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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, 2012

OR

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

For the transition period from to

Commission file number 1-10765

UNIVERSAL HEALTH SERVICES, INC.
(Exact name of registrant as specified in its charter)

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

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

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

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

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

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

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

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

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, 2012:

Class A	6,625,708
Class B	89,499,771
Class C	664,000
Class D	32,388

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In this Report on Form 10-Q for the quarterly period ended March 31, 2012, "we," "us," "our" and the "Company" refer to Universal Health Services, Inc. and its subsidiaries. UHS is a registered trademark of UHS of Delaware, Inc., the management company for, and a wholly-owned subsidiary of Universal Health Services, Inc. Universal Health Services, Inc. is a holding company and operates through its subsidiaries including its management company, UHS of Delaware, Inc. All healthcare and management operations are conducted by subsidiaries of Universal Health Services, Inc. To the extent any reference to "UHS" or "UHS facilities" in this report including letters, narratives or other forms contained herein relates to our healthcare or management operations it is referring to Universal Health Services, Inc.'s subsidiaries including UHS of Delaware, Inc. Further, the terms "we," "us," "our" or the "Company" in such context similarly refer to the operations of Universal Health Services Inc.'s subsidiaries including UHS of Delaware, Inc. Any reference to employees or employment contained herein refers to employment with or employees of the subsidiaries of Universal Health Services, Inc. including UHS of Delaware, Inc.

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,	
	2012	2011
Net revenues before provision for doubtful accounts	$1,977,003	$1,910,528
Less: Provision for doubtful accounts	151,714	153,116
Net revenues	1,825,289	1,757,412
Operating charges:		
Salaries, wages and benefits	889,506	845,864
Other operating expenses	359,541	349,446
Supplies expense	209,532	207,170
Depreciation and amortization	73,820	71,351
Lease and rental expense	23,862	23,168
	1,556,261	1,496,999
Income from operations	269,028	260,413
Interest expense, net	46,710	56,417
Income before income taxes	222,318	203,996
Provision for income taxes	79,748	74,009
Net income	142,570	129,987
Less: Income attributable to noncontrolling interests	13,963	15,794
Net income attributable to UHS	$ 128,607	$ 114,193
Basic earnings per share attributable to UHS	$ 1.33	$ 1.17
Diluted earnings per share attributable to UHS	$ 1.31	$ 1.15
Weighted average number of common shares - basic	96,593	97,381
Add: Other share equivalents	1,198	1,487
Weighted average number of common shares and equivalents - diluted	97,791	98,868

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

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

	Three months ended March 31,	
	2012	2011
Net income	$142,570	$129,987
Other comprehensive income (loss):		
Unrealized derivative gains on cash flow hedges	1,615	2,307
Amortization of terminated hedge	(84)	(84)
Other comprehensive income before tax	1,531	2,223
Income tax expense related to items of other comprehensive income	582	860
Total other comprehensive income, net of tax	949	1,363
Comprehensive income	143,519	131,350
Less: Comprehensive income attributable to noncontrolling interests	13,963	15,794
Comprehensive income attributable to UHS	$129,556	$115,556

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

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

	March 31, 2012	December 31, 2011
Assets		
Current assets:		
Cash and cash equivalents	$ 41,999	$ 41,229
Accounts receivable, net	1,116,634	969,802
Supplies	96,974	96,775
Other current assets	91,622	99,859
Deferred income taxes	115,916	108,324
Current assets held for sale	0	48,916
Total current assets	1,463,145	1,364,905
Property and equipment	5,185,774	5,106,160
Less: accumulated depreciation	(1,881,538)	(1,818,180)
	3,304,236	3,287,980
Other assets:		
Goodwill	2,629,765	2,627,602
Deferred charges	105,870	111,780
Other	280,265	272,978
	$ 7,783,281	$ 7,665,245
Liabilities and Stockholders' Equity		
Current liabilities:		
Current maturities of long-term debt	$ 2,512	$ 2,479
Accounts payable and accrued liabilities	814,173	832,125
Current liabilities held for sale	0	2,329
Federal and state taxes	75,305	0
Total current liabilities	891,990	836,933
Other noncurrent liabilities	403,071	401,908
Long-term debt	3,581,844	3,651,428
Deferred income taxes	198,645	209,592
Redeemable noncontrolling interests	228,928	218,266
UHS common stockholders' equity	2,427,312	2,296,352
Noncontrolling interest	51,491	50,766
Total equity	2,478,803	2,347,118
	$ 7,783,281	$ 7,665,245

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

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

	Three months ended March 31,	
	2012	2011
Cash Flows from Operating Activities:		
Net income	$ 142,570	$ 129,987
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation & amortization	73,820	71,526
Stock-based compensation expense	5,486	3,954
Changes in assets & liabilities, net of effects from acquisitions and dispositions:		
Accounts receivable	(146,670)	(103,919)
Accrued interest	13,280	12,875
Accrued and deferred income taxes	75,471	68,994
Other working capital accounts	(48,074)	(27,056)
Other assets and deferred charges	7,120	6,777
Other	(2,082)	11,208
Accrued insurance expense, net of commercial premiums paid	24,581	23,744
Payments made in settlement of self-insurance claims	(18,279)	(14,913)
Net cash provided by operating activities	127,223	183,177
Cash Flows from Investing Activities:		
Property and equipment additions, net of disposals	(92,563)	(56,558)
Proceeds received from sale of assets and businesses	53,461	991
Costs incurred for purchase and implementation of electronic health records application	(14,501)	(8,145)
Return of deposit on terminated purchase agreement	6,500	0
Net cash used in investing activities	(47,103)	(63,712)
Cash Flows from Financing Activities:		
Reduction of long-term debt	(70,942)	(136,403)
Additional borrowings	0	73,500
Financing costs	0	(23,140)
Repurchase of common shares	(2,017)	(3,170)
Dividends paid	(4,832)	(4,876)
Issuance of common stock	1,016	1,251
Profit distributions to noncontrolling interests	(2,575)	(4,025)
Net cash used in financing activities	(79,350)	(96,863)
Increase in cash and cash equivalents	770	22,602
Cash and cash equivalents, beginning of period	41,229	29,474
Cash and cash equivalents, end of period	$ 41,999	$ 52,076
Supplemental Disclosures of Cash Flow Information:		
Interest paid	$ 25,945	$ 37,130
Income taxes paid, net of refunds	$ 3,419	$ 4,527

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(1) General

This Report on Form 10-Q is for the quarterly period ended March 31, 2012. In this Quarterly Report, "we," "us," "our" and the "Company" refer to Universal Health Services, Inc. and its subsidiaries.

The condensed consolidated financial statements include the accounts of our majority-owned subsidiaries and partnerships and limited liability companies controlled by us, or our subsidiaries, as managing general partner or managing member. The condensed consolidated financial statements included herein have been prepared by us, without audit, pursuant to the rules and regulations of the Securities and Exchange Commission ("SEC") and reflect all normal and recurring adjustments which, in our opinion, are necessary to fairly state results for the interim periods. Certain information and footnote disclosures normally included in financial statements prepared in accordance with accounting principles generally accepted in the United States of America have been condensed or omitted pursuant to such rules and regulations, although we believe that the accompanying disclosures are adequate to make the information presented not misleading. It is suggested that these condensed consolidated financial statements be read in conjunction with the consolidated financial statements, significant accounting policies and the notes thereto included in our Annual Report on Form 10-K for the year ended December 31, 2011.

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

Relationship with Universal Health Realty Income Trust:

At March 31, 2012, we held approximately 6.2% of the outstanding shares of Universal Health Realty Income Trust (the "Trust"). We serve as Advisor to the Trust under an annually renewable advisory agreement pursuant to the terms of which we conduct the Trust's day-to-day affairs, provide administrative services and present investment opportunities. In addition, certain of our officers and directors are also officers and/or directors of the Trust. Management believes that it has the ability to exercise significant influence over the Trust, therefore we account for our investment in the Trust using the equity method of accounting. We earned an advisory fee from the Trust, which is included in net revenues in the accompanying condensed consolidated statements of income, of $515,000 and $471,000 during the three-month periods ended March 31, 2012 and 2011, respectively. Our pre-tax share of income from the Trust was $300,000 for each of the three-month periods ended March 31, 2012 and 2011. The carrying value of this investment was $9.8 million and $9.9 million at March 31, 2012 and December 31, 2011, respectively, and is included in other assets in the accompanying condensed consolidated balance sheets. The market value of this investment, based on the closing price of the Trust's stock on the respective dates, was $31.2 million at March 31, 2012 and $30.7 million at December 31, 2011.

Total rent expense under the operating leases on the hospital facilities with the Trust was $4.1 million during each of the three-month periods ended March 31, 2012 and 2011. In addition, certain of our subsidiaries are tenants in several medical office buildings owned by limited liability companies in which the Trust holds either 100% ownership interests or non-controlling majority ownership interests.

The table below details the renewal options and terms for each of our four hospital facilities leased from the Trust, giving effect to the above-mentioned renewals:

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

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

Other Related Party Transactions:

In December, 2010, our Board of Directors approved the Company's entering into supplemental life insurance plans and agreements on the lives of our chief executive officer and his wife. As a result of these agreements, based on actuarial tables and other assumptions, during the life expectancies of the insureds, we would pay approximately $25 million in premiums and certain trusts, owned by our chief executive officer, would pay approximately $8 million in premiums. Based on the projected premiums mentioned above, and assuming the policies remain in effect until the death of the insureds, we will be entitled to receive death benefit proceeds of no less than $33 million representing the $25 million of aggregate premiums paid by us as well as the $8 million of aggregate premiums paid by the trusts. These agreements did not have a material effect on our consolidated financial statements or results of operations during 2011 or the first quarter of 2012.

A member of our Board of Directors and member of the Executive Committee is Of Counsel to the law firm used by us as our principal outside counsel. This Board member is also the trustee of certain trusts for the benefit of our Chief Executive Officer ("CEO") and his family. This law firm also provides personal legal services to our CEO.

(3) Other Noncurrent liabilities and Redeemable/Noncontrolling Interests

Other noncurrent liabilities include the long-term portion of our professional and general liability, workers' compensation reserves, pension liability, and interest rate swaps.

Outside owners hold noncontrolling, minority ownership interests of: (i) approximately 28% in our five acute care facilities located in Las Vegas, Nevada; (ii) 20% in an acute care facility located in Washington, D.C.; (iii) approximately 11% in an acute care facility located in Laredo, Texas, and; (iv) 20% in a behavioral health care facility located in Philadelphia, Pennsylvania. The redeemable noncontrolling interest balances of $229 million and $218 million as of March 31, 2012 and December 31, 2011, respectively, and the noncontrolling interest balances of $51 million at both March 31, 2012 and December 31, 2011, consist primarily of the third-party ownership interests in these hospitals.

In connection with the five acute care facilities located in Las Vegas, Nevada, the minority ownership interests of which are reflected as redeemable noncontrolling interests on our Consolidated Balance Sheet, the outside owners have certain "put rights", that are currently exercisable, that if exercised, require us to purchase the minority member's interests at fair market value. The put rights are exercisable upon the occurrence of: (i) certain specified financial conditions falling below established thresholds; (ii) breach of the management contract by the managing member (a subsidiary of ours), or; (iii) if the minority member's ownership percentage is reduced to less than certain thresholds. In connection with the behavioral health care facility located in Philadelphia, Pennsylvania, the minority ownership interest of which is also reflected as redeemable noncontrolling interests on our Consolidated Balance Sheet, the outside owner has a "put option" to put its entire ownership interest to us at any time. If exercised, the put option requires us to purchase the minority member's interest at fair market value. As of March 31, 2012, we believe the fair market value of the minority ownership interests in these facilities approximates the book value of the redeemable noncontrolling interests.

(4) Long-term debt and cash flow hedges

Debt:

On November 15, 2010, we entered into a credit agreement (the "Credit Agreement") with various financial institutions. The Credit Agreement is a senior secured facility which provided an initial aggregate commitment amount of $3.45 billion, comprised of a new $800 million revolving credit facility, a $1.05 billion Term Loan A facility and a $1.6 billion Term Loan B facility. Prior to the effectiveness of the Credit Agreement Amendment in March, 2011 (as discussed below), we prepaid the principal amount and permanently reduced the Term Loan B commitment by $125 million. During the first quarter of 2012, we made scheduled principal payments of $35 million on the Term Loan A and $13 million on the Term Loan B. The revolving credit facility and the Term Loan A mature on November 15, 2015 and the Term Loan B matures on November 15, 2016. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Credit Agreement is secured by substantially all of the assets of the Company and our material subsidiaries and guaranteed by our material subsidiaries.

On March 15, 2011, we entered into a first amendment to the Credit Agreement (the "Amendment") which became effective immediately and provides, among other things, for a reduction in the interest rates payable in connection with borrowings under the Credit Agreement. Upon the effectiveness of the Amendment, borrowings under the Credit Agreement bear interest at the ABR rate which is defined as the rate per annum equal to, at our election (1) the greatest of (a) the lender's prime rate, (b) the weighted average of the federal funds rate, plus 0.5% and (c) one month Eurodollar rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.50% to 1.25% for revolving credit and Term Loan A borrowings and 1.75% to 2.00% for Term Loan B borrowings or (2) the one, two, three or six month Eurodollar rate (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.50% to 2.25% for revolving credit and Term Loan A borrowings and ranging from 2.75% to 3.00% for Term Loan B borrowings. The current applicable margins are 0.75% for ABR-based loans, 1.75% for Eurodollar-based loans under the revolving credit and Term Loan A facilities and 2.75% under the Term Loan B facility. Upon the effectiveness of the Amendment, the minimum Eurodollar rate for the Term Loan B facility was reduced from 1.50% to 1.00%. In connection with the Amendment, we paid a fee of 1.00% of the amounts outstanding under the Term Loan B in accordance with the terms of the Credit Agreement.

In October, 2010, we amended our accounts receivable securitization program ("Securitization") with a group of conduit lenders and liquidity banks. We increased the size of the Securitization to $240 million (the "Commitments"), from $200 million, and extended the maturity date to October 25, 2013. Substantially all of the patient-related accounts receivable of our acute care hospitals ("Receivables") serve as collateral for the outstanding borrowings. The interest rate on the borrowings is based on the commercial paper rate plus a spread of 0.475% and there is a facility fee of 0.375% required on 102% on the Commitments. We have accounted for this Securitization as borrowings. We maintain effective control over the Receivables since, pursuant to the terms of the Securitization, the Receivables are sold from certain of our subsidiaries to special purpose entities that are wholly-owned by us. The Receivables, however, are owned by the special purpose entities, can be used only to satisfy the debts of the wholly-owned special purpose entities, and thus are not available to us except through our ownership interest in the special purpose entities. The wholly-owned special purpose entities use the Receivables to collateralize the loans obtained from the group of third-party conduit lenders and liquidity banks. The group of third-party conduit lenders and liquidity banks do not have recourse

to us beyond the assets of the wholly-owned special purpose entities that securitize the loans. At March 31, 2012, we had $240 million of outstanding borrowings and no additional capacity pursuant to the terms of our accounts receivable securitization program.

As of March 31, 2012, we had $9 million outstanding borrowings under a short-term, on-demand credit facility. Outstanding borrowings pursuant to this facility are classified as long-term debt on our Consolidated Balance Sheet since we have the intent and ability to refinance through available borrowings under the terms of our Credit Agreement.

As of March 31, 2012, we had an aggregate of $509 million of available borrowing capacity pursuant to the terms of our Credit Agreement and Securitization, net of $219 million of outstanding borrowings, $63 million of outstanding letters of credit and $9 million of outstanding borrowings under a short-term, on-demand credit facility.

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

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

In connection with the entering into of the Credit Agreement on November 15, 2010, and in accordance with the Indenture dated January 20, 2000 governing the rights of our existing notes, we entered into a supplemental indenture pursuant to which our 7.125% Notes (due in 2015) were equally and ratably secured with the lenders under the Credit Agreement with respect to the collateral for so long as the lenders under the Credit Agreement are so secured.

