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, 2021

OR

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

For the transition period from to

Commission file number 1-10765

UNIVERSAL HEALTH SERVICES, INC.

(Exact name of registrant as specified in its charter)

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

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

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

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

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

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

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

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

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

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

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

Indicate the number of shares outstanding of each of the issuer's classes of common stock, as of the latest practicable date. Common shares outstanding, as of April 30, 2021:

Class A	6,577,100
Class B	77,972,436
Class C	661,688
Class D	18,191

UNIVERSAL HEALTH SERVICES, INC.

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This Quarterly Report on Form 10-Q is for the quarter ended March 31, 2021. This Report modifies and supersedes documents filed prior to this Report. Information that we file with the Securities and Exchange Commission (the "SEC") in the future will automatically update and supersede information contained in this Report.

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

PART I. FINANCIAL INFORMATION

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

	Three months ended March 31,	
	2021	2020
Net revenues	$ 3,012,987	$ 2,829,667
Operating charges:		
Salaries, wages and benefits	1,497,773	1,432,669
Other operating expenses	709,708	689,790
Supplies expense	347,110	317,827
Depreciation and amortization	131,403	124,394
Lease and rental expense	31,324	28,293
	2,717,318	2,592,973
Income from operations	295,669	236,694
Interest expense, net	21,957	36,351
Other (income) expense, net	835	9,560
Income before income taxes	272,877	190,783
Provision for income taxes	63,807	46,323
Net income	209,070	144,460
Less: Net income (loss) attributable to noncontrolling interests	(21)	2,423
Net income attributable to UHS	$ 209,091	$ 142,037
Basic earnings per share attributable to UHS	$ 2.46	$ 1.64
Diluted earnings per share attributable to UHS	$ 2.43	$ 1.64
Weighted average number of common shares - basic	84,782	86,212
Add: Other share equivalents	1,014	243
Weighted average number of common shares and equivalents - diluted	85,796	86,455

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

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

	Three months ended March 31,	
	2021	2020
Net income	$ 209,070	$ 144,460
Other comprehensive income (loss):		
Foreign currency translation adjustment	(10,346)	(39,201)
Other comprehensive income (loss) before tax	(10,346)	(39,201)
Income tax expense (benefit) related to items of other comprehensive income (loss)	(1,466)	(2,108)
Total other comprehensive income (loss), net of tax	(8,880)	(37,093)
Comprehensive income	200,190	107,367
Less: Comprehensive income (loss) attributable to noncontrolling interests	(21)	2,423
Comprehensive income attributable to UHS	$ 200,211	$ 104,944

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

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

	March 31, 2021	December 31, 2020
Assets		
Current assets:		
Cash and cash equivalents	$ 764,502	$ 1,224,490
Accounts receivable, net	1,668,650	1,728,928
Supplies	193,961	190,417
Other current assets	157,052	138,034
Total current assets	2,784,165	3,281,869
Property and equipment	10,119,037	9,885,888
Less: accumulated depreciation	(4,623,435)	(4,512,764)
	5,495,602	5,373,124
Other assets:		
Goodwill	3,886,973	3,882,715
Deferred income taxes	23,514	22,689
Right of use assets-operating leases	326,703	336,513
Deferred charges	4,782	4,985
Other	574,590	574,984
Total Assets	$ 13,096,329	$ 13,476,879
Liabilities and Stockholders' Equity		
Current liabilities:		
Current maturities of long-term debt	$ 107,281	$ 331,998
Accounts payable and other liabilities	1,779,700	1,668,671
Medicare accelerated payments and deferred CARES Act and other grants	189,320	376,151
Operating lease liabilities	60,812	59,796
Federal and state taxes	102,266	44,423
Total current liabilities	2,239,379	2,481,039
Other noncurrent liabilities	476,377	458,549
Operating lease liabilities noncurrent	267,707	278,303
Medicare accelerated payments noncurrent	0	322,617
Long-term debt	3,505,822	3,524,253
Deferred income taxes	735	5,582
Redeemable noncontrolling interests	4,470	4,569
Equity:		
UHS common stockholders' equity	6,513,862	6,317,146
Noncontrolling interest	87,977	84,821
Total equity	6,601,839	6,401,967
Total Liabilities and Stockholders' Equity	$ 13,096,329	$ 13,476,879

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY
For the Three Months ended March 31, 2021
(amounts in thousands, unaudited)

	Redeemable Noncontrolling Interest	Class A Common	Class B Common	Class C Common	Class D Common	Cumulative Dividends	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	UHS Common Stockholders' Equity	Noncontrolling Interest	Total
Balance, January 1, 2021	$ 4,569	$ 66	$ 778	$ 7	$ 0	$ (479,503)	$ 6,747,678	$ 48,120	$ 6,317,146	$ 84,821	$ 6,401,967
Common Stock											
Issued/(converted)	—	—	4	—	—	—	3,356	—	3,360	—	3,360
Repurchased	—	—	(1)	—	—	—	(7,463)	—	(7,464)	—	(7,464)
Restricted share-based compensation expense	—	—	—	—	—	—	2,862	—	2,862	—	2,862
Dividends paid	—	—	—	—	—	(17,018)	—	—	(17,018)	—	(17,018)
Stock option expense	—	—	—	—	—	—	14,765	—	14,765	—	14,765
Distributions to noncontrolling interests	—	—	—	—	—	—	—	—	—	(4,525)	(4,525)
Purchase of ownership interests by minority members	—	—	—	—	—	—	—	—	—	7,603	7,603
Comprehensive income:											
Net income to UHS / noncontrolling interests	(99)	—	—	—	—	—	209,091	—	209,091	78	209,169
Foreign currency translation adjustments, net of income tax	—	—	—	—	—	—	—	(8,880)	(8,880)	—	(8,880)
Subtotal - comprehensive income	(99)	—	—	—	—	—	209,091	(8,880)	200,211	78	200,289
Balance, March 31, 2021	$ 4,470	$ 66	$ 781	$ 7	$ 0	$ (496,521)	$ 6,970,289	$ 39,240	$ 6,513,862	$ 87,977	$ 6,601,839

