the outcome of any legal proceedings that may be instituted against the parties or others following announcement of the transactions contemplated by the merger agreement; challenges, disruptions and costs of closing, integrating the business and achieving anticipated synergies, or that such synergies will take longer to realize than expected; failure to retain key employees of Talkspace during the period prior to closing or thereafter; failure to retain a significant portion of Talkspace's providers or relationships with payors, risks that the merger and other transactions contemplated by the merger agreement disrupt current plans and operations that may harm the parties' businesses or divert management's attention from the parties' ongoing business operations; and the amount of any costs, fees, expenses, impairments and charges related to the merger including costs and use of capital related to financing the merger.

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

As of December 31, 2025, we had an aggregate available repurchase authorization of $1.4 billion 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, 2026, we have repurchased approximately 675,000 shares at an aggregate cost of approximately $127.3 million (average price of approximately $188.54 per share) pursuant to the terms of our stock repurchase program. In addition, during the three-month period ended March 31, 2026, 191,694 shares were repurchased in connection with income tax withholding obligations resulting from stock-based compensation programs.

During the period of January 1, 2026 through March 31, 2026, 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) (a.) |
|---|---|---|---|---|---|---|---|---|---|
| January, 2026 | $ - | 2,721 | — | $ 0.01 | — | $ - | $ - | — | $ 1,425,086 |
| February, 2026 | $ - | 5,246 | — | $ 0.01 | — | $ - | $ - | — | $ 1,425,086 |
| March, 2026 | $ - | 858,727 | — | $ 0.01 | 675,000 | $ 188.54 | $ 127,268 | — | $ 1,297,819 |
| Total January through March, 2026 | $ - | 866,694 | — | $ 0.01 | 675,000 | — | 188.54 | $ 127,268 | |

**Dividends**

During the quarter ended March 31, 2026, 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 5. Other Information**

(c) None of the Company's directors or officers adopted, modified or terminated a Rule 10b5-1 trading arrangement or a non-Rule 10b5-1 trading arrangement during the Company's quarter ended March 31, 2026, as such terms are defined under Item 408(a) of Regulation S-K.

**Item 6. Exhibits**

| | |
|---|---|
| 4.1 | Fourth Supplemental Indenture, dated as of April 22, 2026, among the Company, the Subsidiary Guarantors party thereto, and U.S. Bank Trust Company, National Association (as successor to U.S. Bank National Association), as trustee, to the indenture, dated as of September 21, 2020, governing the 2030 Notes, previously filed as Exhibit 4.1 to the Company's Current Report on Form 8-K dated April 24, 2026, is incorporated herein by reference. |
| 4.2 | Third Supplemental Indenture, dated as of April 22, 2026, among the Company, the Subsidiary Guarantors party thereto, and U.S. Bank Trust Company, National Association (as successor to U.S. Bank National Association), as trustee, to the indenture, dated as of August 24, 2021, governing the 2026 Notes and the 2032 Notes, previously filed as Exhibit 4.2 to the Company's Current Report on Form 8-K dated April 24, 2026, is incorporated herein by reference. |
| 4.3 | Second Supplemental Indenture, dated as of April 22, 2026, among the Company, the Subsidiary Guarantors party thereto, and U.S. Bank Trust Company, National Association (as successor to U.S. Bank National Association), as trustee, to the indenture, dated as of September 26, 2024, governing the 2029 Notes and the 2034 Notes, previously filed as Exhibit 4.3 to the Company's Current Report on Form 8-K dated April 24, 2026, is incorporated herein by reference. |
| 10.1 | Eleventh Amendment and Increased Facility Activation Notice dated as of April 22, 2026, to Credit Agreement, dated as of November 15, 2010 and as amended and restated as of September 21, 2012, August 7, 2014, October 23, 2018, August 21, 2021, September 10, 2021, June 23, 2022 and September 26, 2024, among the Company, JP Morgan Chase Bank, N.A., as administrative agent and other financial institutions or entities from time to time parties thereto, including the amendment and restatement thereof, effective as of April 22, 2026, attached as Exhibit A thereto and referred to herein as the Senior Secured Credit Facility, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated April 24, 2026, is incorporated herein by reference. |
| 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 |
| 104 | The cover page from the Company’s Quarterly Report on Form 10-Q for the quarter ended March 31, 2026, has been formatted in Inline XBRL. |

**UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES**

**Signatures**

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

Universal Health Services, Inc.
(Registrant)

Date: May 7, 2026

/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)**

Exhibit 22.1

**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, 2026.

Description of Notes

1.650% Senior Secured Notes due 2026
4.625% Senior Secured Notes due 2029
2.650% Senior Secured Notes due 2030
2.650% Senior Secured Notes due 2032
5.050% Senior Secured Notes due 2034