Our Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens and indebtedness, transactions with affiliates and dividends; and requires compliance with financial covenants including maximum leverage and minimum interest coverage ratios. We are in compliance with all required covenants as of March 31, 2012.

The carrying amount and fair value of our debt was $3.58 billion and $3.65 billion at March 31, 2012, respectively. The fair value of our debt was computed based upon quotes received from financial institutions and we consider these to be “level 2” in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with debt instruments.

Cash Flow Hedges:

We manage our ratio of fixed to floating rate debt with the objective of achieving a mix that management believes is appropriate. To manage this risk in a cost-effective manner, we, from time to time, enter into interest rate swap agreements in which we agree to exchange various combinations of fixed and/or variable interest rates based on agreed upon notional amounts. We account for our derivative and hedging activities using the Financial Accounting Standard Board’s (“FASB”) guidance which requires all derivative instruments, including certain derivative instruments embedded in other contracts, to be carried at fair value on the balance sheet. For derivative transactions designated as hedges, we formally document all relationships between the hedging instrument and the related hedged item, as well as its risk-management objective and strategy for undertaking each hedge transaction.

Derivative instruments designated in a hedge relationship to mitigate exposure to variability in expected future cash flows, or other types of forecasted transactions, are considered cash flow hedges. Cash flow hedges are accounted for by recording the fair value of the derivative instrument on the balance sheet as either an asset or liability, with a corresponding amount recorded in accumulated other comprehensive income (“AOCI”) within stockholders’ equity. Amounts are reclassified from AOCI to the income statement in the period or periods in which the hedged transaction affects earnings. We use interest rate derivatives in our cash flow hedge transactions. Such derivatives are designed to be highly effective in offsetting changes in the cash flows related to the hedged liability. For derivative instruments designated as cash flow hedges, the ineffective portion of the changes in expected cash flows of the hedged item are recognized currently in the income statement.

For hedge transactions that do not qualify for the short-cut method, at the hedge’s inception and on a regular basis thereafter, a formal assessment is performed to determine whether changes in the fair values or cash flows of the derivative instruments have been highly effective in offsetting changes in cash flows of the hedged items and whether they are expected to be highly effective in the future.

The fair value of interest rate swap agreements approximates the amount at which they could be settled, based on estimates obtained from the counterparties. We assess the effectiveness and consideration of nonperformance risk of our hedge instruments on a quarterly basis. We performed periodic assessments of the cash flow hedge instruments during 2011 and the first quarter of 2012 and determined the hedges to be highly effective. We also determined that no

portion of the hedges is ineffective and therefore there was no material effect on our consolidated financial position, operations or cash flows. The counterparties to the interest rate swap agreements expose us to credit risk in the event of nonperformance. We do not anticipate nonperformance by our counterparties. At March 31, 2012, each swap agreement entered into by us was in a net liability position which would require us to make the net settlement payments to the counterparties. We do not hold or issue derivative financial instruments for trading purposes.

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

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

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

During the fourth quarter of 2007, we entered into an interest rate swap whereby we pay a fixed rate on a total notional principal amount of $75 million and receive three-month LIBOR. The fixed rate payable is 4.76% and it matures in October, 2012.

We measure our interest rate swaps at fair value on a recurring basis. The fair value of our interest rate swaps is based primarily on quotes from banks. We consider those inputs to be “level 2” in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with derivative instruments and hedging activities. The fair value of our interest rate swaps was a liability of $46 million at March 31, 2012, of which $2 million is included in other current liabilities and $44 million is included in other noncurrent liabilities on the accompanying balance sheet.

(5) Commitments and Contingencies

Professional and General Liability Claims and Property Insurance

Professional and General Liability

Effective January 1, 2008, most of our subsidiaries became self-insured for professional and general liability exposure up to $10 million per occurrence. Prior to our acquisition of Psychiatric Solutions, Inc. (“PSI”) in November, 2010, our subsidiaries purchased several excess policies through commercial insurance carriers which provide for coverage in excess of $10 million up to $200 million per occurrence and in the aggregate. However, we are liable for 10% of the claims paid pursuant to the commercially insured coverage in excess of $10 million up to $60 million per occurrence and in the aggregate.

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

Since our acquisition of PSI on November 15, 2010, the former PSI subsidiaries are self-insured for professional and general liability exposure up to $3 million per occurrence and our legacy subsidiaries (which are not former PSI subsidiaries) are self-insured for professional and general liability exposure up to $10 million per occurrence. Effective November, 2010, our subsidiaries (including the former PSI subsidiaries) were provided with several excess policies through commercial insurance carriers which provide for coverage in excess of the applicable per occurrence self-insured retention (either $3 million or $10 million) up to $200 million per occurrence and in the aggregate. We remain liable for 10% of the claims paid pursuant to the commercially insured coverage in excess of $10 million up to $60 million per occurrence and in the aggregate.

Our estimated liability for self-insured professional and general liability claims is based on a number of factors including, among other things, the number of asserted claims and reported incidents, estimates of losses for these claims based on recent and historical settlement amounts, estimates of incurred but not reported claims based on historical experience, and estimates of amounts recoverable under our commercial insurance policies. While we continuously monitor these factors, our ultimate liability for professional and general liability claims could change materially from our current estimates due to inherent uncertainties involved in making this estimate. Given our significant self-insured

exposure for professional and general liability claims, there can be no assurance that a sharp increase in the number and/or severity of claims asserted against us will not have a material adverse effect on our future results of operations.

As of March 31, 2012 and December 31, 2011, the total accrual for our professional and general liability claims, including the estimated claims related to the facilities acquired from PSI, was $297 million and $292 million, respectively, of which $60 million is included in current liabilities as of each date.

Property Insurance

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

Our property insurance coverage is scheduled for renewal on June 1, 2012. Due to an increase in property losses experienced nationwide in recent years, the cost of commercial property insurance has increased. As a result, catastrophic coverage for earthquake and flood has been limited to annual aggregate losses (as opposed to per occurrence losses). Given these insurance market conditions, there can be no assurance that a continuation of these unfavorable trends, or a sharp increase in uninsured property losses sustained by us, will not have a material adverse effect on our future results of operations.

Other

We entered into an agreement in April, 2012 with the United States Department of Health and Human Services, the Secretary of Health and Human Services, and the Centers for Medicare and Medicaid Services (referred to collectively as “HHS”) that is expected to result in an aggregate cash payment to us of approximately $36 million, the majority of which we expect to receive on or about June 30, 2012. After reductions for estimated related expenses and the portion attributable to third-party non-controlling ownership interests, this settlement favorably impacted our pre-tax consolidated financial results during the three-month period ended March 31, 2012 by approximately $30 million. This agreement was part of an industry-wide settlement with HHS related to litigation that was pending for several years contending that acute care hospitals in the U.S. were underpaid from the Medicare inpatient prospective payment system during a number of prior years. The underpayments resulted from calculations related to rural floor budget neutrality adjustments that were implemented in connection with the Balanced Budget Act of 1997.

As of March 31, 2012 and December 31, 2011, our accounts receivable includes approximately $73 million and $54 million, respectively, due from Illinois. Collection of these receivables continues to be delayed due to state budgetary and funding pressures. Approximately $50 million as of March 31, 2012, and $41 million as of December 31, 2011, of the receivables due from Illinois have been outstanding in excess of 60 days, as of each respective date, and a large portion will likely remain outstanding for the foreseeable future. Since we expect to eventually collect all amounts due to us, no related reserves have been established in our consolidated financial statements. However, we can provide no assurance that we will eventually collect all amounts due to us from Illinois. Failure to ultimately collect all outstanding amounts due from Illinois would have an adverse impact on our future consolidated results of operations and cash flows.

As of March 31, 2012, we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds which totaled $83 million consisting of: (i) $66 million related to our self-insurance programs, and; (ii) $17 million of other debt and public utility guarantees.

Legal Proceedings

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

U.S. v. Marion and UHS:

In November, 2009, the United States Department of Justice (“DOJ”) and the Virginia Attorney General intervened in a qui tam case that had been filed by former employees of Marion Youth Center under seal in 2007 against Universal Health Services, Inc. (“UHS”), and Keystone Marion, LLC (“Marion”) and Keystone Education and Youth Services, LLC (“Keystone”). The intervention by the DOJ followed the issuance of a series of subpoenas from the Office of the Inspector General for the Department of Health and Human Services seeking documents related to the treatment of Medicaid beneficiaries at Marion. The amended complaint filed by the DOJ and Virginia Attorney General alleged causes of action pursuant to the federal and state false claims acts and the Virginia fraud statute. The former employees filed a separate amended complaint alleging employment and retaliation claims as well as false claim act violations. During the third quarter of 2011, we reached agreements in principle to settle all of the claims. During the first quarter of 2012, the settlement agreements were finalized. We had previously established a reserve in connection with this matter, which did not have a material impact on our financial statements. Settlement payments were made in April, 2012.

Martin v. UHS of Delaware:

UHS of Delaware, Inc., a wholly-owned subsidiary of ours, has been named as defendants in a state False Claim Act case in Sacramento County Superior Court. Plaintiffs are a former student and employees of the Elmira School who claim that the UHS schools in California unlawfully retained public education funding from the state of California for the operation of these schools but failed to meet state requirements pertaining to the operation of non-public schools. We deny liability and intend to defend this case vigorously. We have established a reserve in connection with this matter which did not have a material impact on our consolidated financial statements.

Department of Justice ICD Investigation:

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

Two Rivers Psychiatric Hospital:

In April, 2011, the Centers for Medicare and Medicaid Services ("CMS") issued notice of its decision terminating Two Rivers Psychiatric Hospital ("Two Rivers") in Kansas City, Missouri from participation in the Medicare and Medicaid program. The termination notice was issued as a result of surveys conducted which allegedly found Two Rivers to be out of compliance with the conditions of participation required for participation in the Medicare program and for Two Rivers' alleged failure to alleviate an "immediate jeopardy" situation. Two Rivers filed an administrative appeal with the U.S. Department of Health and Human Services, Departmental Appeal Board, Civil Remedies Division, seeking review and reversal of that decision. In addition, Two Rivers filed a complaint in the U.S. District Court for the Western District of Missouri seeking a temporary restraining order and preliminary injunction against CMS rescinding the termination action. Later in April, 2011, the District Court issued a temporary restraining order abating the termination action pending a preliminary injunction hearing or an agreement with CMS. In May, 2011, Two Rivers and CMS entered into a settlement agreement which resulted in the rescission of the termination notice and actions by CMS. Pursuant to the terms of the agreement, Two Rivers was required to submit an acceptable plan of correction relative to the immediate jeopardy citation and engage independent experts in various disciplines to analyze and develop implementation plans for Two Rivers to meet the applicable Medicare conditions of participation. Both of these actions have occurred. Pursuant to the agreement, CMS conducted an initial survey of Two Rivers in April 2012 to determine if the Medicare conditions of participation, which formed the basis of the termination action in April 2011, have been met. In late April, 2012, CMS advised Two Rivers that it has successfully passed this initial survey. Pursuant to the terms of the agreement, a second survey will be conducted either late 2012 or early 2013 to further confirm that Two Rivers is in compliance with all Medicare/Medicaid Conditions of Participation. During the term of this agreement, Two Rivers remains eligible to receive reimbursements for services rendered to Medicare and Medicaid beneficiaries. Two Rivers remains fully committed to providing high-quality healthcare to their patients and the community it serves. We therefore intend to work expeditiously and collaboratively with CMS in an effort to resolve these matters. We can provide no assurance that Two Rivers will not ultimately lose its Medicare certification. The operating results of Two Rivers did not have a material impact on our consolidated results of operations or financial condition for the three-month period ended March 31, 2012 or the year ended December 31, 2011.

Matters Relating to PSI:

The following matters pertain to PSI or former PSI facilities (owned by subsidiaries of Psychiatric Solutions, Inc.) for which we have assumed the defense as a result of our acquisition of PSI which was completed in November, 2010:

Garden City Employees' Retirement System v. PSI:

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

Department of Justice Investigation of Sierra Vista:

In 2009, Sierra Vista Hospital in Sacramento, California learned of an investigation by the U.S. Department of Justice ("DOJ") relating to Medicare services provided by the facility. The DOJ ultimately notified the facility that with respect to partial hospitalization and outpatient services, the DOJ believed that the medical record documentation did not adequately support the claims submitted for reimbursement by Medicare. We reached a settlement with the DOJ which was finalized during the second quarter of 2012. As part of that agreement, the facility will be subject to a corporate integrity agreement. The reserve established in connection with this matter did not have a material impact on our consolidated financial statements.

Department of Justice Investigation of Friends Hospital:

In October, 2010, Friends Hospital in Philadelphia, Pennsylvania, received a subpoena from the DOJ requesting certain documents from the facility. The requested documents have been collected and provided to the DOJ for review and examination. Another subpoena was issued to the facility in July 2011 requesting additional documents, a portion of which have been collected and delivered to the DOJ, pursuant to their request. At present,

we are uncertain as to the focus, scope or extent of the investigation, liability of the facility and/or potential financial exposure, if any, in connection with this matter.

Department of Justice Investigation of Riveredge Hospital:

In 2008, Riveredge Hospital in Chicago, Illinois received a subpoena from the DOJ requesting certain information from the facility. Additional requests for documents were also received from the DOJ in 2009 and 2010. The requested documents have been provided to the DOJ and we continue to cooperate with the DOJ with respect to this investigation. At present, we are uncertain as to the focus, scope or extent of the investigation, liability of the facility and/or potential financial exposure, if any, in connection with this matter.

Virginia Department of Medical Assistance Services Recoupment Claims:

The Virginia Department of Medical Assistance Services ("DMAS") has conducted audits at seven former PSI Residential Treatment Centers operated in the Commonwealth of Virginia to confirm compliance with provider rules under the state's Medicaid Provider Services Manual ("Manual"). As a result of those audits, DMAS claims the facilities failed to comply with the requirements of the Manual and has requested repayment of Medicaid payments to those facilities. PSI had previously filed appeals to repayment demands at each facility which are currently pending. The aggregate refund of Medicaid payments made to those facilities, as requested by DMAS, and the corresponding reserve established on our consolidated balance sheet, was not material to our consolidated financial position or results of operations.

General:

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

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

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

(6) Segment Reporting

Our reportable operating segments consist of acute care hospital services and behavioral health care services. The "Other" segment column below includes centralized services including information services, purchasing, reimbursement, accounting, taxation, legal, advertising, design and construction and patient accounting as well as the operating results for our other operating entities including outpatient surgery and radiation centers. The chief operating decision making group for our acute care hospital services and behavioral health care services is comprised of the Chief Executive Officer, the President and the Presidents of each operating segment. The Presidents of each operating segment also manage the profitability of each respective segment's various facilities. The operating segments are managed separately because each operating segment represents a business unit that offers different types of healthcare services or operates in different healthcare environments. The accounting policies of the operating segments are the same as those described in the summary of significant accounting policies included in our Annual Report on Form 10-K for the year ended December 31, 2011. The corporate overhead allocations, as reflected below, are utilized for internal reporting purposes and are comprised of each period's projected corporate-level operating expenses (excluding

interest expense). The overhead expenses are captured and allocated directly to each segment, to the extent possible, with the non-directly allocated overhead expenses allocated based upon each segment's respective percentage of total facility-based operating expenses.