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY
For the Three Months ended March 31, 2020
(amounts in thousands, unaudited)

	Redeemable Noncontrolling Interest	Class A Common	Class B Common	Class C Common	Class D Common	Cumulative Dividends	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	UHS Common Stockholders' Equity	Noncontrolling Interest	Total
Balance, January 1, 2020	$ 4,333	$ 66	$ 794	$ 7	$ 0	$ (462,159)	$ 5,933,504	$ 31,893	$ 5,504,105	$ 74,766	$ 5,578,871
Common Stock											
Issued/(converted)	—	—	2	—	—	—	3,110	—	3,112	—	3,112
Repurchased	—	—	(20)	—	—	—	(199,272)	—	(199,292)	—	(199,292)
Restricted share-based compensation expense	—	—	—	—	—	—	2,355	—	2,355	—	2,355
Dividends paid	—	—	—	—	—	(17,344)	—	—	(17,344)	—	(17,344)
Stock option expense	—	—	—	—	—	—	15,329	—	15,329	—	15,329
Distributions to noncontrolling interests	(500)	—	—	—	—	—	—	—	—	(5,234)	(5,234)
Comprehensive income:											
Net income to UHS / noncontrolling interests	120	—	—	—	—	—	142,037	—	142,037	2,302	144,339
Foreign currency translation adjustments	—	—	—	—	—	—	—	(37,093)	(37,093)	—	(37,093)
Subtotal - comprehensive income	120	—	—	—	—	—	142,037	(37,093)	104,944	2,302	107,246
Balance, March 31, 2020	$ 3,953	$ 66	$ 776	$ 7	$ 0	$ (479,503)	$ 5,897,063	$ (5,200)	$ 5,413,209	$ 71,834	$ 5,485,043

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

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

	Three months ended March 31,	
	2021	2020
Cash Flows from Operating Activities:		
Net income	$ 209,070	$ 144,460
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation & amortization	131,403	124,394
Stock-based compensation expense	18,022	18,047
Changes in assets & liabilities, net of effects from acquisitions and dispositions:		
Accounts receivable	56,851	69,763
Accrued interest	10,133	(4,412)
Accrued and deferred income taxes	53,769	45,200
Other working capital accounts	82,663	73,929
Medicare accelerated payments and deferred CARES Act and other grants	(509,448)	-
Other assets and deferred charges	(17)	11,084
Other	2,623	(3,038)
Accrued insurance expense, net of commercial premiums paid	35,467	49,559
Payments made in settlement of self-insurance claims	(18,741)	(26,924)
Net cash provided by operating activities	71,795	502,062
Cash Flows from Investing Activities:		
Property and equipment additions, net of disposals	(247,459)	(184,102)
Inflows (outflows) from foreign exchange contracts that hedge our net U.K. investment	(14,264)	51,691
Decrease in capital reserves of commercial insurance subsidiary	100	-
Costs incurred for purchase and implementation of information technology applications	(575)	(1,857)
Investment in, and advances to, joint ventures and other	(129)	(751)
Net cash used in investing activities	(262,327)	(135,019)
Cash Flows from Financing Activities:		
Reduction of long-term debt	(251,830)	(185,098)
Additional borrowings	-	5,453
Repurchase of common shares	(7,464)	(172,092)
Dividends paid	(17,018)	(17,344)
Issuance of common stock	3,357	3,002
Profit distributions to noncontrolling interests	(4,525)	(5,735)
Purchase of ownership interests by minority members	7,603	-
Net cash used in financing activities	(269,877)	(371,814)
Effect of exchange rate changes on cash, cash equivalents and restricted cash	423	(1,673)
Decrease in cash, cash equivalents and restricted cash	(459,986)	(6,444)
Cash, cash equivalents and restricted cash, beginning of period	1,279,154	105,667
Cash, cash equivalents and restricted cash, end of period	$ 819,168	$ 99,223
Supplemental Disclosures of Cash Flow Information:		
Interest paid	$ 11,421	$ 39,483
Income taxes paid, net of refunds	$ 8,654	$ 6,783
Noncash purchases of property and equipment	$ 60,124	$ 58,935

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

(1) General

This Quarterly Report on Form 10-Q is for the quarterly period ended March 31, 2021. In this Quarterly Report, "we," "us," "our" "UHS" and the "Company" refer to Universal Health Services, Inc. and its subsidiaries.

The condensed consolidated interim financial statements include the accounts of our majority-owned subsidiaries and partnerships and limited liability companies controlled by us, or our subsidiaries, as managing general partner or managing member. The condensed consolidated interim financial statements included herein have been prepared by us, without audit, pursuant to the rules and regulations of the Securities and Exchange Commission ("SEC") and reflect all adjustments (consisting only of normal recurring adjustments) which, in our opinion, are necessary to fairly state results for the interim periods. Certain information and footnote disclosures normally included in audited consolidated financial statements prepared in accordance with accounting principles generally accepted in the United States of America have been condensed or omitted pursuant to such rules and regulations, although we believe that the accompanying disclosures are adequate to make the information presented not misleading. These condensed consolidated interim financial statements should be read in conjunction with the audited consolidated financial statements, significant accounting policies and the notes thereto included in our Annual Report on Form 10-K for the year ended December 31, 2020.