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 |
| 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 |

| Name of Subsidiary | Jurisdiction of Organization | Obligor Type |
|---|---|---|
| BHC Fairfax Hospital, Inc. | Tennessee | Guarantor |
| 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 | Delaware | 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 |

| Name of Subsidiary | Jurisdiction of Organization | Obligor Type |
|---|---|---|
| DVH Hospital Alliance LLC | Delaware | Guarantor |
| 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 |

| Name of Subsidiary | Jurisdiction of Organization | Obligor Type |
|---|---|---|
| HSA Hill Crest Corporation | Alabama | Guarantor |
| 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 |

| Name of Subsidiary | Jurisdiction of Organization | Obligor Type |
|---|---|---|
| Northwest Texas Healthcare System, Inc. | Texas | Guarantor |
| 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 East End Corporation | District of Columbia | Guarantor |

| Name of Subsidiary | Jurisdiction of Organization | Obligor Type |
|---|---|---|
| UHS East End Sub, LLC | District of Columbia | Guarantor |
| UHS Funding, LLC | Delaware | Guarantor |
| 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 Kansas City, LLC | 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 |

| Name of Subsidiary | Jurisdiction of Organization | Obligor Type |
|---|---|---|
| UHS of Provo Canyon, Inc. | Delaware | Guarantor |
| UHS of Puerto Rico, Inc. | Delaware | Guarantor |
| UHS of Ridge, LLC | Delaware | Guarantor |
| 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 |

| Name of Subsidiary | Jurisdiction of Organization | Obligor Type |
|---|---|---|
| Wellstone Regional Hospital Acquisition, LLC | Indiana | Guarantor |
| Willow Springs, LLC | Delaware | Guarantor |
| 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 March 31, 2026, 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 |
| 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 |

| Name of Issuer | Issuer Jurisdiction of Organization | Percent of Interest Owned | Percent of Interest Pledged |
|---|---|---|---|
| BHC Fairfax Hospital, Inc. | Tennessee | 100 | 100 |
| BHC Fox Run Hospital, Inc. | Tennessee | 100 | 100 |
| BHC Fremont Hospital, Inc. | Tennessee | 100 | 100 |
| 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 | Delaware | 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 |

| Name of Issuer | Issuer Jurisdiction of Organization | Percent of Interest Owned | Percent of Interest Pledged |
|---|---|---|---|
| Edinburg Ambulatory Surgical Center, Inc. | Texas | 100 | 100 |
| Edinburg Holdings, Inc. | Delaware | 100 | 100 |
| Edinburg MOB Properties, LLC | Florida | 100 | 100 |
| 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 |

| Name of Issuer | Issuer Jurisdiction of Organization | Percent of Interest Owned | Percent of Interest Pledged |
|---|---|---|---|
| Horizon Mental Health Management, LLC | Texas | 100 | 100 |
| HRI Clinics, Inc. | Massachusetts | 100 | 100 |
| HRI Hospital, Inc. | Massachusetts | 100 | 100 |
| 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 |

| Name of Issuer | Issuer Jurisdiction of Organization | Percent of Interest Owned | Percent of Interest Pledged |
|---|---|---|---|
| Mesilla Valley Hospital, Inc. | New Mexico | 100 | 100 |
| Michigan BH JV, LLC | Michigan | 74 | 74 |
| Michigan Healthcare Staffing, LLC | Michigan | 100 | 100 |
| 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 |

| Name of Issuer | Issuer Jurisdiction of Organization | Percent of Interest Owned | Percent of Interest Pledged |
|---|---|---|---|
| Riveredge Hospital, Inc. | Illinois | 100 | 100 |
| Riveredge Real Estate, Inc. | Illinois | 100 | 100 |
| 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 |

| Name of Issuer | Issuer Jurisdiction of Organization | Percent of Interest Owned | Percent of Interest Pledged |
|---|---|---|---|
| Turning Point Care Center, LLC | Georgia | 100 | 100 |
| Two Rivers Psychiatric Hospital, Inc. | Delaware | 100 | 100 |
| 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 East End Corporation | District of Columbia | 100 | 100 |
| UHS East End Sub, LLC | District of Columbia | 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 |

| Name of Issuer | Issuer Jurisdiction of Organization | Percent of Interest Owned | Percent of Interest Pledged |
|---|---|---|---|
| UHS of Indiana, Inc. | Indiana | 100 | 100 |
| UHS of Kansas City, LLC | Delaware | 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 |
| 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 |

| Name of Issuer | Issuer Jurisdiction of Organization | Percent of Interest Owned | Percent of Interest Pledged |
|---|---|---|---|
| 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 |
| 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 7, 2026

/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 7, 2026

/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, 2026, 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 7, 2026

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, 2026, 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 7, 2026

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.