	Three months ended March 31, 2012			
	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 3,349,035	$ 1,422,085	—	$4,771,120
Gross outpatient revenues	$ 1,598,517	$ 161,258	$ 12,270	$1,772,045
Total net revenues	$ 954,232	$ 864,873	$ 6,184	$1,825,289
Income/(loss) before allocation of corporate overhead and income taxes	$ 129,848	$ 202,496	($110,026)	$ 222,318
Allocation of corporate overhead	($ 40,743)	($ 21,061)	$ 61,804	0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 89,105	$ 181,435	($ 48,222)	$ 222,318
Total assets as of 3/31/12	$ 2,946,334	$ 4,425,079	$ 411,868	$7,783,281

	Three months ended March 31, 2011			
	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 3,222,247	$ 1,391,201	—	$4,613,448
Gross outpatient revenues	$ 1,370,118	$ 149,595	$ 12,869	$1,532,582
Total net revenues	$ 922,542	$ 828,948	$ 5,922	$1,757,412
Income/(loss) before allocation of corporate overhead and income taxes	$ 126,984	$ 185,779	($108,767)	$ 203,996
Allocation of corporate overhead	($ 32,806)	($ 15,725)	$ 48,531	0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 94,178	$ 170,054	($ 60,236)	$ 203,996
Total assets as of 3/31/11	$ 2,802,225	$ 4,390,677	$ 420,172	$7,613,074

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

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

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

	Three months ended March 31,	
	2012	2011
Basic and Diluted:		
Net income attributable to UHS	$128,607	$114,193
Less: Net income attributable to unvested restricted share grants	(168)	(149)

	Three months ended March 31,	
	2012	2011
Net income attributable to UHS – basic and diluted	$128,439	$114,044
Weighted average number of common shares - basic	96,593	97,381
Net effect of dilutive stock options and grants based on the treasury stock method	1,198	1,487
Weighted average number of common shares and equivalents - diluted	97,791	98,868
Earnings per basic share attributable to UHS:	$ 1.33	$ 1.17
Earnings per diluted share attributable to UHS:	$ 1.31	$ 1.15

The “Net effect of dilutive stock options and grants based on the treasury stock method”, for all periods presented above, excludes certain outstanding stock options applicable to each period since the effect would have been anti-dilutive. The excluded weighted-average stock options totaled 2.7 million for the three months ended March 31, 2012. There were no significant anti-dilutive stock options during the three months ended March 31, 2011. All classes of our common stock have the same dividend rights.

Stock-Based Compensation: During the three-month periods ended March 31, 2012 and 2011, compensation cost of $4.9 million ($3.0 million after-tax) and $3.5 million ($2.1 million after-tax), respectively, was recognized related to outstanding stock options. In addition, during the three-month periods ended March 31, 2012 and 2011, compensation cost of approximately $577,000 ($359,000 after-tax) and $451,000 ($277,000 after-tax), respectively, was recognized related to restricted stock. As of March 31, 2012 there was $50.5 million of unrecognized compensation cost related to unvested options and restricted stock which is expected to be recognized over the remaining weighted average vesting period of 3.1 years. There were 2,902,950 stock options granted (net of cancellations) during the first three months of 2012 with a weighted-average grant date fair value of $10.72 per share. There were 54,127 restricted stock shares granted during the first three months of 2012, with a weighted-average grant date fair value of $36.95 per share.

(8) Dispositions and acquisitions

Subsequent to March 31, 2012:

- We executed a definitive agreement to sell Auburn Regional Medical Center, a 213-bed acute care hospital located in Auburn, Washington, for total cash proceeds of approximately $98 million including estimated working capital. The transaction, which is subject to customary regulatory approvals, is expected to occur by the end of the third quarter of 2012. We expect to realize a substantial gain on the divestiture of this hospital which will be recorded in our consolidated financial statements upon closing of the transaction.
- As a result of the seller’s inability to obtain the removal of the deed restriction on its hospital, we provided the seller with a notice of termination of the previously executed purchase agreement in connection with our planned acquisition of the Knapp Medical Center located in Weslaco, Texas.

Three-month period ended March 31, 2012:

There were no acquisitions during the first quarter of 2012.

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

Three-month period ended March 31, 2011:

There were no acquisitions during the first quarter of 2011.

During the first quarter of 2011, we sold the real property of a closed acute care hospital for net cash proceeds of approximately $1 million. This transaction did not have a material impact on our consolidated financial statements or results of operations.

(9) Dividends

We declared and paid dividends of $4.8 million, or $.05 per share, during the first quarter of 2012 and $4.9 million, or $.05 per share, during the first quarter of 2011.

(10) Pension Plan

The following table shows the components of net periodic pension cost for our defined benefit pension plan as of March 31, 2012 and 2011 (amounts in thousands):

	Three months ended March 31,	
	2012	2011
Service cost	$ 286	$ 334
Interest cost	1,165	1,452
Expected return on assets	(1,540)	(1,509)
Recognized actuarial loss	1,055	744
Net periodic pension cost	$ 966	$ 1,021

During the three months ended March 31, 2012, we made contributions totaling $7.1 million to our pension plan.

(11) Income Taxes

As of January 1, 2012, our unrecognized tax benefits were approximately $7 million. The amount, if recognized, that would affect the effective tax rate is approximately $5 million. During the quarter ended March 31, 2012, 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, 2012, we have approximately $1 million of accrued interest and penalties. The U.S. federal statute of limitations remains open for the 2008 and subsequent years. Foreign and U.S. state and local jurisdictions have statutes of limitations generally ranging from 3 to 4 years. The statute of limitations on certain jurisdictions could expire within the next twelve months.

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

(12) Supplemental Condensed Consolidating Financial Information

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

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

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF INCOME
FOR THE THREE MONTHS ENDED MARCH 31, 2012
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net revenues before provision for doubtful accounts	$ 0	$1,363,923	$619,406	$ (6,326)	$1,977,003
Less: Provision for doubtful accounts	0	92,490	59,224	0	151,714
Net revenues	0	1,271,433	560,182	(6,326)	1,825,289
Operating charges:					
Salaries, wages and benefits	0	636,208	253,298	0	889,506
Other operating expenses	0	242,048	123,724	(6,231)	359,541
Supplies expense	0	132,128	77,404	0	209,532
Depreciation and amortization	0	53,135	20,685	0	73,820
Lease and rental expense	0	15,132	8,825	(95)	23,862
	0	1,078,651	483,936	(6,326)	1,556,261
Income from operations	0	192,782	76,246	0	269,028
Interest expense	45,154	787	769	0	46,710
Interest (income) expense, affiliate	0	22,782	(22,782)	0	0
Equity in net income of consolidated affiliates	(156,478)	(41,077)	0	197,555	0
Income before income taxes	111,324	210,290	98,259	(197,555)	222,318
Provision for income taxes	(17,283)	74,108	22,923	0	79,748
Net income	128,607	136,182	75,336	(197,555)	142,570
Less: Income attributable to noncontrolling interests	0	0	13,963	0	13,963
Net income attributable to UHS	$ 128,607	$ 136,182	$ 61,373	$ (197,555)	$ 128,607

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF INCOME
FOR THE THREE MONTHS ENDED MARCH 31, 2011
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net revenues before provision for doubtful accounts	$ 0	$1,320,128	$596,707	$ (6,307)	$1,910,528
Less: Provision for doubtful accounts	0	94,375	58,741	0	153,116
Net revenues	0	1,225,753	537,966	(6,307)	1,757,412
Operating charges:					
Salaries, wages and benefits	0	608,308	237,556	0	845,864
Other operating expenses	0	241,077	114,581	(6,212)	349,446
Supplies expense	0	131,595	75,575	0	207,170
Depreciation and amortization	0	52,390	18,961	0	71,351
Lease and rental expense	0	15,981	7,282	(95)	23,168
	0	1,049,351	453,955	(6,307)	1,496,999
Income from operations	0	176,402	84,011	0	260,413
Interest expense, net	54,870	793	754	0	56,417
Interest (income) expense, affiliate	0	15,904	(15,904)	0	0
Equity in net income of consolidated affiliates	(147,608)	(50,202)	0	197,810	0
Income before income taxes	92,738	209,907	99,161	(197,810)	203,996
Provision for income taxes	(21,455)	74,961	20,503	0	74,009
Net income	114,193	134,946	78,658	(197,810)	129,987
Less: Income attributable to noncontrolling interests	0	0	15,794	0	15,794
Net income attributable to UHS	$ 114,193	$ 134,946	$ 62,864	$ (197,810)	$ 114,193

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME
FOR THE THREE MONTHS ENDED MARCH 31, 2012
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net income	$128,607	$136,182	$ 75,336	$ (197,555)	$ 142,570
Other comprehensive income (loss):					
Unrealized derivative gains on cash flow hedges	1,615	0	0	0	1,615
Amortization of terminated hedge	(84)	0	0	0	(84)
Other comprehensive income before tax	1,531	0	0	0	1,531
Income tax expense related to items of other comprehensive income	582	0	0	0	582
Total other comprehensive income, net of tax	949	0	0	0	949
Comprehensive income	129,556	136,182	75,336	(197,555)	143,519
Less: Comprehensive income attributable to noncontrolling interests	0	0	13,963	0	13,963
Comprehensive income attributable to UHS	$129,556	$136,182	$ 61,373	$ (197,555)	$ 129,556

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME
FOR THE THREE MONTHS ENDED MARCH 31, 2011
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net income	$114,193	$134,946	$ 78,658	$ (197,810)	$ 129,987
Other comprehensive income (loss):					
Unrealized derivative gains on cash flow hedges	2,307	0	0	0	2,307
Amortization of terminated hedge	(84)	0	0	0	(84)
Other comprehensive income before tax	2,223	0	0	0	2,223
Income tax expense related to items of other comprehensive income	860	0	0	0	860
Total other comprehensive income, net of tax	1,363	0	0	0	1,363
Comprehensive income	115,556	134,946	78,658	(197,810)	131,350
Less: Comprehensive income attributable to noncontrolling interests	0	0	15,794	0	15,794
Comprehensive income attributable to UHS	$115,556	$134,946	$ 62,864	$ (197,810)	$ 115,556

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING BALANCE SHEET
AS OF MARCH 31, 2012
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Assets					
Current assets:					
Cash and cash equivalents	$ 0	$ 33,417	$ 8,582	$ 0	$ 41,999
Accounts receivable, net	2,090	781,738	332,806	0	1,116,634
Supplies	0	59,023	37,951	0	96,974
Other current assets	2,330	78,068	11,224	0	91,622
Deferred income taxes	74,700	41,216	322	(322)	115,916
Total current assets	79,120	993,462	390,885	(322)	1,463,145
Investments in subsidiaries	5,370,051	1,222,926	0	(6,592,977)	0
Intercompany receivable	687,617	0	82,614	(770,231)	0
Intercompany note receivable	0	0	1,148,839	(1,148,839)	0
Property and equipment	0	3,717,908	1,467,866	0	5,185,774
Less: accumulated depreciation	0	(1,229,753)	(651,785)	0	(1,881,538)
	0	2,488,155	816,081	0	3,304,236
Other assets:					
Goodwill	820	2,134,593	494,352	0	2,629,765
Deferred charges	97,570	6,001	2,299	0	105,870
Other	9,906	232,457	37,902	0	280,265
	$6,245,084	$ 7,077,594	$2,972,972	$(8,512,369)	$ 7,783,281
Liabilities and Stockholders' Equity					
Current liabilities:					
Current maturities of long-term debt	$ 0	$ 1,084	$ 1,428	$ 0	$ 2,512
Accounts payable and accrued liabilities	25,963	604,046	184,164	0	814,173
Federal and state taxes	74,459	226	620	0	75,305
Total current liabilities	100,422	605,356	186,212	0	891,990
Intercompany payable	0	770,231	0	(770,231)	0
Other noncurrent liabilities	49,863	247,280	105,928	0	403,071
Long-term debt	3,526,521	3,360	51,963	0	3,581,844
Intercompany note payable	0	1,148,839	0	(1,148,839)	0
Deferred income taxes	140,966	58,001	0	(322)	198,645
Redeemable noncontrolling interests	0	0	228,928	0	228,928
UHS common stockholders' equity	2,427,312	4,244,527	2,348,450	(6,592,977)	2,427,312
Noncontrolling interest	0	0	51,491	0	51,491
Total equity	2,427,312	4,244,527	2,399,941	(6,592,977)	2,478,803
	$6,245,084	$ 7,077,594	$2,972,972	$(8,512,369)	$ 7,783,281

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING BALANCE SHEET
AS OF DECEMBER 31, 2011
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Assets					
Current assets:					
Cash and cash equivalents	$ 0	$ 33,221	$ 8,008	$ 0	$ 41,229
Accounts receivable, net	8,891	663,593	297,318	0	969,802
Supplies	0	59,467	37,308	0	96,775
Other current assets	33,057	56,864	9,938	0	99,859
Deferred income taxes	67,189	41,755	322	(942)	108,324
Current assets held for sale	0	48,916	0	0	48,916
Total current assets	109,137	903,816	352,894	(942)	1,364,905
Investments in subsidiaries	5,213,573	1,181,849	0	(6,395,422)	0
Intercompany receivable	669,112	0	74,155	(743,267)	0
Intercompany note receivable	0	0	1,148,839	(1,148,839)	0
Property and equipment	0	3,650,025	1,456,135	0	5,106,160
Less: accumulated depreciation	0	(1,184,283)	(633,897)	0	(1,818,180)
	0	2,465,742	822,238	0	3,287,980
Other assets:					
Goodwill	820	2,132,103	494,679	0	2,627,602
Deferred charges	103,434	5,972	2,374	0	111,780
Other	10,412	241,107	21,459	0	272,978
	$6,106,488	$ 6,930,589	$2,916,638	$(8,288,470)	$ 7,665,245
Liabilities and Stockholders' Equity					
Current liabilities:					
Current maturities of long-term debt	$ 0	$ 1,133	$ 1,346	$ 0	$ 2,479
Accounts payable and accrued liabilities	14,201	616,026	201,898	0	832,125
Current liabilities held for sale	0	2,329	0	0	2,329
Federal and state taxes	0	0	620	(620)	0
Total current liabilities	14,201	619,488	203,864	(620)	836,933
Intercompany payable	0	743,267	0	(743,267)	0
Other noncurrent liabilities	49,840	249,033	103,035	0	401,908
Long-term debt	3,594,182	3,616	53,630	0	3,651,428
Intercompany note payable	0	1,148,839	0	(1,148,839)	0
Deferred income taxes	151,913	58,001	0	(322)	209,592
Redeemable noncontrolling interests	0	0	218,266	0	218,266
UHS common stockholders' equity	2,296,352	4,108,345	2,287,077	(6,395,422)	2,296,352
Noncontrolling interest	0	0	50,766	0	50,766
Total equity	2,296,352	4,108,345	2,337,843	(6,395,422)	2,347,118
	$6,106,488	$ 6,930,589	$2,916,638	$(8,288,470)	$ 7,665,245

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
FOR THE THREE MONTHS ENDED MARCH 31, 2012
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net cash provided by operating activities	**$ 93,390**	**$ 10,893**	**$ 22,940**	**$ 0**	**$ 127,223**
Cash Flows from Investing Activities:					
Property and equipment additions, net of disposals	0	(79,339)	(13,224)	0	(92,563)
Proceeds received from sale of assets and businesses	0	49,984	3,477	0	53,461
Costs incurred for purchase and development of electronic health records application	0	(14,501)	0	0	(14,501)
Return of deposit on terminated purchase agreement	0	6,500	0	0	6,500
Net cash used in investing activities	**0**	**(37,356)**	**(9,747)**	**0**	**(47,103)**
Cash Flows from Financing Activities:					
Reduction of long-term debt	(69,052)	(305)	(1,585)	0	(70,942)
Repurchase of common shares	(2,017)	0	0	0	(2,017)
Dividends paid	(4,832)	0	0	0	(4,832)
Issuance of common stock	1,016	0	0	0	1,016
Profit distributions to noncontrolling interests	0	0	(2,575)	0	(2,575)
Changes in intercompany balances with affiliates, net	(18,505)	26,964	(8,459)	0	0
Net cash (used in) provided by financing activities	**(93,390)**	**26,659**	**(12,619)**	**0**	**(79,350)**
Increase (decrease) in cash and cash equivalents	0	196	574	0	770
Cash and cash equivalents, beginning of period	0	33,221	8,008	0	41,229
Cash and cash equivalents, end of period	$ 0	$ 33,417	$ 8,582	$ 0	$ 41,999

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
FOR THE THREE MONTHS ENDED MARCH 31, 2011
(amounts in thousands)

	Parent	Guarantors	Non Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Net cash provided by operating activities	**$ 59,016**	**$109,876**	**$ 14,285**	**$ 0**	**$ 183,177**
Cash Flows from Investing Activities:					
Property and equipment additions, net of disposals	0	(41,016)	(15,542)	0	(56,558)
Proceeds received from sale of assets and businesses	0	991	0	0	991
Costs incurred for purchase and development of electronic health records application	0	(8,145)	0	0	(8,145)
Net cash used in investing activities	**0**	**(48,170)**	**(15,542)**	**0**	**(63,712)**
Cash Flows from Financing Activities:					
Reduction of long-term debt	(135,334)	(396)	(673)	0	(136,403)
Additional borrowings	73,500	0	0	0	73,500
Financing costs	(23,140)	0	0	0	(23,140)
Repurchase of common shares	(3,170)	0	0	0	(3,170)
Dividends paid	(4,876)	0	0	0	(4,876)
Issuance of common stock	1,251	0	0	0	1,251
Profit distributions to noncontrolling interests	0	0	(4,025)	0	(4,025)
Changes in intercompany balances with affiliates, net	32,753	(37,292)	4,539		0
Net cash (used in) provided by financing activities	**(59,016)**	**(37,688)**	**(159)**	**0**	**(96,863)**
Increase (decrease) in cash and cash equivalents	0	24,018	(1,416)	0	22,602
Cash and cash equivalents, beginning of period	0	21,385	8,089	0	29,474
Cash and cash equivalents, end of period	$ 0	$ 45,403	$ 6,673	$ 0	$ 52,076

(13) Recent Accounting Standards

Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities: During the first quarter of 2012, we adopted the Financial Accounting Standards Board's Accounting Standards Update ("ASU") No. 2011-07, "Health Care Entities (Topic 954): Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities," which required certain health care entities to change the presentation in their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). As a result, the provision for doubtful accounts for our acute care and behavioral health care facilities is reflected as a deduction from net revenues in the accompanying consolidated statements of income for the three-month periods ended March 31, 2012 and 2011. The adoption of this standard had no impact on our financial position or overall results of operations.