The impact of the COVID-19 pandemic, which began during the second half of March, 2020, has had a material unfavorable effect on our operations and financial results since that time. The COVID-19 vaccination process commenced during the first quarter of 2021 and, while we expect the administration of vaccines will assist in easing the number of COVID-19 patients, the pace of distribution and the portion of the population that will ultimately become vaccinated is difficult to predict. The extent to which the COVID-19 pandemic and measures taken in response thereto impact our business, results of operations and financial condition will depend on numerous factors and future developments, most of which are beyond our control or ability to predict. The ultimate impact of the COVID-19 pandemic is highly uncertain and subject to change. We are not able to fully quantify the impact that these factors will have on our future financial results.

We believe that the adverse impact that COVID-19 will have on our future operations and financial results will depend upon many factors, most of which are beyond our capability to control or predict. Such factors include, but are not limited to, the scope and duration of stay-at-home policies and business closures and restrictions, government imposed or recommended suspensions of elective surgeries and procedures, continued declines in patient volumes for an indeterminable length of time, increases in the number of uninsured and underinsured patients as a result of higher sustained rates of unemployment, incremental expenses required for supplies and personal protective equipment, and changes in professional and general liability exposure. Because of these and other uncertainties, we cannot estimate the length or severity of the impact of COVID-19 on our business. Decreases in cash flows and results of operations may have an impact on the inputs and assumptions used in significant accounting estimates, including estimated implicit price concessions related to uninsured patient accounts, professional and general liability reserves, and potential impairments of goodwill and long-lived assets.

During the first quarter of 2021, we received approximately $188 million of additional funds from the federal government in connection with the CARES Act. We expect to return the $188 million of funds to the appropriate government agencies in May, 2021 utilizing a portion of our cash and cash equivalents held on deposit. Since our intent was to return these funds, our results of operations for the first quarter ended March 31, 2021 include no impact from the receipt of the funds.

Also, in March of 2021, we funded the early repayment of $695 million of funds received during 2020 pursuant to the Medicare Accelerated and Advance Payment Program. These funds were returned to the government utilizing a portion of our cash and cash equivalents held on deposit.

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

Relationship with Universal Health Realty Income Trust:

At March 31, 2021, we held approximately 5.7% of the outstanding shares of Universal Health Realty Income Trust (the "Trust"). We serve as Advisor to the Trust under an annually renewable advisory agreement, which is scheduled to expire on December 31st of each year, pursuant to the terms of which we conduct the Trust's day-to-day affairs, provide administrative services and present investment opportunities. The advisory agreement was amended and restated effective January 1, 2019. The advisory agreement was renewed by the Trust for 2021 at the same rate as the prior three years, providing for an advisory fee computation at 0.70% of the Trust's average invested real estate assets. We earned an advisory fee from the Trust, which is included in net revenues in the accompanying consolidated statements of income, of approximately $1.1 and $1.0 million during the three-month periods ended March 31, 2021 and 2020, respectively.

In addition, certain of our officers and directors are also officers and/or directors of the Trust. Management believes that it has the ability to exercise significant influence over the Trust, therefore we account for our investment in the Trust using the equity method of accounting.

Our pre-tax share of income from the Trust, which is included in other income, net, on the accompanying consolidated statements of income for each period was approximately $300,000 during each of the three-month periods ended March 31, 2021 and 2020. We received dividends from the Trust amounting to $547,000 and $540,000 during the three-month periods ended March 31, 2021 and 2020, respectively. The carrying value of our investment in the Trust was approximately $5.1 million and $5.4 million at March 31, 2021 and December 31, 2020, respectively, and is included in other assets in the accompanying consolidated balance sheets. The market value of our investment in the Trust was $53.4 million at March 31, 2021 and $50.6 million at December 31, 2020, based on the closing price of the Trust's stock on the respective dates.

The Trust commenced operations in 1986 by purchasing certain properties from us and immediately leasing the properties back to our respective subsidiaries. Most of the leases were entered into at the time the Trust commenced operations and provided for initial terms of 13 to 15 years with up to six additional 5-year renewal terms. Each lease also provides for additional or bonus rents as discussed below. The base rents are paid monthly and the bonus rents are computed and paid on a quarterly basis, based upon a computation that compares current quarter revenue to a corresponding quarter in the base year. The leases with those subsidiaries are unconditionally guaranteed by us and are cross-defaulted with one another.

Total rent expense under the operating leases on the three wholly-owned hospital facilities with the Trust was approximately $4 million during each of the three months ended March 31, 2021 and 2020. Pursuant to the terms of the three wholly-owned hospital leases with the Trust, we have the option to renew the leases at the lease terms described above and below by providing notice to the Trust at least 90 days prior to the termination of the then current term. We also have the right to purchase the respective leased hospitals at their appraised fair market value upon any of the following: (i) at the end of the lease terms or any renewal terms; (ii) upon one month's notice should a change of control of the Trust occur, or; (iii) within the time period as specified in the lease in the event that we provide notice to the Trust of our intent to offer a substitution property/properties in exchange for one (or more) of the three hospital properties leased from the Trust should we be unable to reach an agreement with the Trust on the properties to be substituted. In addition, we have rights of first refusal to: (i) purchase the respective leased facilities during and for 180 days after the lease terms at the same price, terms and conditions of any third-party offer, or; (ii) renew the lease on the respective leased facility at the end of, and for 180 days after, the lease term at the same terms and conditions pursuant to any third-party offer.

The table below details the renewal options and terms for each of our three wholly-owned acute care hospital facilities leased from the Trust:

Hospital Name	Annual Minimum Rent	End of Lease Term	Renewal Term (years)
McAllen Medical Center	$ 5,485,000	December, 2026	5(a)
Wellington Regional Medical Center	$ 3,030,000	December, 2021	10(b)
Southwest Healthcare System, Inland Valley Campus	$ 2,648,000	December, 2021	10(b)

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

In addition, we are the managing majority member in a joint venture that operates a newly constructed, and recently opened, 100-bed behavioral health care facility located in Clive, Iowa. The real property of this facility is leased from the Trust pursuant to the terms of a triple net lease with an initial term of 20 years with five, 10-year renewals.