Presentation of Comprehensive Income: In June 2011, the FASB amended its guidance governing the presentation of comprehensive income. The amended guidance eliminates the option to report other comprehensive income and its components in the statement of changes in equity. Under the new guidance, an entity can elect to present items of net income and other comprehensive income in one continuous statement referred to as the statement of comprehensive income or in two separate, but consecutive, statements. While the options for presenting other comprehensive income change under the guidance, other portions of the current guidance will not change. For public entities, these changes are effective for fiscal years, and interim periods within those years, beginning after December 15, 2011. The adoption of this standard did not have an impact on our consolidated financial position or results of operations.

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

Overview

Our principal business is owning and operating, through our subsidiaries, acute care hospitals, behavioral health centers, surgical hospitals, ambulatory surgery centers and radiation oncology centers. As of March 31, 2012, we owned and/or operated 25 acute care hospitals and 196 behavioral health centers located in 36 states, Washington, D.C., Puerto Rico and the U.S. Virgin Islands. As part of our ambulatory treatment centers division, we manage and/or own outright or in partnerships with physicians, 6 surgical hospitals and surgery and radiation oncology centers located in 4 states and Puerto Rico.

During the first quarter of 2012, we adopted the Financial Accounting Standards Board's Accounting Standards Update ("ASU") No. 2011-07, "Health Care Entities (Topic 954): Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities," which required certain health care entities to change the presentation in their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). As a result, the provision for doubtful accounts for our acute care and behavioral health care facilities is reflected as a deduction from net revenues in the accompanying consolidated statements of income for the three-month periods ended March 31, 2012 and 2011. The adoption of this standard had no impact on our financial position or overall results of operations.

Net revenues from our acute care hospitals, surgical hospitals, surgery centers and radiation oncology centers accounted for 53% of our consolidated net revenues during each of the three-month periods ended March 31, 2012 and 2011. Net revenues from our behavioral health care facilities accounted for 47% of our consolidated net revenues during each of the three-month periods ended March 31, 2012 and 2011.

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

Forward-Looking Statements and Risk Factors

You should carefully review the information contained in this Quarterly Report, and should particularly consider any risk factors that we set forth in this Quarterly Report and in other reports or documents that we file from time to time with the Securities and Exchange Commission (the "SEC"). In this Quarterly Report, we state our beliefs of future events and of our future financial performance. This Quarterly Report contains "forward-looking statements" that reflect our current estimates, expectations and projections about our future results, performance, prospects and opportunities. Forward-looking statements include, among other things, the information concerning our possible future results of operations, business and growth strategies, financing plans, expectations that regulatory developments or other matters will not have a material adverse effect on our business or financial condition, our competitive position and the effects of competition, the projected growth of the industry in which we operate, and the benefits and synergies to be obtained from our completed and any future acquisitions, and statements of our goals and objectives, and other similar expressions concerning matters that are not historical facts. Words such as "may," "will," "should," "could," "would," "predicts," "potential," "continue," "expects," "anticipates," "future," "intends," "plans," "believes," "estimates," "appears," "projects" and similar 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 detailed in our filings with the SEC including those set forth herein and in our Annual Report on Form 10-K for the year ended December 31, 2011 in *Item 1A Risk Factors* and in *Item 7 Management's Discussion and Analysis of Financial Condition and Results of Operations – Forward Looking Statements and Risk Factors*. Those factors may cause our actual results to differ materially from any of our forward-looking statements.

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

- our ability to comply with the existing laws and government regulations, and/or changes in laws and government regulations;
- an increasing number of legislative initiatives have recently been passed into law that may result in major changes in the health care delivery system on a national or state level. No assurances can be given that the implementation of these new laws will not have a material adverse effect on our business, financial condition or results of operations;
- possible unfavorable changes in the levels and terms of reimbursement for our charges by third party payors or government programs, including Medicare or Medicaid;
- an increase in the number of uninsured and self-pay patients treated at our acute care facilities that unfavorably impacts our ability to satisfactorily and timely collect our self-pay patient accounts;
- our ability to enter into managed care provider agreements on acceptable terms and the ability of our competitors to do the same, including contracts with United/Sierra Healthcare in Las Vegas, Nevada;

- the outcome of known and unknown litigation, government investigations, false claim act allegations, and liabilities and other claims asserted against us, including matters as disclosed in *Item 1. Legal Proceedings*;
- the potential unfavorable impact on our business of deterioration in national, regional and local economic and business conditions, including a continuation or worsening of unfavorable credit market conditions;
- competition from other healthcare providers (including physician owned facilities) in certain markets, including McAllen/Edinburg, Texas, the site of one of our largest acute care facilities and Riverside County, California;
- technological and pharmaceutical improvements that increase the cost of providing, or reduce the demand for healthcare;
- our ability to attract and retain qualified personnel, nurses, physicians and other healthcare professionals and the impact on our labor expenses resulting from a shortage of nurses and other healthcare professionals;
- demographic changes;
- our acquisition of PSI which has substantially increased our level of indebtedness which could, among other things, adversely affect our ability to raise additional capital to fund operations, limit our ability to react to changes in the economy or our industry and could potentially prevent us from meeting our obligations under the agreements related to our indebtedness;
- our ability to successfully integrate and improve our recent acquisitions and the availability of suitable acquisitions and divestiture opportunities;
- we receive Medicaid revenues in excess of $100 million annually from each of Texas, Pennsylvania, Virginia, Illinois and Washington, D.C., making us particularly sensitive to reductions in Medicaid and other state based revenue programs (which have been implemented in various forms with respect to our areas of operation in the respective 2012 state fiscal years) as well as regulatory, economic, environmental and competitive changes in those states. In the states in which we operate, based upon the state budgets for the 2012 fiscal year (which generally began at various times during the second half of 2011), we estimate that, on a blended basis, our aggregate Medicaid rates have been reduced by approximately 3% to 4% (or approximately $45 million to $55 million annually) from the average rates in effect during the states' 2011 fiscal years (which generally ended during the third quarter of 2011). Our consolidated results of operations for the year ended December 31, 2011 and the three-month period ended March 31, 2012 include the pro rata portion of these Medicaid rate reductions. We can provide no assurance that further reductions to Medicaid revenues (which have been proposed in certain states for fiscal year 2013), particularly in the above-mentioned states, will not have a material adverse effect on our future results of operations;
- our ability to continue to obtain capital on acceptable terms, including borrowed funds, to fund the future growth of our business;
- some of our acute care facilities continue to experience decreasing inpatient admission trends;
- our financial statements reflect large amounts due from various commercial and private payors and there can be no assurance that failure of the payors to remit amounts due to us will not have a material adverse effect on our future results of operations;
- the Department of Health and Human Services ("HHS") published final regulations in July, 2010 implementing the health information technology ("HIT") provisions of the American Recovery and Reinvestment Act (referred to as the "HITECH Act"). The final regulation defines the "meaningful use" of Electronic Health Records ("EHR") and establishes the requirements for the Medicare and Medicaid EHR payment incentive programs. The implementation period for these new Medicare and Medicaid incentive payments started in federal fiscal year 2011 and can end as late as 2016 for Medicare and 2021 for the state Medicaid programs. Our acute care hospitals may qualify for these EHR incentive payments upon implementation of the EHR application assuming they meet the "meaningful use criteria". Certain of our acute care hospitals implemented an EHR application in 2011 and we plan to continue the implementation at each of our acute care hospitals, on a facility-by-facility basis, during 2012 and 2013. However, there can be no assurance that we (our acute care hospitals) will ultimately qualify for these incentive payments and, should we qualify, we are unable to quantify the amount of incentive payments we may receive since the amounts are dependent upon various factors including the implementation timing at each hospital. Should we qualify for incentive payments, there may be timing differences in the recognition of the revenues and expenses recorded in connection with the implementation of the EHR application which may cause material period-to-period changes in our future results of operations. Hospitals that do not qualify as a meaningful user of EHR by 2015 are subject to a reduced market basket update to the inpatient prospective payment system ("IPPS") standardized amount in 2015 and each subsequent fiscal year. Although we believe that our acute care hospitals will be in compliance with the EHR standards by 2015, there can be no assurance that all of our facilities will be in compliance and therefore not subject to the penalty provision of the HITECH Act;
- in August, 2011, the Budget Control Act of 2011 (the "2011 Act") was enacted into law. The 2011 Act imposed annual spending limits for most federal agencies and programs aimed at reducing budget deficits by $917 billion between 2012 and 2021, according to a report released by the Congressional Budget Office. Among its other provisions, the law established a bipartisan Congressional committee, known as the Joint Select Committee on Deficit Reduction (the "Joint Committee"), which was tasked with making recommendations aimed at reducing future federal budget deficits by an additional $1.5 trillion over 10 years. The Joint Committee was unable to reach an agreement by the November 23, 2011 deadline and, as a result, across-the-board cuts to discretionary, national defense and Medicare spending were implemented which, if triggered, would result in Medicare payment

reductions of up to 2% per fiscal year with a uniform percentage reduction across all Medicare programs starting in 2013. We cannot predict whether Congress will attempt to suspend or restructure the automatic budget cuts or what other deficit reduction initiatives may be proposed by Congress;

- the ability to obtain adequate levels of general and professional liability insurance on current terms;
- changes in our business strategies or development plans;
- fluctuations in the value of our common stock, and;
- other factors referenced herein or in our other filings with the Securities and Exchange Commission.

Given these uncertainties, risks and assumptions, as outlined above, you are cautioned not to place undue reliance on such forward-looking statements. Our actual results and financial condition could differ materially from those expressed in, or implied by, the forward-looking statements. Forward-looking statements speak only as of the date the statements are made. We assume no obligation to publicly update any forward-looking statements to reflect actual results, changes in assumptions or changes in other factors affecting forward-looking information, except as may be required by law. All forward-looking statements attributable to us or persons acting on our behalf are expressly qualified in their entirety by this cautionary statement.

Critical Accounting Policies and Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires us to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes. We consider our critical accounting policies to be those that require us to make significant judgments and estimates when we prepare our consolidated financial statements. For a summary of our significant accounting policies, please see *Note 1 to the Consolidated Financial Statements* as included in our Annual Report on Form 10-K for the year ended December 31, 2011.

Revenue recognition: We record revenues and related receivables for health care services at the time the services are provided. Medicare and Medicaid revenues represented 39% and 41% of our net patient revenues during the three-month periods ended March 31, 2012 and 2011, respectively. Revenues from managed care entities, including health maintenance organizations and managed Medicare and Medicaid programs, accounted for 48% and 46% of our net patient revenues during the three-month periods ended March 31, 2012 and 2011, respectively.

Provision for Doubtful Accounts: On a consolidated basis, we monitor our total self-pay receivables to ensure that the total allowance for doubtful accounts provides adequate coverage based on historical collection experience. Our accounts receivable are recorded net of allowance for doubtful accounts of $268 million at March 31, 2012 and $253 million at December 31, 2011.

Our accounts receivable includes $73 million as of March 31, 2012 and $54 million as of December 31, 2011 due from Illinois, the collection of which continues to be delayed due to budgetary and funding pressures experienced by the state. Although approximately $50 million of the receivables due from Illinois as of March 31, 2012 have been outstanding in excess of 60 days, and a large portion will likely remain outstanding for the foreseeable future, we expect to eventually collect all amounts due to us and therefore no related reserves have been established in our consolidated financial statements. However, we can provide no assurance that we will eventually collect all amounts due to us from Illinois. Failure to ultimately collect all outstanding amounts due from Illinois would have an adverse impact on our future consolidated results of operations and cash flows.

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

Results of Operations

Three-month periods ended March 31, 2012 and 2011:

The following table summarizes our results of operations and is used in the discussion below for the three-month periods ended March 31, 2012 and 2011 (dollar amounts in thousands):

	Three months ended March 31, 2012		Three months ended March 31, 2011	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$ 1,977,003		$ 1,910,528	
Less: Provision for doubtful accounts	151,714		153,116	
Net revenues	1,825,289	100.0%	1,757,412	100.0%
Operating charges:				
Salaries, wages and benefits	889,506	48.7%	845,864	48.1%
Other operating expenses	359,541	19.7%	349,446	19.9%
Supplies expense	209,532	11.5%	207,170	11.8%
Depreciation and amortization	73,820	4.0%	71,351	4.1%
Lease and rental expense	23,862	1.3%	23,168	1.3%
Subtotal-operating expenses	1,556,261	85.3%	1,496,999	85.2%
Income from operations	269,028	14.7%	260,413	14.8%
Interest expense, net	46,710	2.6%	56,417	3.2%
Income before income taxes	222,318	12.2%	203,996	11.6%
Provision for income taxes	79,748	4.4%	74,009	4.2%
Net income	142,570	7.8%	129,987	7.4%
Less: Income attributable to noncontrolling interests	13,963	0.8%	15,794	0.9%
Net income attributable to UHS	$ 128,607	7.0%	$ 114,193	6.5%

Net revenues increased 4% or $68 million to $1.83 billion during the three-month period ended March 31, 2012 as compared to $1.76 billion during the comparable quarter of the prior year. The increase was attributable to:

- a $50 million or 3% increase in net revenues generated at our acute care hospitals and behavioral health care facilities owned during both periods (which we refer to as “same facility”);
- $36 million of revenues resulting from an agreement, which was part of an industry-wide settlement related to underpayments of Medicare inpatient prospective payments during a number of prior years, entered into with the United States Department of Health and Human Services, the Secretary of Health and Human Services, and the Centers for Medicare and Medicaid Services, and;
- $18 million of other combined net decreases in revenues resulting primarily from the divestiture of a behavioral health care facility in January, 2012 (San Juan Capestrano) and temporary closure of a behavioral health care facility that was closed during the third quarter of 2011 from flood damage (the facility re-opened in March, 2012).

Income before income taxes (before deduction for income attributable to noncontrolling interests) increased $18 million to $222 million during the three-month period ended March 31, 2012 as compared to $204 million during the comparable quarter of the prior year. Included in our income before income taxes during the first quarter of 2012, as compared to the comparable prior year quarter, was the following:

a. a decrease of $19 million at our acute care facilities as discussed below in Acute Care Hospital Services, excluding impact of the items mentioned in c., and e. below;

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

c. an increase of $33 million (net of related expenses) resulting from an agreement, which was part of an industry-wide settlement related to underpayments of Medicare inpatient prospective payments during a number of prior years, entered into with the United States Department of Health and Human Services, the Secretary of Health and Human Services, and the Centers for Medicare and Medicaid Services;

d. an increase of $7 million representing the 2011 portion of the net Medicaid supplemental reimbursements earned pursuant to the Oklahoma Supplemental Hospital Offset Payment Program (“SHOPP”) which is expected to provide annual aggregate net reimbursements of $14 million to our facilities located in the state during the state’s fiscal years of 2012 and 2013, retroactive to July 1, 2011;

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

f. an increase of $10 million due to a decrease in interest expense resulting primarily from a decrease in our average effective interest rate (due primarily to an amendment to our credit agreement in March of 2011 which, among other things, provided for reductions in the rates payable for borrowings outstanding under our Term Loan A, Term Loan B and revolving credit facility) and average borrowings outstanding, and;

g. $12 million of other combined net decreases including increased corporate overhead expenses.

Net income attributable to UHS increased $14 million to $129 million during the three-month period ended March 31, 2012 as compared to $114 million during the comparable prior year quarter. The increase during the first quarter of 2012, as compared to the comparable prior year quarter, consisted of:

- an increase of $18 million in income before income taxes, as discussed above;
- an increase of $2 million resulting from a decrease in income attributable to noncontrolling interests, and;
- a decrease of $6 million resulting from an increase in the provision for income taxes resulting primarily from the income tax provision recorded on the $20 million increase in pre-tax income ($18 million increase in income before income taxes and the $2 million increase in income due to a decrease in the income attributable to noncontrolling interests).

Acute Care Hospital Services

Same Facility Basis Acute Care Hospitals

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

The following table summarizes the results of operations for our acute care facilities, on a same facility and all acute care basis, and is used in the discussion below for the three-month periods ended March 31, 2012 and 2011 (dollar amounts in thousands):

	Three months ended March 31, 2012		Three months ended March 31, 2011	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$1,058,134		$1,054,293	
Less: Provision for doubtful accounts	128,455		131,751	
Net revenues	929,679	100.0%	922,542	100.0%
Operating charges:				
Salaries, wages and benefits	407,825	43.9%	391,960	42.5%
Other operating expenses	185,648	20.0%	179,571	19.5%
Supplies expense	163,200	17.6%	161,702	17.5%
Depreciation and amortization	49,183	5.3%	47,784	5.2%
Lease and rental expense	14,752	1.6%	13,535	1.5%
Subtotal-operating expenses	820,608	88.3%	794,552	86.1%
Income from operations	109,071	11.7%	127,990	13.9%
Interest expense, net	1,178	0.1%	1,006	0.1%
Income before income taxes	107,893	11.6%	126,984	13.8%

During the three-month period ended March 31, 2012, as compared to the comparable prior year quarter, net revenues at our acute care hospitals increased $7 million or 1%. Income before income taxes (and before income attributable to noncontrolling interests) decreased $19 million or 15% to $108 million or 11.6% of net revenues during the first quarter of 2012 as compared to $127 million or 13.8% of net revenues during the comparable prior year quarter.

During the three-month period ended March 31, 2012, as compared to the comparable prior year quarter, inpatient admissions to our acute care facilities decreased 2.0% and adjusted admissions (adjusted for outpatient activity) increased 1.6%. Patient days at these facilities

decreased 2.6% during the first quarter of 2012 and adjusted patient days increased 1.0% during the three-month period ended March 31, 2012 as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities was 4.5 days during each of the three-month periods ended March 31, 2012 and 2011, respectively. The occupancy rate, based on the average available beds at these facilities, was 57% and 60% during the three-month periods ended March 31, 2012 and 2011, respectively. During the three-month period ended March 31, 2012, net revenue per adjusted admission decreased 0.8% and net revenue per adjusted patient day decreased 0.2%, as compared to the comparable quarter of the prior year.

The decreases in income from operations and net revenue per adjusted admission and adjusted patient day experienced at our acute care hospitals during the three-month period ended March 31, 2012, as compared to the comparable quarter of the prior year, were largely due to difficult comparisons to the prior year quarter when our acute care net revenues were favorably impacted by positive changes in payor mix and acuity of patients treated at our hospitals and a stabilization of uninsured patient volumes.

Charity care and uninsured discounts:

A significant portion of the patients treated throughout our portfolio of acute care hospitals are uninsured patients which, in part, has resulted from an increase in the number of patients who are employed but do not have health insurance or who have policies with relatively high deductibles. We provide care to patients who meet certain financial or economic criteria without charge or at amounts substantially less than our established rates. Because we do not pursue collection of amounts that qualify as charity care, they are not reported in net revenues or in accounts receivable, net. Our acute care hospitals provided charity care and uninsured discounts, based on charges at established rates, amounting to $315 million and $223 million during three-month periods ended March 31, 2012 and 2011, respectively.

The estimated costs of providing the charity services was $52 million and $39 million during the three-month periods ended March 31, 2012 and 2011, respectively. The estimated costs 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 gross charity care and uninsured discount amounts. The percentage of cost to gross charges is calculated based on the total operating expenses for our acute care facilities divided by gross patient service revenue for those facilities. An increase in the level of uninsured patients to our facilities and the resulting adverse trends in the provision for doubtful accounts and charity care provided could have a material unfavorable impact on our future operating results.

All Acute Care Hospitals

The following table summarizes the results of operations for our acute care hospitals for the three-month periods ended March 31, 2012 and 2011. Included in the financial results below for the three-month period ended March 31, 2012, in addition to our acute care hospitals', same facility basis financial results as discussed above, were the following items. There were no such adjustments required to our same facility acute care results for the three-month period ended March 31, 2011.

- $36 million of net revenues and $3 million of related operating expenses resulting from an agreement, which was part of an industry-wide settlement related to underpayments of Medicare inpatient prospective payments during a number of prior years, entered into with the United States Department of Health and Human Services, the Secretary of Health and Human Services, and the Centers for Medicare and Medicaid Services, and;
- (i) a $7 million reduction to net revenues resulting from the revised Supplemental Security Income ratios utilized for calculating Medicare disproportionate share hospital reimbursements for federal fiscal years 2006 through 2009, and; (ii) a $4 million reduction to net revenues resulting from the write-off of receivables related to revenues recorded during 2011 at two of our acute care hospitals located in Florida resulting from reductions in certain county reimbursements due to reductions in federal matching Inter-Governmental Transfer funds.

	Three months ended March 31, 2012		Three months ended March 31, 2011	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$1,082,687		$1,054,293	
Less: Provision for doubtful accounts	128,455		131,751	
Net revenues	954,232	100.0%	922,542	100.0%
Operating charges:				
Salaries, wages and benefits	407,825	42.7%	391,960	42.5%

Other operating expenses	188,246	19.7%	179,571	19.5%
Supplies expense	163,200	17.1%	161,702	17.5%
Depreciation and amortization	49,183	5.2%	47,784	5.2%
Lease and rental expense	14,752	1.5%	13,535	1.5%
Subtotal-operating expenses	823,206	86.3%	794,552	86.1%
Income from operations	131,026	13.7%	127,990	13.9%
Interest expense, net	1,178	0.1%	1,006	0.1%
Income before income taxes	129,848	13.6%	126,984	13.8%

Behavioral Health Services

The following table summarizes the results of operations for our behavioral health care facilities, on a same facility basis, and is used in the discussion below for the three-month periods ended March 31, 2012 and 2011 (dollar amounts in thousands):

Same Facility – Behavioral Health

	Three months ended March 31, 2012		Three months ended March 31, 2011	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$877,839		$832,929	
Less: Provision for doubtful accounts	23,035		21,013	
Net revenues	854,804	100.0%	811,916	100.0%
Operating charges:				
Salaries, wages and benefits	428,523	50.1%	409,268	50.4%
Other operating expenses	152,406	17.8%	144,410	17.8%
Supplies expense	44,600	5.2%	43,018	5.3%
Depreciation and amortization	22,636	2.6%	21,000	2.6%
Lease and rental expense	8,387	1.0%	8,180	1.0%
Subtotal-operating expenses	656,552	76.8%	625,876	77.1%
Income from operations	198,252	23.2%	186,040	22.9%
Interest expense, net	377	0.1%	531	0.1%
Income before income taxes	197,875	23.1%	185,509	22.8%

On a same facility basis, during the first quarter of 2012, as compared to the first quarter of 2011, net revenues at our behavioral health care facilities increased 5% or $43 million to $855 million from $812 million. Income before income taxes increased $12 million or 7% to $198 million or 23.1% of net revenues during the three-month period ended March 31, 2012, as compared to $186 million or 22.8% of net revenues during the comparable prior year quarter.

On a same facility basis, inpatient admissions and adjusted admissions (adjusted for outpatient activity) to our behavioral health facilities increased 8.6% and 9.2%, respectively, during the three-month period ended March 31, 2012 as compared to the comparable quarter of the prior year. Patient days and adjusted patient days increased 2.3% and 2.8%, respectively, during the three-month period ended March 31, 2012 as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities was 13.7 days and 14.6 days during the three-month periods ended March 31, 2012 and 2011, respectively. The occupancy rate, based on the average available beds at these facilities, was 76% and 75% during the three-month periods ended March 31, 2012 and 2011, respectively. During the three-month period ended March 31, 2012, net revenue per adjusted admission decreased 3.6% and net revenue per adjusted patient day increased 2.4%, as compared to the comparable quarter of the prior year.

All Behavioral Health Care Facilities

The following table summarizes the results of operations for our behavioral health care facilities for the three-month periods ended March 31, 2012 and 2011. Included in the financial results below for the three-month period ended March 31, 2012, in addition to our behavioral health care facilities' same facility basis financial results as discussed above, were the following items:

- $7 million of net revenues recorded during the three-month period ended March 31, 2012 representing the 2011 portion of the net Medicaid supplemental reimbursements earned pursuant to the Oklahoma Supplemental Hospital Offset Payment Program ("SHOPP") which is expected to provide annual aggregate net reimbursements of $14 million to our facilities located in the state during the state's fiscal years of 2012 and 2013, retroactive to July 1, 2011, and;
- The operating results of San Juan Capestrano that was divested in January, 2012, and a behavioral health care facility that was temporarily closed beginning in the third quarter of 2011 from flood damage (the facility re-opened in March, 2012).

	Three months ended March 31, 2012		Three months ended March 31, 2011	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$888,177		$850,308	
Less: Provision for doubtful accounts	23,304		21,360	
Net revenues	864,873	100.0%	828,948	100.0%
Operating charges:				
Salaries, wages and benefits	434,083	50.2%	419,065	50.6%
Other operating expenses	151,433	17.5%	149,409	18.0%
Supplies expense	44,953	5.2%	44,090	5.3%
Depreciation and amortization	22,972	2.7%	21,443	2.6%
Lease and rental expense	8,559	1.0%	8,609	1.0%
Subtotal-operating expenses	662,000	76.5%	642,616	77.5%
Income from operations	202,873	23.5%	186,332	22.5%
Interest expense, net	377	0.1%	553	0.1%
Income before income taxes	202,496	23.4%	185,779	22.4%

During the first quarter of 2012, as compared to the comparable prior year quarter, net revenues at our behavioral health care facilities increased 4% or $36 million. Income before income taxes increased $17 million or 9% to $202 million or 23.4% of net revenues during the first quarter of 2012, as compared to $186 million or 22.4% of net revenues during the first quarter of 2011. The increases in net revenues and income before income taxes were primarily attributable to the same facility basis increases, as discussed above.

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.

The following tables show the approximate percentages of net patient revenue during the past three years (excludes sources of revenues for all periods presented for divested facilities which are reflected as discontinued operations in our Consolidated Financial Statements) for: (i) our Acute Care and Behavioral Health Care Facilities Combined; (ii) our Acute Care Facilities, and; (iii) our Behavioral Health Care Facilities. Net patient revenue is defined as revenue from all sources after deducting contractual allowances and discounts from established billing rates, which we derived from various sources of payment for the years indicated.

The following table shows the approximate percentages of net patient revenue for the three month period ended March 31, 2012 and 2011 presented: (i) on a combined basis for both our acute care and behavioral health facilities; (ii) for our acute care facilities only, and; (iii) for our behavioral health facilities only:

Acute Care and Behavioral Health Facilities Combined	Percentage of Net Patient Revenues	
	Three Months Ended March 31,	
	2012	2011
Third Party Payors:		
Medicare	24%	24%
Medicaid	15%	17%
Managed Care (HMO and PPOs)	48%	46%
Other Sources	13%	13%
Total	100%	100%

Acute Care Facilities	Percentage of Net Patient Revenues	
	Three Months Ended March 31,	
	2012	2011
Third Party Payors:		
Medicare	29%	30%
Medicaid	7%	9%
Managed Care (HMO and PPOs)	55%	51%
Other Sources	9%	10%
Total	100%	100%

Behavioral Health Facilities	Percentage of Net Patient Revenues	
	Three Months Ended March 31,	
	2012	2011
Third Party Payors:		
Medicare	18%	17%
Medicaid	24%	26%
Managed Care (HMO and PPOs)	40%	39%
Other Sources	18%	18%
Total	100%	100%

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

Under the Medicare program, for inpatient services, our general acute care hospitals receive reimbursement under the inpatient prospective payment system ("IPPS"). Under the IPPS, hospitals are paid a predetermined fixed payment amount for each hospital discharge. The fixed payment amount is based upon each patient's Medicare severity diagnosis related group ("MS-DRG"). Every MS-DRG is assigned a payment rate based upon the estimated intensity of hospital resources necessary to treat the average patient with that particular diagnosis. The MS-DRG payment rates are based upon historical national average costs and do not consider the actual costs incurred by a hospital in providing care. This MS-DRG assignment also affects the predetermined capital rate paid with each MS-DRG. The MS-DRG and capital payment rates are adjusted annually by the predetermined geographic adjustment factor for the geographic region in which a particular hospital is located and are weighted based upon a statistically normal distribution of severity. While we generally will not receive payment from Medicare for inpatient services, other than the MS-DRG payment, a hospital may qualify for an "outlier" payment if a particular patient's treatment costs are extraordinarily high and exceed a specified threshold.

MS-DRG rates are adjusted by an update factor each federal fiscal year, which begins on October 1. The index used to adjust the MS-DRG rates, known as the "hospital market basket index," gives consideration to the inflation experienced by hospitals in purchasing goods and

services. Generally, however, the percentage increases in the MS-DRG payments have been lower than the projected increase in the cost of goods and services purchased by hospitals.

In July, 2010, CMS published its final IPPS 2011 payment rule which provided for a 2.6% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors and annual geographic wage index updates and the documenting and coding adjustments were considered, our overall decrease from the federal fiscal year 2011 rule was 1.1%. In addition, as outlined in the Sources of Revenues and Health Care Reform discussion below, CMS was also required by federal law to reduce the update factor by 0.25% in federal fiscal year 2011.

In August, 2011, CMS published its final IPPS 2012 payment rule which provided for a 3.0% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments and Health Care Reform productivity adjustments are considered, we estimate our overall increase from the final federal fiscal year 2012 rule will approximate 0.6%. CMS also includes a 2.0% market basket reduction related to prior year documentation and coding adjustments as well as a 1.1% increase related to the correction of a prior year wage index budget neutrality adjustment. In addition, as outlined in the Sources of Revenues and Health Care Reform discussion below, CMS was also required by federal law to reduce the update factor by 0.10% in federal fiscal year 2012. The projected impact from this IPPS rule noted above reflects all of the adjustments described in this paragraph.