As previously disclosed, a wholly-owned subsidiary of ours has notified the Trust that it is planning to terminate the existing lease on Southwest Healthcare System, Inland Valley Campus, upon the scheduled expiration of the current lease term on December 31, 2021. As permitted pursuant to the terms of the lease, we have the right to purchase the leased property at its appraised fair market value at the end of the existing lease term. However, we have proposed exchanging potential substitution properties, with an aggregate fair market value substantially equal to that of Southwest Healthcare System, Inland Valley Campus, in return for the real estate assets of the Inland Valley Campus. The proposed substitution properties consist of one acute care hospital (including a behavioral health pavilion) and a newly constructed behavioral health hospital. The Independent Trustees (of the Board of Trustees) of the Trust have approved the proposed property substitution subject to satisfactory due diligence and completion of definitive agreements. The effective date of the property substitution is expected to coincide with the scheduled lease maturity date of December 31, 2021.

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

Other Related Party Transactions:

In December, 2010, our Board of Directors approved the Company's entering into supplemental life insurance plans and agreements on the lives of Alan B. Miller (our Executive Chairman of the Board) and his wife. As a result of these agreements, as amended in October, 2016, based on actuarial tables and other assumptions, during the life expectancies of the insureds, we would pay approximately $28 million in premiums, and certain trusts owned by our Executive Chairman of the Board, would pay approximately $9 million in premiums. Based on the projected premiums mentioned above, and assuming the policies remain in effect until the death of the insureds, we will be entitled to receive death benefit proceeds of no less than approximately $37 million representing the $28 million of aggregate premiums paid by us as well as the $9 million of aggregate premiums paid by the trusts. In connection with these policies, we will pay/we paid approximately $1.0 million and $1.1 million, net, in premium payments during the 2021 and 2020 years, respectively.

In August, 2015, Marc D. Miller, our President and Chief Executive Officer member of our Board of Directors, was appointed to the Board of Directors of Premier, Inc. ("Premier"), a healthcare performance improvement alliance. During 2013, we entered into a new group purchasing organization agreement ("GPO") with Premier. In conjunction with the GPO agreement, we acquired a minority interest in Premier for a nominal amount. During the fourth quarter of 2013, in connection with the completion of an initial public offering of the stock of Premier, we received cash proceeds for the sale of a portion of our ownership interest in the GPO. Also in connection with this GPO agreement, we received shares of restricted stock of Premier which vested ratably over a seven-year period (2014 through 2020), contingent upon our continued participation and minority ownership interest in the GPO. During the third quarter of 2020, we entered into an agreement with Premier pursuant to the terms of which, among other things, our ownership interest in Premier was converted into shares of Class A Common Stock of Premier. We have elected to retain a portion of the previously vested shares of Premier, the market value of which is included in other assets on our consolidated balance sheet. Based upon the closing price of Premier's stock on each respective date, the market value of our shares of Premier on which the restrictions have lapsed was $76 million as of March 31, 2021 and $78 million as of December 31, 2020. The $2 million decrease in market value of our vested Premier shares since December 31, 2020 was recorded as an unrealized loss and included in "Other (income) expense, net" in our condensed consolidated statements of income for the three-month period ended March 31, 2021. Additionally, during the first quarter of 2021, Premier declared a quarterly cash dividend of $0.19 per share. Our share of the dividend for the quarter ended March 31, 2021 is approximately $400,000 and is included in "Other (income) expense, net" in our condensed consolidated statements of income for the three-month period ended March 31, 2021.

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

(3) Other Noncurrent liabilities and Redeemable/Noncontrolling Interests

Other noncurrent liabilities include the long-term portion of our professional and general liability, workers' compensation reserves, pension and deferred compensation liabilities, payment deferral of the employer's share of Social Security taxes as provided for by the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"), and liabilities incurred in connection with split-dollar life insurance agreements on the lives of our chief executive officer and his wife.

As of March 31, 2021, outside owners held noncontrolling, minority ownership interests of: (i) 20% in an acute care facility located in Washington, D.C.; (ii) approximately 11% in an acute care facility located in Texas; (iii) 20%, 30% and 20% in three behavioral health care facilities located in Pennsylvania, Ohio and Washington, respectively, and; (iv) approximately 5% in an acute care facility located in Nevada. The noncontrolling interest and redeemable noncontrolling interest balances of $88 million and $4 million, respectively, as of March 31, 2021, consist primarily of the third-party ownership interests in these hospitals.

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

(4) Treasury

Credit Facilities and Outstanding Debt Securities:

On October 23, 2018, we entered into a Sixth Amendment (the "Sixth Amendment") to our credit agreement dated as of November 15, 2010, as amended on March 15, 2011, September 21, 2012, May 16, 2013, August 7, 2014 and June 7, 2016, among UHS, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders, JPMorgan Chase Bank, N.A., as administrative agent, and the other agents party thereto (the "Senior Credit Agreement").

The Sixth Amendment to the Senior Credit Agreement, among other things: (i) increased the aggregate amount of the revolving credit facility to $1 billion; (ii) increased the aggregate amount of the tranche A term loan commitments to $2 billion, and; (iii) extended the maturity date of the revolving credit and tranche A term loan facilities to October 23, 2023 from August 7, 2019.

On October 31, 2018, we added a seven-year tranche B term loan facility in the aggregate principal amount of $500 million pursuant to the Senior Credit Agreement. The tranche B term loan matures on October 31, 2025. We used the proceeds to repay borrowings under the revolving credit facility, the Securitization (as defined below), to redeem our $300 million, 3.75% Senior Notes that were scheduled to mature in 2019 and for general corporate purposes.