In April, 2012, CMS published its proposed IPPS 2013 payment rule which provided for a 3.0% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments and Health Care Reform mandated adjustments are considered, we estimate our overall increase from the proposed federal fiscal year 2013 rule will approximate 0.8%. The projected impact from this IPPS proposed rule noted above reflects all of the adjustments described in this paragraph.

In September, 2007, the “TMA, Abstinence Education, and QI Programs Extension Act of 2007” legislation took effect and scaled back cuts in hospital reimbursement that CMS was set to impose. In federal fiscal years 2010 to 2012, the new law requires CMS to make adjustments to the Medicare standardized amounts in these years to reflect the removal of actual aggregate payment increases or decreases for documentation and coding adjustments that occurred during federal fiscal years 2008 and 2009 as compared to the initial CMS estimates. In federal fiscal year 2010, CMS made its initial statutory mandated adjustment under this legislation and will continue to do so in subsequent fiscal years to ensure the implementation of MS-DRGs was budget neutral among all affected hospitals. In July, 2010, the IPPS 2011 proposed payment rule applied a 2.9% reduction to the 2011 market basket update and indicated another 2.9% reduction would also be applied in 2012 for documenting and coding. In this same rule, CMS indicated a remaining documenting and coding adjustment of 3.9% reduction is still required to be made to future IPPS updates. In the 2012 IPPS final rule, CMS offset 2.0% of this remaining reduction and has proposed to offset the remaining 1.9% in the IPPS 2013 payment rule described above.

On January 1, 2005, CMS implemented a new Psychiatric Prospective Payment System (“Psych PPS”) for inpatient services furnished by psychiatric hospitals under the Medicare program. This system replaced the cost-based reimbursement guidelines with a per diem Psych PPS with adjustments to account for certain facility and patient characteristics. The Psych PPS also contained provisions for outlier payments and an adjustment to a psychiatric hospital’s base payment if it maintains a full-service emergency department. According to the April, 2010 CMS notice, the market basket increase was 2.4% for the period of July 1, 2010 through June 30, 2011. In April, 2011 CMS published its final Psych PPS rule for the fifteen month period July 1, 2011 to September 30, 2012. The market basket increase for this time period is scheduled to be 2.95%, which includes a 0.25% reduction required by the federal Health Care Reform legislation enacted in 2010.

In November 2010, CMS published its annual final Medicare Outpatient Prospective Payment System (“OPPS”) rule for 2011. The final market basket increase to the OPPS base rate is 2.46%. In addition, as outlined in the Sources of Revenues and Health Care Reform discussion below, CMS is also required by federal law to reduce the update factor by 0.25% in federal fiscal year 2011. When other statutorily required adjustments and hospital patient service mix are considered, the overall Medicare OPPS payment increase for 2011 is estimated to be 3.2%.

In November, 2011, CMS published its annual final Medicare OPPS rule for 2012. The market basket increase to the OPPS base rate is 3.0%. In addition, as outlined in the Sources of Revenues and Health Care Reform discussion below, CMS is also required by federal law to reduce the update factor by 0.1% in federal fiscal year 2012 and to reduce the annual update by a productivity adjustment which is 1.1%. In the final rule, CMS is also implementing a significant decrease in the 2012 Medicare rates for both hospital-based and community mental health center (CMHC) partial hospitalization programs. When other statutorily required adjustments, hospital patient service mix and the aforementioned partial hospitalization rates are considered, our overall Medicare OPPS payment decrease for 2012 is estimated to be 0.7%. Excluding the behavioral health division partial hospitalization rate impact, our Medicare OPPS payment increase for 2012 is estimated to be 2.1%.

In August, 2011, the Budget Control Act of 2011 (the “2011 Act”) was enacted into law. Included in this law are the imposition of annual spending limits for most federal agencies and programs aimed at reducing budget deficits by $917 billion between 2012 and 2021, according to a report released by the Congressional Budget Office. Among its other provisions, the law established a bipartisan Congressional committee, known as the Joint Committee, which was responsible for developing recommendations aimed at reducing future federal budget deficits by an additional $1.5 trillion over 10 years. The Joint Committee was unable to reach an agreement by the November 23, 2011

deadline and, as a result, across-the-board cuts to discretionary, national defense and Medicare spending were implemented which, if triggered, would result in Medicare payment reductions of up to 2% per fiscal year with a uniform percentage reduction across all Medicare programs starting in 2013. We cannot predict whether Congress will attempt to suspend or restructure the automatic budget cuts or what other deficit reduction initiatives may be proposed by Congress.

We entered into an agreement in April, 2012 with the United States Department of Health and Human Services, the Secretary of Health and Human Services, and the Centers for Medicare and Medicaid Services (referred to collectively as "HHS") that is expected to result in an aggregate cash payment to us of approximately $36 million, the majority of which we expect to receive on or about June 30, 2012. After reductions for estimated related expenses and the portion attributable to third-party non-controlling ownership interests, this settlement favorably impacted our pre-tax consolidated financial results during the three-month period ended March 31, 2012 by approximately $30 million. This agreement was part of an industry-wide settlement with HHS related to litigation that was pending for several years contending that acute care hospitals in the U.S. were underpaid from the Medicare inpatient prospective payment system during a number of prior years. The underpayments resulted from calculations related to rural floor budget neutrality adjustments that were implemented in connection with the Balanced Budget Act of 1997.

During March, 2012, CMS issued new Supplemental Security Income ("SSI") ratios utilized for calculating Medicare Disproportionate Share Hospital reimbursements ("Medicare DSH") for federal fiscal years 2006 through 2009. As a result of these new SSI ratios, acute care hospitals are required to recalculate their Medicare DSH for the affected years and record adjustments for differences in estimated reimbursements. In addition, two of our acute care hospitals located in Florida were notified that the respective counties in which they operate were no longer funding the hospitals with certain reimbursements resulting from reductions in federal matching Inter-Governmental Transfer funds. As a result of the unfavorable adjustments required from the revised SSI ratios, and the write-off of receivables from certain counties located in Florida, our pre-tax consolidated financial results during the three-month period ended March 31, 2012 were unfavorably impacted by an aggregate of approximately $8 million (net of the portion attributable to third-party non-controlling ownership interests).

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

Our acute care facilities have begun implementing an EHR application, on a facility-by-facility basis, beginning in 2011. The implementation is scheduled to be completed in 2013. However, there can be no assurance that we will ultimately qualify for these incentive payments and, should we qualify, the amount of incentive payments received is dependent upon various factors including the implementation timing at each facility. Should we qualify for incentive payments, there may be timing differences in the recognition of the revenues and expenses recorded in connection with the implementation of the EHR application which may cause material period-to-period changes in our future results of operations.

There are no EHR-related revenues included in our consolidated results of operations for the three-month periods ended March 31, 2012 and 2011. Although we received an aggregate of approximately $17 million of state Medicaid, EHR incentive payments as of March 31, 2012, these payments have been reflected as deferred revenue on our consolidated balance sheet as of that date (included in other current liabilities). These payments will be recorded as revenue in our consolidated statements of income in the periods in which the applicable hospitals are deemed to have met the meaningful use criteria. Also, if our hospitals meet the meaningful use criteria, we may become entitled to additional Medicaid incentive payments in future periods. Hospitals that do not qualify as a meaningful user of EHR by 2015 are subject to a reduced market basket update to the IPPS standardized amount in 2015 and each subsequent fiscal year. Although we believe that our acute care hospitals will be in compliance with the EHR standards by 2015, there can be no assurance that all of our facilities will be in compliance and therefore not subject to the penalty provision of the HITECH Act. Although our results of operations for the three-month periods ended March 31, 2012 and 2011 include certain EHR-related expenses, the amounts did not have a material impact on our consolidated financial results.

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

We receive Medicaid revenues in excess of $100 million annually from each of Texas, Pennsylvania, Virginia, Illinois and Washington, D.C., making us particularly sensitive to reductions in Medicaid and other state based revenue programs (which have been implemented in various forms with respect to our areas of operation in the respective 2012 state fiscal years) as well as regulatory, economic, environmental and competitive changes in those states. In the states in which we operate, based upon the state budgets for the 2012 fiscal year (which generally began at various times during the second half of 2011), we estimate that, on a blended basis, our aggregate Medicaid rates have been reduced by approximately 3% to 4% (or approximately $45 million to $55 million annually) from the average rates in effect during the states' 2011 fiscal years (which generally ended during the third quarter of 2011). Our consolidated results of operations for the three months ended March 31, 2012 include the pro rata portion of these Medicaid rate reductions. We can provide no assurance that further reductions to Medicaid revenues (which have been proposed in certain states for fiscal year 2013), particularly in the above-mentioned states, will not have a material adverse effect on our future results of operations.

Certain of our acute care hospitals located in various counties of Texas (Hildalgo, Maverick, Potter and Webb) participate in CMS-approved private Medicaid supplemental payment ("UPL") programs. These hospitals also have affiliation agreements with third-party hospitals to provide free hospital and physician care to qualifying indigent residents of these counties. Our hospitals receive both UPL payments from the Medicaid program and indigent care payments from third-party, affiliated hospitals. The UPL payments are contingent on the county or hospital district making an Inter-Governmental Transfer ("IGT") to the state Medicaid program while the indigent care payment is contingent on a transfer of funds from the applicable affiliated hospitals. We received $7 million and $10 million during the three-month periods ended March 31, 2012 and 2011, respectively, of aggregate, net UPL and affiliated hospital indigent care payments. For state fiscal year 2012, Texas Medicaid will operate under a CMS-approved Section 1115 five-year Medicaid waiver demonstration program. During the first five years of this program, the Texas Health and Human Services Commission ("THHSC") will transition away from UPL payments to new waiver incentive payment programs. During the first year of transition, which commenced on October 1, 2011, THHSC will make payments to Medicaid UPL recipient providers that received payments during the state's prior fiscal year. During transition years two through five, THHSC will make incentive payments under the program after certain qualifying criteria are met by hospitals. If the applicable hospital district or county makes IGTs consistent with 2011 levels, we believe we would be entitled to aggregate net payments pursuant to these programs of approximately $18 million during the remaining nine months of 2012.

We incur health-care related taxes ("Provider Taxes") imposed by states in the form of a licensing fee, assessment or other mandatory payment which are related to: (i) healthcare items or services; (ii) the provision of, or the authority to provide, the health care items of services, or; (iii) the payment for the health care items or services. Such Provider Taxes are subject to various federal regulations that limit the scope and amount of the taxes that can be levied by states in order to secure federal matching dollars as part of their respective state Medicaid programs. We derive a related Medicaid reimbursement benefit from assessed Provider Taxes in the form of Medicaid claims based payment increases and/or lump sum Medicaid supplemental payments. We earned an aggregate net benefit of approximately $5 million during each of the three-month periods ended March 31, 2012 and 2011 from Medicaid supplemental payments, after assessed Provider Taxes were considered (exclusive of our hospitals located in Oklahoma, as discussed below). Excluding Oklahoma, we estimate that our aggregate net benefit from these Provider Tax programs will approximate $16 million during the remaining nine months of 2012. The aggregate net benefit is earned from multiple states and therefore no particular state's portion is individually material to our consolidated financial statements. However, Provider Taxes are governed by both federal and state laws and are subject to future legislative changes that, if reduced from current rates in several states, could have a material adverse impact on our consolidated future results of operations.

In January, 2012, the state of Oklahoma was granted federal approval by the Centers for Medicare and Medicaid Services ("CMS") for the Supplemental Hospital Offset Payment Program ("SHOPP") which grants the Oklahoma Health Care Authority the authority to assess a 2.5% fee on certain Oklahoma hospitals and to make Medicaid supplemental payments to hospitals through December 31, 2014, retroactive to July 1, 2011. The state finalized the initial supplemental payment program amounts in March, 2012. Pursuant to the terms and conditions of the SHOPP program during the state's fiscal years of 2012 and 2013, we estimate that we are entitled to annual net reimbursements of approximately $14 million, retroactive to July 1, 2011. Our pre-tax consolidated financial results for the three-month period ended March 31, 2012 were favorably impacted by approximately $11 million consisting of revenues related to the SHOPP program covering the period of July 1, 2011 through March 31, 2012.

In California, a Medicaid state plan amendment ("SPA") was submitted to CMS by the state requesting and extension of a prior provider tax and related Medicaid supplemental payment program retroactive to July 1, 2011 through December 31, 2013. In Indiana, a similar Medicaid SPA was submitted to CMS by the state requesting retroactive approval of the program to July 1, 2011 with the program operating through June 30, 2013. If these SPAs are approved by CMS, we estimate that we may be entitled to net annual reimbursement which would have a favorable impact on our future results of operations.

In July, 2011 in accordance with the state 2012-2013 General Appropriations Act (the "Act"), the Texas Health and Human Services Commission ("THHSC") published a proposed rule that changes the reimbursement methodology for inpatient services by establishing a statewide base standard dollar amount ("SDA") rate along with certain hospital specific SDA rate adjustments for geographic location, trauma level designation and teaching hospital status. The new SDA payment methodology became effective September 1, 2011. Similarly, THHSC also incorporated changes in conformance with the Act which results in reductions to various categories of Medicaid hospital outpatient services. The expected reduction to our annual Medicaid inpatient reimbursement resulting from the proposed inpatient SDA payment methodology has been factored into the fiscal year 2012 Medicaid reductions (3% to 4%), as mentioned above.

Managed Care: A significant portion of our net patient revenues are generated from managed care companies, which include health maintenance organizations, preferred provider organizations and managed Medicare (referred to as Medicare Part C or Medicare Advantage) and Medicaid programs. In general, we expect the percentage of our business from managed care programs to continue to grow. The consequent growth in managed care networks and the resulting impact of these networks on the operating results of our facilities vary among the markets in which we operate. Typically, we receive lower payments per patient from managed care payors than we do from traditional indemnity insurers, however, during the past few years we have secured price increases from many of our commercial payors including managed care companies.

Commercial Insurance: Our hospitals also provide services to individuals covered by private health care insurance. Private insurance carriers typically make direct payments to hospitals or, in some cases, reimburse their policy holders, based upon the particular hospital's established charges and the particular coverage provided in the insurance policy. Private insurance reimbursement varies among payors and states and is generally based on contracts negotiated between the hospital and the payor.

Commercial insurers are continuing efforts to limit the payments for hospital services by adopting discounted payment mechanisms, including predetermined payment or DRG-based payment systems, for more inpatient and outpatient services. To the extent that such efforts are successful and reduce the insurers' reimbursement to hospitals and the costs of providing services to their beneficiaries, such reduced levels of reimbursement may have a negative impact on the operating results of our hospitals.

Other Sources: Our hospitals provide services to individuals that do not have any form of health care coverage. Such patients are evaluated, at the time of service or shortly thereafter, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other state assistance programs, as well as our local hospitals' indigent and charity care policy. Patients without health care coverage who do not qualify for Medicaid or indigent care write-offs are offered substantial discounts in an effort to settle their outstanding account balances.

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

Upon meeting certain conditions and serving a disproportionately high share of Texas' and South Carolina's low income patients, five of our facilities located in Texas and one facility located in South Carolina received additional reimbursement from each state's DSH fund. The Texas and South Carolina programs have been renewed for each state's 2012 fiscal years (covering the period of October 1, 2011 through September 30, 2012 for each state). In connection with these DSH programs, included in our financial results was an aggregate of $10 million and $12 million during the three-month periods ended March 31, 2012 and 2011, respectively.

In April, 2012, the THHSC published a proposed rule that would change the Texas Medicaid Disproportionate Share Hospital ("Texas Medicaid DSH") methodology, which, if implemented, could reduce reimbursements to us effective July 1, 2012. Although we can provide no assurance as to the ultimate outcome of this rule, or its ultimate impact on our consolidated financial results, if this proposed rule is implemented as currently drafted, our future Texas Medicaid DSH reimbursements could be reduced by approximately $16 million annually, beginning July 1, 2012. As of March 31, 2012, we have approximately $20 million of receivables recorded in connection with Texas Medicaid DSH reimbursements covering the period of October, 2011 through March, 2012, $8 million of which was paid to us in April, 2012. Although at this time we expect to fully collect the remainder of the Texas Medicaid DSH receivables, as previously disclosed, since receipt of the Texas Medicaid DSH reimbursements is contingent on certain public hospitals in Texas making Inter-Governmental Transfers to the state, we can provide no assurance that we will ultimately collect all of the estimated amounts due to us.