As of March 31, 2021, we had no borrowings outstanding pursuant to our $1 billion revolving credit facility and we had $997 million of available borrowing capacity net of $3 million of outstanding letters of credit.

Pursuant to the terms of the Sixth Amendment, the tranche A term loan, which had $1.875 billion of borrowings outstanding as of March 31, 2021, provides for installment payments of $25 million per quarter until maturity in October of 2023, when all outstanding amounts will be due.

The tranche B term loan, which had approximately $489 million of borrowings outstanding as of March 31, 2021, provides for installment payments of $1.25 million per quarter which are scheduled to continue until maturity in October of 2025, when all outstanding amounts will be due.

Borrowings under the Senior Credit Agreement bear interest at our election at either (1) the ABR rate which is defined as the rate per annum equal to the greatest of (a) the lender's prime rate, (b) the weighted average of the federal funds rate, plus 0.5% and (c) one month LIBOR rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.375% to 0.625% for revolving credit and term loan A borrowings and 0.75% for tranche B borrowings, or (2) the one, two, three or six month LIBOR rate (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.375% to 1.625% for revolving credit and term loan A borrowings and 1.75% for the tranche B term loan. As of March 31, 2021, the applicable margins were 0.375% for ABR-based loans and 1.375% for LIBOR-based loans under the revolving credit and term loan A facilities. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Senior Credit Agreement is secured by certain assets of the Company and our material subsidiaries (which generally excludes asset classes such as substantially all of the patient-related accounts receivable of our acute care hospitals, and certain real estate assets and assets held in joint-ventures with third parties) and is guaranteed by our material subsidiaries.

The Senior Credit Agreement includes a material adverse change clause that must be represented at each draw. The Senior Credit Agreement contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens and indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage. We are in compliance with all required covenants as of March 31, 2021 and December 31, 2020.

In March, 2021, we provided notice to the group of conduit lenders, liquidity banks, and PNC Bank, National Association, as administrative agent, in connection with our $450 million accounts receivable securitization program ("Securitization"), expressing our intent to terminate the aggregate borrowing commitments under the facility, which occurred effective as of March 31, 2021. The Securitization was amended as of April 26, 2021 (the eighth amendment) to: (i) reduce the aggregate borrowing commitments to $20 million; (ii) slightly reduce the borrowing rates and commitment fee, and; (iii) extend the maturity date to April 25, 2022. Substantially all other material terms and conditions remained unchanged.

As of March 31, 2021, we had combined aggregate principal of $1.2 billion from the following senior secured notes:

- $800 million aggregate principal amount of 2.65% senior secured notes due in October, 2030 ("2030 Notes") which were issued on September 21, 2020.
- $400 million aggregate principal amount of 5.00% senior secured notes due in June, 2026 ("2026 Notes") which were issued on June 3, 2016.

Interest on the 2026 Notes is payable on June 1 and December 1 until the maturity date of June 1, 2026. Interest on the 2030 Notes payable on April 15 and October 15, commencing April 15, 2021, until the maturity date of October 15, 2030. The 2026 Notes and 2030 Notes were offered only to qualified institutional buyers under Rule 144A and to non-U.S. persons outside the United States in reliance on Regulation S under the Securities Act of 1933, as amended (the "Securities Act"). The 2026 Notes and 2030 Notes have not been registered under the Securities Act and may not be offered or sold in the United States absent registration or an applicable exemption from registration requirements.

The 2030 Notes are guaranteed (the "*Guarantees*") on a senior secured basis by all of our existing and future direct and indirect subsidiaries (the "*Subsidiary Guarantors*") that guarantee our Senior Credit Agreement, dated as of November 15, 2010, as amended, restated or supplemented from time to time, or other first lien obligations or any junior lien obligations. The 2030 Notes and the Guarantees are secured by first-priority liens, subject to permitted liens, on certain of the Company's and the Subsidiary Guarantors' assets now owned or acquired in the future by the Company or the Subsidiary Guarantors (other than real property, accounts receivable sold pursuant to the Company's Existing Receivables Facility (as defined in the Indenture pursuant to which the 2030 Notes were issued (the "Indenture")), and certain other excluded assets). The Company's obligations with respect to the 2030 Notes, the obligations of the Subsidiary Guarantors under the Guarantees, and the performance of all of the Company's and the Subsidiary Guarantors' other obligations under the Indenture are secured equally and ratably with the Company's and the Subsidiary Guarantors' obligations under the Senior Credit Agreement and the Company's 2026 Notes by a perfected first-priority security interest, subject to

permitted liens, in the collateral owned by the Company and its Subsidiary Guarantors, whether now owned or hereafter acquired. However, the liens on the collateral securing the 2030 Notes and the Guarantees will be released if: (i) the 2030 Notes have investment grade ratings; (ii) no default has occurred and is continuing, and; (iii) the liens on the collateral securing all first lien obligations (including the Senior Credit Agreement and the 2026 Notes) and any junior lien obligations are released or the collateral under the Senior Credit Agreement, any other first lien obligations and any junior lien obligations is released or no longer required to be pledged. The liens on any collateral securing the 2030 Notes and the Guarantees will also be released if the liens on that collateral securing the Senior Credit Agreement, other first lien obligations and any junior lien obligations are released.

In connection with the issuance of the 2030 Notes, the Company, the Subsidiary Guarantors and the representatives of the several initial purchasers, entered into a Registration Rights Agreement (the "*Registration Rights Agreement*"), whereby the Company and the Subsidiary Guarantors have agreed, at their expense, to use commercially reasonable best efforts to: (i) cause to be filed a registration statement enabling the holders to exchange the 2030 Notes and the Guarantees for registered senior secured notes issued by the Company and guaranteed by the then Subsidiary Guarantors under the Indenture (the "*Exchange Securities*"), containing terms identical to those of the 2030 Notes (except that the Exchange Securities will not be subject to restrictions on transfer or to any increase in annual interest rate for failure to comply with the Registration Rights Agreement); (ii) cause the registration statement to become effective; (iii) complete the exchange offer not later than 60 days after such effective date and in any event on or prior to a target registration date of March 21, 2023, and; (iv) file a shelf registration statement for the resale of the 2030 Notes if the exchange offer cannot be effected within the time periods listed above. The interest rate on the 2030 Notes will increase and additional interest thereon will be payable if the Company does not comply with its obligations under the Registration Rights Agreement.

On September 28, 2020, we redeemed the entire $700 million aggregate principal amount of our previously outstanding 4.75% Senior Secured Notes due 2022 (the "2022 Notes"), at a cash redemption price equal to the sum of: (i) 100% of the aggregate principal amount of the 2022 Notes redeemed, and; (ii) accrued and unpaid interest on the 2022 Notes to the redemption date.

At March 31, 2021, the carrying value and fair value of our debt were each approximately $3.6 billion. At December 31, 2020, the carrying value and fair value of our debt were each approximately $3.9 billion. The fair value of our debt was computed based upon quotes received from financial institutions. We consider these to be "level 2" in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with debt instruments.

Cash Flow Hedges:

During the three-month period ended March 31, 2021 and the year ended December 31, 2020, we had no cash flow hedges outstanding.

Foreign Currency Forward Exchange Contracts:

We use forward exchange contracts to hedge our net investment in foreign operations against movements in exchange rates. The effective portion of the unrealized gains or losses on these contracts is recorded in foreign currency translation adjustment within accumulated other comprehensive income and remains there until either the sale or liquidation of the subsidiary. In connection with these forward exchange contracts, we recorded net cash outflows of $14 million during the three-month period ended March 31, 2021 and net cash inflows of $52 million during the three-month period ended March 31, 2020.

Derivatives Hedging Relationships:

The following table presents the effects of our foreign currency foreign exchange contracts on our results of operations for the three-month periods ended March 31, 2021 and 2020 (in thousands):

	Gain/(Loss) recognized in AOCI	
	Three months ended	
	March 31, 2021	March 31, 2020
Net Investment Hedge relationships		
Foreign currency foreign exchange contracts	$ (21,114)	$ 40,546

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

Cash, Cash Equivalents and Restricted Cash:

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

	March 31, 2021		March 31, 2020
Cash and cash equivalents	$ 764,502		$ 54,619
Restricted cash and cash equivalents (a)	54,666		44,604
Total cash, cash equivalents and restricted cash	$ 819,168	(b)	$ 99,223

(a) Restricted cash and cash equivalents is included in other assets on the accompanying consolidated balance sheet.
(b) Consists primarily of short-term cash accounts on which interest is being earned at various annual rates ranging from 0.20% to 0.35%.

(5) Fair Value Measurement

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

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

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

(in thousands)	Balance at March 31, 2021	Balance Sheet Location	Basis of Fair Value Measurement Level 1	Level 2	Level 3
Assets:					
Term Deposit	250,000	Cash and cash equivalents		250,000	
Money market mutual funds	119,400	Cash and cash equivalents	119,400		
Money market mutual funds	70,974	Other assets	70,974		
Certificates of deposit	2,200	Other assets		2,200	
Available for sale securities	75,576	Other assets	75,576		
Deferred compensation assets	42,702	Other assets	42,702		
Foreign currency exchange contracts	3,136	Other current assets		3,136	
	$ 563,988		308,652	255,336	-
Liabilities:					
Deferred compensation liability	42,702	Other noncurrent liabilities	42,702		
	$ 42,702		42,702	-	-

(in thousands)	Balance at December 31, 2020	Balance Sheet Location	Basis of Fair Value Measurement Level 1	Level 2	Level 3
Assets:					
Term Deposit	540,000	Cash and cash equivalents		540,000	
Money market mutual funds	37,100	Cash and cash equivalents	37,100		
Money market mutual funds	70,995	Other assets	70,995		
Certificates of deposit	2,300	Other assets		2,300	
Available for sale securities	78,367	Other assets	78,367		
Deferred compensation assets	42,044	Other assets	42,044		
Foreign currency exchange contracts	9,987	Other current assets		9,987	
	$ 780,793		228,506	552,287	-
Liabilities:					
Deferred compensation liability	$ 42,044	Other noncurrent liabilities	42,044		
	$ 42,044		42,044	-	-

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

As of March 31, 2021, in addition to the $369 million reflected above in cash and cash equivalents, we have approximately $380 million of other cash accounts that earn interest at variable rates ranging from .20% to .25%.

As of December 31, 2020, in addition to the $577 million reflected above in cash and cash equivalents, we have approximately $581 million of other cash accounts that earn interest at variable rates ranging from .20% to .25%.

(6) Commitments and Contingencies

Professional and General Liability, Workers' Compensation Liability

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

These subsidiaries are provided with several excess policies through commercial insurance carriers which provide for coverage in excess of the applicable per occurrence self-insured retention or underlying policy limits up to $155 million per occurrence and in the aggregate in 2021, $250 million per occurrence and in the aggregate for claims incurred from 2014-2020, $200 million per occurrence and in the aggregate for claims incurred from 2010-2013. In addition, from time to time based upon marketplace conditions, we may elect to purchase additional commercial coverage for certain of our facilities or businesses. Our behavioral health care facilities located in the U.K. have policies through a commercial insurance carrier located in the U.K. that provides for £10 million of professional liability coverage and £25 million of general liability coverage.