Assuming that the South Carolina DSH program is renewed for the state's 2013 fiscal year at amounts similar to the 2012 fiscal year program, and assuming the Texas DSH program is renewed for the state's 2013 fiscal year at an reduced annual rate as contemplated in the above-mentioned proposed rule (resulting in a $16 million annual reduction effective July 1, 2012), we estimate our aggregate reimbursements pursuant to these programs to be approximately $28 million during the remaining nine months of 2012. Failure to renew these DSH programs beyond their scheduled termination dates, failure of the public hospitals to provide the necessary IGTs for the states' share of the DSH programs, failure of our hospitals that currently receive DSH payments to qualify for future DSH funds under these programs, or reductions in reimbursements, could have a material adverse effect on our future results of operations.

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

In March, 2010, the Health Care and Education Reconciliation Act of 2010 (H.R. 4872, P.L. 111-152), (the "Reconciliation Act") and the Patient Protection and Affordable Care Act (P.L. 111-148), (the "Affordable Care Act"), were enacted into law and created significant

changes to health insurance coverage for U.S. citizens as well as material revisions to the federal Medicare and state Medicaid programs. Medicare, Medicaid and other health care industry changes which are scheduled to be implemented at various times during this decade are noted below.

Immediate Medicare Reductions:

The Reconciliation Act reduced the market basket update for inpatient and outpatient hospitals and inpatient behavioral health facilities by 0.25% in each of 2010 and 2011 and by 0.10% in 2012 and 2013. Further, the Affordable Care Act implemented certain reforms to Medicare Advantage payments, effective in 2011.

Future Medicare Reductions:

Future changes to the Medicare program include:

- A Medicare shared savings program (effective 2012)
- A hospital readmissions reduction program (effective 2012)
- A national pilot program on payment bundling (effective 2013)
- A value-based purchasing program for hospitals (effective 2012)
- Reduction to Medicare disproportionate share hospital ("DSH") payments (effective 2014)

Medicaid Revisions:

- Expanded Medicaid eligibility and related special federal payments (effective 2014)
- Reduction to Medicaid DSH (effective 2014)

Health Insurance Revisions:

- Large employer insurance reforms (effective 2014)
- Individual insurance mandate and related federal subsidies (effective 2014)
- Federally mandated insurance coverage reforms (2010 and forward)

Although the above-mentioned Medicare market basket reductions implemented in 2010 did not have a material impact on our results of operations to date, we are unable to estimate the future impact of the other legislative changes as outlined above.

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

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

Other Operating Results

The combined net revenues and income before income taxes generated at our surgical hospitals, ambulatory surgery centers and radiation oncology centers was not material to our results of operations during each of the three month periods ended March 31, 2012 and 2011.

Interest Expense:

Interest expense was $47 million and $56 million during the three-month periods ended March 31, 2012 and 2011, respectively. Below is a schedule of our interest expense for the three month periods ended March 31, 2012 and 2011 (amounts in thousands):

	Three Months Ended March 31, 2012	Three Months Ended March 31, 2011
Revolving credit & demand notes	$ 1,640	$ 2,169
$200 million, 6.75% Senior Notes due 2011 (a.)	—	3,378
$400 million, 7.125% Senior Notes due 2016 (b.)	7,124	7,124

	Three Months Ended March 31, 2012	Three Months Ended March 31, 2011
$250 million, 7.00% Senior Notes due 2018	4,375	4,375
Term loan facility A	5,794	8,756
Term loan facility B	14,113	20,371
Accounts receivable securitization program	687	665
Subtotal-revolving credit, demand notes, Senior Notes, term loan facilities and accounts receivable securitization program	33,733	46,838
Interest rate swap expense, net	5,158	1,405
Amortization of financing fees	7,277	6,545
Other combined interest expense	1,576	1,673
Capitalized interest on major construction and other projects	(1,005)	—
Interest income	(29)	(44)
Interest expense, net	$ 46,710	$ 56,417

(a.) The $200 million, 6.75% Senior Notes matured and were paid in full on November 15, 2011 utilizing borrowings pursuant to our revolving credit agreement.

(b.) In June, 2008, we issued an additional $150 million of senior notes (the “Notes”) which formed a single series with the original $250 million of Notes issued in June, 2006 (see *Note 4—Long Term Debt*). Other than their date of issuance and initial price to the public, the terms of the Notes issued in June, 2008 are identical to, and trade interchangeably with, the Notes which were originally issued in June, 2006. The proceeds from this issuance were used to repay outstanding borrowings.

Interest expense decreased $10 million during the three-month period ended March 31, 2012, as compared to the comparable quarter of 2011. The decreased interest expense was due primarily to decreases in our average effective interest rate (due primarily to an amendment to our credit agreement in March of 2011 which, among other things, provided for reductions in the rates payable for borrowings outstanding under our Term Loan A, Term Loan B and revolving credit facility) and average borrowings outstanding.

Discontinued Operations

In connection with the receipt of antitrust clearance from the Federal Trade Commission (“FTC”) in connection with our acquisition of PSI in November, 2010, we agreed to divest three former PSI facilities as well as one of our legacy behavioral health facilities in Puerto Rico. Pursuant to the terms of our agreement with the FTC, we divested:

- in July, 2011, the Meadowood Behavioral Health System, a 58-bed facility located in New Castle, Delaware;
- in December, 2011, the Montevista Hospital (101-bed) and Red Rock Hospital (21-bed), both of which are located in Las Vegas, Nevada, and;
- in January, 2012, the Hospital San Juan Capestrano, a 108-bed facility located in Rio Piedras, Puerto Rico.

The operating results for the three former PSI facilities located in Delaware and Nevada are reflected as discontinued operations during the first quarter of 2011. Since the aggregate income from discontinued operations before income tax expense for these facilities is not material to our consolidated financial statements, it is included as a reduction to other operating expenses. The aggregate pre-tax net gain on the divestiture of San Juan Capestrano in January, 2012 did not have a material impact on our consolidated results of operations during the first quarter of 2012. Assets and liabilities for the Hospital San Juan Capestrano were reflected as “held for sale” on our Consolidated Balance Sheet as of December 31, 2011.

The following table shows the results of operations for the former PSI facilities located in Delaware and Nevada, on a combined basis, which were reflected as discontinued operations during the first quarter of 2011 (amounts in thousands):

	Three Months Ended March 31, 2011
Net revenues	$ 10,260
Income from discontinued operations, before income tax expense	2,331
Income tax expense	(899)
Income from discontinued operations, net of income tax expense	$ 1,432

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, 2012 and 2011 (dollar amounts in thousands):

	Three Months Ended March 31,	
	2012	2011
Provision for income taxes	$ 79,748	$ 74,009
Income before income taxes	222,318	203,996
Effective tax rate	35.9%	36.3%

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

The effective tax rates, as calculated by dividing the provision for income taxes by the difference in income before income taxes, minus net income attributable to noncontrolling interests, were as follows for each of the three-month periods ended March 31, 2012 and 2011 (dollar amounts in thousands):

	Three Months Ended March 31,	
	2012	2011
Provision for income taxes	$ 79,748	$ 74,009
Income before income taxes	222,318	203,996
Less: Net income attributable to noncontrolling interests	(13,963)	(15,794)
Income before income taxes, less net income attributable to noncontrolling interests	208,355	188,202
Effective tax rate	38.3%	39.3%

The decrease in the effective tax rates during the three-month period ended March 31, 2012, as compared to the comparable prior year quarter, was primarily attributable to a decrease in our blended effective state income tax rate.

Liquidity

Net cash provided by operating activities

Net cash provided by operating activities was $127 million during the three-month period ended March 31, 2012 and $183 million during the comparable quarter of the prior year. The net decrease of $56 million was primarily attributable to the following:

- a favorable change of $16 million due to an increase in net income plus depreciation and amortization expense and stock-based compensation;
- a $43 million unfavorable change in accounts receivable, as discussed below;
- a $21 million unfavorable change in other working capital accounts due primarily to the timing of accrued compensation payments, and;
- $8 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 56 days at March 31, 2012 and 48 days at March 31, 2011.

Our net accounts receivable balance as of March 31, 2012 increased approximately $147 million over the balance as of December 31, 2011 (excluding the impact of the divestiture of a behavioral health facility during the first quarter of 2012). The increase was due primarily to: (i) $36 million of revenues recorded during the first quarter of 2012 resulting from the above-mentioned agreement entered into with the United

States Department of Health and Human Services, the Secretary of Health and Human Services, and the Centers for Medicare and Medicaid Services related to Medicare inpatient prospective payment system underpayments during a number of prior years; (ii) increased revenues experienced by our behavioral health care facilities during the first quarter of 2012 as a result of increases in adjusted patient days and revenue per adjusted day; (iii) an increase in other receivables including state-based revenue program receivables in certain states, most particularly Illinois, as discussed below, and; (iv) an increase in receivables recorded in connection with Texas Medicaid DSH reimbursements ($20 million outstanding covering the period of October, 2011 through March, 2012, $8 million of which was paid to us in April, 2012).

As of March 31, 2012 and December 31, 2011, our accounts receivable includes approximately $73 million and $54 million, respectively, due from Illinois. Collection of these receivables continues to be delayed due to state budgetary and funding pressures. Approximately $50 million as of March 31, 2012, and $41 million as of December 31, 2011, of the receivables due from Illinois have been outstanding in excess of 60 days, as of each respective date, and a large portion will likely remain outstanding for the foreseeable future. Since we expect to eventually collect all amounts due to us, no related reserves have been established in our consolidated financial statements. However, we can provide no assurance that we will eventually collect all amounts due to us from Illinois. Failure to ultimately collect all outstanding amounts due from Illinois would have an adverse impact on our future consolidated results of operations and cash flows.

Net cash used in investing activities

During the first three months of 2012, we used $47 million of net cash in investing activities as follows:

- spent $93 million to finance capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities, including the construction costs related to the newly constructed Temecula Valley Hospital, a 140-bed acute care facility located in Temecula, California which is scheduled to be completed and opened in mid-2013;
- spent $14 million in connection with the purchase and implementation of an electronic health records application;
- received $53 million in connection with the divestiture of the Hospital San Juan Capestrano and the divestiture of the real property of a previously closed behavioral health care facility, and;
- received $7 million from a deposit returned to us in connection with the termination of an agreement to purchase an acute care hospital located in Texas (see Note 8 to the Consolidated Financial Statements).

During the first three months of 2011, we used $64 million of net cash in investing activities as follows:

- spent $57 million to finance capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities;
- spent $8 million in connection with the purchase and implementation of an electronic health records application, and;
- received $1 million for the sale of the real property of a closed acute care facility.

Net cash provided by/used in financing activities

During the first three months of 2012, we used $79 million of net cash in financing activities as follows:

- spent $71 million on net repayments of debt due primarily to repayments pursuant to our Term Loan A ($35 million), Term Loan B ($13 million) and revolving credit ($22 million) facilities;
- spent $3 million to pay profit distributions related to noncontrolling interests in majority owned businesses;
- spent $2 million to repurchase shares of our Class B Common Stock;
- spent $5 million to pay quarterly cash dividends of $.05 per share, and;
- generated $1 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 2011, we used $97 million of net cash in financing activities as follows:

- spent $136 million on net repayments of debt due primarily to repayments pursuant to our Term Loan A and Term Loan B credit facilities;
- generated $73 million of cash primarily from additional borrowings pursuant to our revolving credit facility and accounts receivable securitization program;
- spent $23 million on financing costs in connection with an amendment to our credit agreement (which includes our revolving credit agreement, Term Loan A and Term Loan B facilities) which was completed in March, 2011;
- spent $4 million to pay profit distributions related to noncontrolling interests in majority owned businesses;
- spent $3 million to repurchase shares of our Class B Common Stock;
- spent $5 million to pay quarterly cash dividends of $.05 per share, and;

- generated $1 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

Expected Capital Expenditures During the Remainder of 2012:

During the remaining nine months of 2012, we expect to spend approximately $260 million to $285 million on capital expenditures. We believe that our capital expenditure program is adequate to expand, improve and equip our existing hospitals. We expect to finance all capital expenditures and acquisitions with internally generated funds and/or additional funds, as discussed below.

Capital Resources

Credit Facilities and Outstanding Debt Securities

On November 15, 2010, we entered into a credit agreement (the "Credit Agreement") with various financial institutions. The Credit Agreement is a senior secured facility which provided an initial aggregate commitment amount of $3.45 billion, comprised of a new $800 million revolving credit facility, a $1.05 billion Term Loan A facility and a $1.6 billion Term Loan B facility. Prior to the effectiveness of the Credit Agreement Amendment in March, 2011 (as discussed below), we prepaid the principal amount and permanently reduced the Term Loan B commitment by $125 million. During the first quarter of 2012, we made scheduled principal payments of $35 million on the Term Loan A and $13 million on the Term Loan B. The revolving credit facility and the Term Loan A mature on November 15, 2015 and the Term Loan B matures on November 15, 2016. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Credit Agreement is secured by substantially all of the assets of the Company and our material subsidiaries and guaranteed by our material subsidiaries.

On March 15, 2011, we entered into a first amendment to the Credit Agreement (the "Amendment") which became effective immediately and provides, among other things, for a reduction in the interest rates payable in connection with borrowings under the Credit Agreement. Upon the effectiveness of the Amendment, borrowings under the Credit Agreement bear interest at the ABR rate which is defined as the rate per annum equal to, at our election (1) the greatest of (a) the lender's prime rate, (b) the weighted average of the federal funds rate, plus 0.5% and (c) one month Eurodollar rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.50% to 1.25% for revolving credit and Term Loan A borrowings and 1.75% to 2.00% for Term Loan B borrowings or (2) the one, two, three or six month Eurodollar rate (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.50% to 2.25% for revolving credit and Term Loan A borrowings and ranging from 2.75% to 3.00% for Term Loan B borrowings. The current applicable margins are 0.75% for ABR-based loans, 1.75% for Eurodollar-based loans under the revolving credit and Term Loan A facilities and 2.75% under the Term Loan B facility. Upon the effectiveness of the Amendment, the minimum Eurodollar rate for the Term Loan B facility was reduced from 1.50% to 1.00%. In connection with the Amendment, we paid a fee of 1.00% of the amounts outstanding under the Term Loan B in accordance with the terms of the Credit Agreement.

In October, 2010, we amended our accounts receivable securitization program ("Securitization") with a group of conduit lenders and liquidity banks. We increased the size of the Securitization to $240 million (the "Commitments"), from $200 million, and extended the maturity date to October 25, 2013. Substantially all of the patient-related accounts receivable of our acute care hospitals ("Receivables") serve as collateral for the outstanding borrowings. The interest rate on the borrowings is based on the commercial paper rate plus a spread of 0.475% and there is a facility fee of 0.375% required on 102% on the Commitments. We have accounted for this Securitization as borrowings. We maintain effective control over the Receivables since, pursuant to the terms of the Securitization, the Receivables are sold from certain of our subsidiaries to special purpose entities that are wholly-owned by us. The Receivables, however, are owned by the special purpose entities, can be used only to satisfy the debts of the wholly-owned special purpose entities, and thus are not available to us except through our ownership interest in the special purpose entities. The wholly-owned special purpose entities use the Receivables to collateralize the loans obtained from the group of third-party conduit lenders and liquidity banks. The group of third-party conduit lenders and liquidity banks do not have recourse to us beyond the assets of the wholly-owned special purpose entities that securitize the loans. At March 31, 2012, we had $240 million of outstanding borrowings and no additional capacity pursuant to the terms of our accounts receivable securitization program.