As of March 31, 2021, the total accrual for our professional and general liability claims was $278 million, of which $74 million was included in current liabilities. As of December 31, 2020, the total accrual for our professional and general liability claims was $264 million, of which $74 million was included in current liabilities.

As a result of unfavorable trends experienced during 2020, included in our results of operations during the first quarter of 2020, was a $20 million increase to our reserves related to prior years for self-insured professional and general liability claims. Our results of operations during the first quarter of 2021 were not materially impacted by adjustments to our prior year reserves for professional and general liability claims. Our estimated liability for self-insured professional and general liability claims is based on a number of factors including, among other things, the number of asserted claims and reported incidents, estimates of losses for these claims based on recent and historical settlement amounts, 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, 2021, the total accrual for our workers' compensation liability claims was $107 million, $55 million of which was included in current liabilities. As of December 31, 2020, the total accrual for our workers' compensation liability claims was $105 million, $55 million of which was included in current liabilities.

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

Property Insurance

We have commercial property insurance policies for our properties covering catastrophic losses, including windstorm damage, up to a $1 billion policy limit, subject to a per occurrence/per location deductible of $2.5 million as of June 1, 2020. Losses resulting from named windstorms are subject to deductibles between 3% and 5% of the total insurable value of the property. In addition, we have commercial property insurance policies covering catastrophic losses resulting from earthquake and flood damage, each subject to aggregated loss limits (as opposed to per occurrence losses). Commercially insured earthquake coverage for our facilities is subject to

various deductibles and limitations including: (i) $300 million limitation for our facilities located in Nevada; (ii) $130 million limitation for our facilities located in California; (iii) $100 million limitation for our facilities located in fault zones within the United States; (iv) $40 million limitation for our facilities located in Puerto Rico, and; (v) $250 million limitation for many of our facilities located in other states. Our commercially insured flood coverage has a limit of $100 million annually. There is also a $10 million sublimit for one of our facilities located in Houston, Texas, and a $1 million sublimit for our facilities located in Puerto Rico. Property insurance for our behavioral health facilities located in the U.K. are provided on an all risk basis up to a £1.5 billion policy limit, with coverage caps per location, that includes coverage for real and personal property as well as business interruption losses.

Legal Proceedings

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

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

Certain legal matters are described below:

Litigation:

Shareholder Class Action

In December 2016 a purported shareholder class action lawsuit was filed in U.S. District Court for the Central District of California against UHS and certain UHS officers alleging violations of the federal securities laws. The case was originally filed as Heed v. Universal Health Services, Inc. et. al. (Case No. 2:16-CV-09499-PSG-JC). The court subsequently appointed Teamsters Local 456 Pension Fund and Teamsters Local 456 Annuity Fund to serve as lead plaintiffs. The case has been transferred to the U.S. District Court for the Eastern District of Pennsylvania and the style of the case has been changed to Teamsters Local 456 Pension Fund, et. al. v. Universal Health Services, Inc. et. al. (Case No. 2:17-CV-02817-LS). In September, 2017, Teamsters Local 456 Pension Fund filed an amended complaint. The amended class action complaint alleges violations of federal securities laws relating to disclosures made in public filings associated with alleged practices and operations at our behavioral health facilities. Plaintiffs seek monetary damages for shareholders during the defined class period as a result of the decrease in share price following various public disclosures or reports. In December, 2017, we filed a motion to dismiss the amended complaint. In August, 2019, the court granted our motion to

dismiss. Plaintiffs subsequently filed a motion with the court seeking leave to file a second amended complaint. In April, 2020, the court denied Plaintiffs' motion to file a second amended complaint. Plaintiffs filed an appeal with the 3rd Circuit Court of Appeals. During the fourth quarter of 2020, and during the pendency of the appeal, we reached an agreement to settle this matter, pending final court approval. The net settlement amount, after anticipated commercial insurance proceeds, did not have a material impact on our consolidated financial statements for the year ended December 31, 2020. The settlement is not an admission of liability.

Shareholder Derivative Cases

In March 2017, a shareholder derivative suit was filed by plaintiff David Heed in the Court of Common Pleas of Philadelphia County. A notice of removal to the United States District Court for the Eastern District of Pennsylvania was filed (Case No. 2:17-cv-01476-LS). Plaintiff filed a motion to remand. In December 2017, the Court denied plaintiff's motion to remand and retained the case in federal court. In May, June and July 2017, additional shareholder derivative suits were filed in the United States District Court for the Eastern District of Pennsylvania. The plaintiffs in those cases are: Central Laborers' Pension Fund (Case No. 17-cv-02187-LS); Firemen's Retirement System of St. Louis (Case No. 17—cv-02317-LS); Waterford Township Police & Fire Retirement System (Case No. 17-cv-02595-LS); and Amalgamated Bank Longview Funds (Case No. 17-cv-03404-LS). The Fireman's Retirement System case has since been voluntarily dismissed. The federal court consolidated all of the cases pending in the Eastern District of Pennsylvania and appointed co-lead plaintiffs and co-lead counsel. Lead Plaintiffs filed a consolidated, amended complaint. We filed a motion to dismiss the amended complaint. In addition, a shareholder derivative case was filed in Chancery Court in Delaware by the Delaware County Employees' Retirement Fund (Case No. 2017-0475-JTL). In December 2017, the Chancery Court stayed this case pending resolution of other contemporaneous matters. Each of these cases have named certain current and former members of the Board of Directors individually and certain officers of Universal Health Services, Inc. as defendants. UHS has also been named as a nominal defendant in these cases. The derivative cases make substantially similar allegations and claims as the shareholder class action relating to practices at our behavioral health facilities and board and corporate oversight of these facilities as well as claims relating to the stock trading by the individual defendants and company repurchase of shares during the relevant time period. The cases make claims of breaches of fiduciary duties by the named board members and officers; alleged violations of federal securities laws; and common law causes of action against the individual defendants including unjust enrichment, corporate waste, abuse of control, constructive fraud and gross mismanagement. The cases seek monetary damages allegedly incurred by the company; restitution and disgorgement of profits, benefits and other compensation from the individual defendants and various forms of equitable relief relating to corporate governance matters. In August, 2019, the court granted our motion to dismiss. Plaintiffs subsequently filed a motion with the court seeking leave to file a second amended complaint. In April, 2020, the court denied Plaintiffs motion to file a second amended complaint. Plaintiffs filed an appeal with the 3rd Circuit Court of Appeals. The defendants deny liability and intend to defend these cases vigorously. The parties continue settlement negotiations during the pendency of the appeal, however, we can provide no assurance that a settlement will be reached. We are uncertain as to potential liability or financial exposure, if any, which may be associated with these matters.