As of March 31, 2012, we had $9 million outstanding borrowings under a short-term, on-demand credit facility. Outstanding borrowings pursuant to this facility are classified as long-term debt on our Consolidated Balance Sheet since we have the intent and ability to refinance through available borrowings under the terms of our Credit Agreement.

As of March 31, 2012, we had an aggregate of $509 million of available borrowing capacity pursuant to the terms of our Credit Agreement and Securitization, net of $219 million of outstanding borrowings, $63 million of outstanding letters of credit and $9 million of outstanding borrowings under a short-term, on-demand credit facility.

On September 29, 2010, we issued $250 million of 7.00% senior unsecured notes (the "Unsecured Notes") which are scheduled to mature on October 1, 2018. The Unsecured Notes were registered in April, 2011. Interest on the Unsecured Notes is payable semiannually in arrears on April 1st and October 1st of each year. The Unsecured Notes can be redeemed in whole at anytime subject to a make-whole call at treasury rate plus 50 basis points prior to October 1, 2014. They are also redeemable in whole or in part at a price of: (i) 103.5% on or after October 1, 2014; (ii) 101.75% on or after October 1, 2015, and; (iii) 100% on or after October 1, 2016. These Unsecured Notes are guaranteed by a group

of subsidiaries (each of which is a 100% directly owned subsidiary of Universal Health Services, Inc.) which fully and unconditionally guarantee the Unsecured Notes on a joint and several basis, subject to certain customary automatic release provisions.

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

In connection with the entering into of the Credit Agreement on November 15, 2010, and in accordance with the Indenture dated January 20, 2000 governing the rights of our existing notes, we entered into a supplemental indenture pursuant to which our 7.125% Notes (due in 2015) were equally and ratably secured with the lenders under the Credit Agreement with respect to the collateral for so long as the lenders under the Credit Agreement are so secured.

Our Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens and indebtedness, transactions with affiliates and dividends; and requires compliance with financial covenants including maximum leverage and minimum interest coverage ratios. We are in compliance with all required covenants as of March 31, 2012.

The carrying amount and fair value of our debt was $3.58 billion and $3.65 billion at March 31, 2012, respectively. The fair value of our debt was computed based upon quotes received from financial institutions and we consider these to be "level 2" in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with debt instruments.

Our total debt as a percentage of total capitalization was 60% at March 31, 2012 and 61% at December 31, 2011.

We expect to finance all capital expenditures and acquisitions, pay dividends and potentially repurchase shares of our common stock utilizing internally generated and additional funds. Additional funds may be obtained through: (i) the issuance of equity; (ii) borrowings under our existing revolving credit facility or through refinancing the existing revolving credit agreement, and/or; (iii) the issuance of other long-term debt. In the event we need to access the capital markets or other sources of financing, there can be no assurance that we will be able to obtain financing on acceptable terms or within an acceptable time. Our inability to obtain financing on terms acceptable to us could have a material unfavorable impact on our results of operations, financial condition and liquidity.

Off-Balance Sheet Arrangements

During the three months ended March 31, 2012, there have been no material changes in the off-balance sheet arrangements consisting of operating leases and standby letters of credit and surety bonds. Reference is made to *Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations – Contractual Obligations and Off-Balance Sheet Arrangements*, in our Annual Report on Form 10-K for the year ended December 31, 2011.

We have various obligations under operating leases or master leases for real property and under operating leases for equipment. The real property master leases are leases for buildings on or near hospital property for which we guarantee a certain level of rental income. We sublease space in these buildings and any amounts received from these subleases are offset against the expense. In addition, we lease four hospital facilities from Universal Health Realty Income Trust with terms scheduled to expire in 2014 and 2016. These leases contain up to four, 5-year renewal options.

As of March 31, 2012, we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds which totaled $83 million consisting of: (i) $66 million related to our self-insurance programs, and; (ii) $17 million of other debt and public utility guarantees.

Item 3. Quantitative and Qualitative Disclosures About Market Risk

There have been no material changes in the quantitative and qualitative disclosures during the three months ended March 31, 2012. 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, 2011.

Item 4. Controls and Procedures

As of March 31, 2012, under the supervision and with the participation of our management, including our Chief Executive Officer ("CEO") and Chief Financial Officer ("CFO"), we performed an evaluation of the effectiveness of our disclosure controls and procedures, as defined in Rule 13a-15(e) or Rule 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "1934 Act"). Based on this evaluation, the CEO and CFO have concluded that our disclosure controls and procedures are effective to ensure that material information is recorded, processed, summarized and reported by management on a timely basis in order to comply with our disclosure obligations under the 1934 Act and the SEC rules thereunder.

Changes in Internal Control Over Financial Reporting

There have been no changes in our internal control over financial reporting or in other factors during the first quarter of 2012 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II. OTHER INFORMATION

Item 1. Legal Proceedings

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

U.S. v. Marion and UHS:

In November, 2009, the United States Department of Justice ("DOJ") and the Virginia Attorney General intervened in a qui tam case that had been filed by former employees of Marion Youth Center under seal in 2007 against Universal Health Services, Inc. ("UHS"), and Keystone Marion, LLC ("Marion") and Keystone Education and Youth Services, LLC ("Keystone"). The intervention by the DOJ followed the issuance of a series of subpoenas from the Office of the Inspector General for the Department of Health and Human Services seeking documents related to the treatment of Medicaid beneficiaries at Marion. The amended complaint filed by the DOJ and Virginia Attorney General alleged causes of action pursuant to the federal and state false claims acts and the Virginia fraud statute. The former employees filed a separate amended complaint alleging employment and retaliation claims as well as false claim act violations. During the third quarter of 2011, we reached agreements in principle to settle all of the claims. During the first quarter of 2012, the settlement agreements were finalized. We had previously established a reserve in connection with this matter, which did not have a material impact on our financial statements. Settlement payments were made in April, 2012.

Martin v. UHS of Delaware:

UHS of Delaware, Inc., a wholly-owned subsidiary of ours, has been named as defendants in a state False Claim Act case in Sacramento County Superior Court. Plaintiffs are a former student and employees of the Elmira School who claim that the UHS schools in California unlawfully retained public education funding from the state of California for the operation of these schools but failed to meet state requirements pertaining to the operation of non-public schools. We deny liability and intend to defend this case vigorously. We have established a reserve in connection with this matter which did not have a material impact on our consolidated financial statements.

Department of Justice ICD Investigation:

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

Two Rivers Psychiatric Hospital:

In April, 2011, the Centers for Medicare and Medicaid Services ("CMS") issued notice of its decision terminating Two Rivers Psychiatric Hospital ("Two Rivers") in Kansas City, Missouri from participation in the Medicare and Medicaid program. The termination notice was issued as a result of surveys conducted which allegedly found Two Rivers to be out of compliance with the conditions of participation required for participation in the Medicare program and for Two Rivers' alleged failure to alleviate an "immediate jeopardy" situation. Two Rivers filed an administrative appeal with the U.S. Department of Health and Human Services, Departmental Appeal Board, Civil Remedies Division, seeking review and reversal of that decision. In addition, Two Rivers filed a complaint in the U.S. District Court for the Western District of Missouri seeking a temporary restraining order and preliminary injunction against CMS rescinding the termination action. Later in April, 2011, the District Court issued a temporary restraining order abating the termination action pending a preliminary injunction hearing or an agreement with CMS. In May, 2011, Two Rivers and CMS entered into a settlement agreement which resulted in the rescission of the termination notice and actions by CMS. Pursuant to the terms of the agreement, Two Rivers was required to submit an acceptable plan of correction relative to the immediate jeopardy citation and engage independent experts in various disciplines to analyze and develop implementation plans for Two Rivers to meet the applicable Medicare conditions of participation. Both of these actions have occurred. Pursuant to the agreement, CMS conducted an initial survey of Two Rivers in April 2012 to determine if the Medicare conditions of participation, which formed the basis of the termination action in April 2011, have been met. In late April, 2012, CMS advised Two Rivers that it has successfully passed this initial survey. Pursuant to the terms of the agreement, a second survey will be conducted either late 2012 or early 2013 to further confirm that Two Rivers is in compliance with all Medicare/Medicaid Conditions of Participation. During the term of this agreement, Two Rivers remains eligible to receive reimbursements for services rendered to Medicare and Medicaid beneficiaries. Two Rivers remains fully committed to providing high-quality healthcare to their patients and the community it serves. We therefore intend to work expeditiously and collaboratively with CMS in an effort to resolve these matters. We can provide no assurance that Two Rivers will not

ultimately lose its Medicare certification. The operating results of Two Rivers did not have a material impact on our consolidated results of operations or financial condition for the three-month period ended March 31, 2012 or the year ended December 31, 2011.

Matters Relating to PSI:

The following matters pertain to PSI or former PSI facilities (owned by subsidiaries of Psychiatric Solutions, Inc.) for which we have assumed the defense as a result of our acquisition of PSI which was completed in November, 2010:

Garden City Employees' Retirement System v. PSI:

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

Department of Justice Investigation of Sierra Vista:

In 2009, Sierra Vista Hospital in Sacramento, California learned of an investigation by the U.S. Department of Justice ("DOJ") relating to Medicare services provided by the facility. The DOJ ultimately notified the facility that with respect to partial hospitalization and outpatient services, the DOJ believed that the medical record documentation did not adequately support the claims submitted for reimbursement by Medicare. We reached a settlement with the DOJ which was finalized during the second quarter of 2012. As part of that agreement, the facility will be subject to a corporate integrity agreement. The reserve established in connection with this matter did not have a material impact on our consolidated financial statements.

Department of Justice Investigation of Friends Hospital:

In October, 2010, Friends Hospital in Philadelphia, Pennsylvania, received a subpoena from the DOJ requesting certain documents from the facility. The requested documents have been collected and provided to the DOJ for review and examination. Another subpoena was issued to the facility in July 2011 requesting additional documents, a portion of which have been collected and delivered to the DOJ, pursuant to their request. At present, we are uncertain as to the focus, scope or extent of the investigation, liability of the facility and/or potential financial exposure, if any, in connection with this matter.

Department of Justice Investigation of Riveredge Hospital:

In 2008, Riveredge Hospital in Chicago, Illinois received a subpoena from the DOJ requesting certain information from the facility. Additional requests for documents were also received from the DOJ in 2009 and 2010. The requested documents have been provided to the DOJ and we continue to cooperate with the DOJ with respect to this investigation. At present, we are uncertain as to the focus, scope or extent of the investigation, liability of the facility and/or potential financial exposure, if any, in connection with this matter.

Virginia Department of Medical Assistance Services Recoupment Claims:

The Virginia Department of Medical Assistance Services ("DMAS") has conducted audits at seven former PSI Residential Treatment Centers operated in the Commonwealth of Virginia to confirm compliance with provider rules under the state's Medicaid Provider Services Manual ("Manual"). As a result of those audits, DMAS claims the facilities failed to comply with the requirements of the Manual and has requested repayment of Medicaid payments to those facilities. PSI had previously filed appeals to repayment demands at each facility which are currently pending. The aggregate refund of Medicaid payments made to those facilities, as requested by DMAS, and the corresponding reserve established on our consolidated balance sheet, was not material to our consolidated financial position or results of operations.

General:

The healthcare industry is subject to numerous laws and regulations which include, among other things, matters such as government healthcare participation requirements, various licensure, certifications, and accreditations, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government action has increased with respect to investigations and/or allegations concerning possible violations of fraud and abuse and false claims statutes and/or regulations by healthcare providers. Currently, and from time to time, some of our facilities are subjected to inquiries and/or actions and receive notices of potential non-compliance of laws and regulations from various federal and state agencies. Providers that are found to have violated these laws and regulations may be excluded from participating in government healthcare programs, subjected to potential licensure, certification, and/or accreditation revocation, subjected to fines or penalties or required to repay amounts received from the government for previously billed patient services. We monitor all aspects of our business and have developed a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards. Because the law in this area is complex and constantly evolving, governmental investigation or litigation may result in

interpretations that are inconsistent with industry practices, including ours. Although we believe our policies, procedures and practices comply with governmental regulations, there is no assurance that we will not be faced with sanctions, fines or penalties in connection with such inquiries or actions, including with respect to the investigations and other matters discussed herein. Even if we were to ultimately prevail, such inquiries and/or actions could have a material adverse effect on us.

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

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

Item 1A. Risk Factors

Our Annual Report on Form 10-K for the year ended December 31, 2011 includes a listing of risk factors to be considered by investors in our securities. There have been no material changes in our risk factors from those set forth in our Annual Report on Form 10-K for the year ended December 31, 2011.

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

In various prior years, our Board of Directors has approved stock repurchase programs authorizing us to purchase shares of our outstanding Class B Common Stock on the open market at prevailing market prices or in negotiated transactions off the market. There is no expiration date for our stock repurchase programs. The most recent approval occurred during 2007 at which time our Board of Directors authorized the purchase of up to 10 million shares, 207,127 shares of which (as reflected below) remains available for purchase as of March 31, 2012. Pursuant to the terms of our program, we purchased 48,993 shares at an average price of $41.18 per share or approximately $2.0 million in the aggregate during the first quarter of 2012. The following schedule provides information related to our stock repurchase programs for each of the three months ended March 31, 2012:

2012 period	Additional shares authorized for repurchase	Total number of shares purchased	Average price paid per share for forfeited restricted shares	Total number of shares purchased as part of publicly announced programs	Average price paid per share for shares purchased as part of publicly announced program	Aggregate purchase price paid	Maximum number of shares that may yet be purchased under the program
January, 2012	—	26,743	N/A	26,743	$ 40.09	$1,072,086	229,377
February, 2012	—	15,634	N/A	15,634	41.95	655,842	213,743
March, 2012	—	6,616	N/A	6,616	43.79	289,717	207,127
Total January through March	—	48,993	N/A	48,993	$ 41.18	$2,017,645	207,127

Dividends

During the quarter ended March 31, 2012, we declared and paid dividends of $.05 per share.

Item 6. Exhibits

(a) Exhibits:

11	Statement re computation of per share earnings is set forth in Note 7 of the Notes to Condensed Consolidated Financial Statements.
31.1	Certification of the Company's Chief Executive Officer pursuant to Rule 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934.
31.2	Certification of the Company's Chief Financial Officer pursuant to Rule 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934.
32.1	Certification of the Company's Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of the Company's Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS**	XBRL Instance Document
101.SCH**	XBRL Taxonomy Extension Schema Document
101.CAL**	XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF**	XBRL Taxonomy Extension Definition Linkbase Document
101.LAB**	XBRL Taxonomy Extension Label Linkbase Document
101.PRE**	XBRL Taxonomy Extension Presentation Linkbase Document

** XBRL (Extensible Business Reporting Language) information is furnished and not filed or a part of a registration statement or prospectus for purposes of Sections 11 or 12 of the Securities Act of 1933, is deemed not filed for purposes of Section 18 of the Securities Exchange Act of 1934, and otherwise is not subject to liability under these sections.

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 8, 2012

/S/ ALAN B. MILLER

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

/S/ STEVE FILTON

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

EXHIBIT INDEX

Exhibit No.	Description
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101.SCH**	XBRL Taxonomy Extension Schema Document
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** XBRL (Extensible Business Reporting Language) information is furnished and not filed or a part of a registration statement or prospectus for purposes of Sections 11 or 12 of the Securities Act of 1933, is deemed not filed for purposes of Section 18 of the Securities Exchange Act of 1934, and otherwise is not subject to liability under these sections.

Exhibit 31.1

CERTIFICATION – Chief Executive Officer

I, Alan B. 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 that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting.

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

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

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

Date: May 8, 2012

/s/ Alan B. 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 that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting.

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

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

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

Date: May 8, 2012

/s/ Steve Filton

Senior 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, 2012, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Alan B. 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/ Alan B. Miller
Chief Executive Officer
May 8, 2012

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, 2012, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Steve Filton, Senior 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
Senior Vice President and Chief Financial Officer
May 8, 2012

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.