The George Washington University v. Universal Health Services, Inc., et. al.

In December 2019, The George Washington University ("University") filed a lawsuit in the Superior Court for the District of Columbia against Universal Health Services, Inc. as well as certain subsidiaries and individuals associated with the ownership and management of The George Washington University Hospital ("GW Hospital") in Washington, D.C. (case No. 2019 CA 008019 B). The lawsuit claims that UHS failed to provide sufficient financial compensation to the University under the terms of various agreements entered into in 1997 between the University and UHS for the joint venture ownership of GW Hospital. The lawsuit includes claims for breach of contract, breach of fiduciary duty, and unjust enrichment. We deny liability and intend to defend this matter vigorously. We filed a motion to dismiss the complaint. In June, 2020, the Court granted the motion in part dismissing the majority of the claims against UHS. At this time, we are uncertain as to potential liability or financial exposure, if any, which may be associated with this matter.

Disproportionate Share Hospital Payment Matter:

In late September, 2015, many hospitals in Pennsylvania, including certain of our behavioral health care hospitals located in the state, received letters from the Pennsylvania Department of Human Services (the "Department") demanding repayment of allegedly excess Medicaid Disproportionate Share Hospital payments ("DSH"), primarily consisting of managed care payments characterized as DSH payments, for the federal fiscal year ("FFY") 2011 amounting to approximately $4 million in the aggregate. Since that time, certain of our behavioral health care hospitals in Pennsylvania have received similar requests for repayment for alleged DSH overpayments for FFYs 2012 through 2015. For FFY 2012, the claimed overpayment amounts to approximately $4 million. For FY 2013, FY 2014 and FY 2015 the initial claimed overpayments and attempted recoupment by the Department were approximately $7 million, $8 million and $7 million, respectively. The Department has agreed to a change in methodology which, upon confirmation of the underlying data being accepted by the Department, could reduce the initial claimed overpayments for FY 2013, FY 2014 and FY 2015 to approximately $2 million, $2 million and $3 million, respectively. We filed administrative appeals for all of our facilities contesting the recoupment efforts for FFYs 2011 through 2015 as we believe the Department's calculation methodology is inaccurate and conflicts with applicable federal and state laws and regulations. The Department has agreed to postpone the recoupment of the state's share for FY 2011 to 2013 until all hospital appeals are resolved but started recoupment of the federal share. For FY 2014 and FY 2015, the Department has initiated the recoupment of the alleged overpayments. Starting in FFY 2016, the first full fiscal year after the

January 1, 2015 effective date of Medicaid expansion in Pennsylvania, the Department no longer characterized managed care payments received by the hospitals as DSH payments. We can provide no assurance that we will ultimately be successful in our legal and administrative appeals related to the Department's repayment demands. If our legal and administrative appeals are unsuccessful, our future consolidated results of operations and financial condition could be adversely impacted by these repayments.

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

Former UHS subsidiary facility employees Mary K. Boley, Kandie Sutter, and Phyllis Johnson, individually and on behalf of a putative class of participants in the UHS Retirement Savings Plan (the "Plan"), filed a complaint in the U.S. District Court for the Eastern District of Pennsylvania against UHS, the Board of Directors of UHS, and the "Plan Committee" of UHS (Case No. 2:20-cv-02644). In subsequent amended complaints, Plaintiffs have dropped the Board of Directors and the "Plan Committee" as defendants and added the UHS Retirement Plans Investment Committee as a new defendant. Plaintiffs allege that UHS breached its fiduciary duties under the Employee Retirement Income Security Act ("ERISA") by offering to participants in the Plan overly expensive investment options when less expensive investment options were available in the marketplace; caused participants to pay excessive recordkeeping fees associated with the Plan; breached its duty to monitor appointed fiduciaries and: in the alternative, engaged in a "knowing breach of trust" separate from the alleged violations under ERISA. UHS disputes Plaintiffs' allegations and is actively defending against Plaintiffs' claims. UHS' motion for partial dismissal of Plaintiffs' claims was denied by the Court. In March 2021, the Court granted Plaintiffs' motion for class certification. We are uncertain as to potential liability or financial exposure, if any, which may be associated with this matter. We maintain commercial insurance coverage for claims of this nature, subject to specified deductibles and limitations.

Other Matters:

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

(7) Segment Reporting

Our reportable operating segments consist of acute care hospital services and behavioral health care services. The "Other" segment column below includes centralized services including, but not limited to, information technology, purchasing, reimbursement, accounting and finance, taxation, legal, advertising and design and construction. The chief operating decision making group for our acute care services and behavioral health care services is comprised of our Chief Executive Officer, the President and the Presidents of each operating segment. The Presidents for each operating segment also manage the profitability of each respective segment's various facilities. The operating segments are managed separately because each operating segment represents a business unit that offers different types of healthcare services or operates in different healthcare environments. The accounting policies of the operating segments are the same as those described in the summary of significant accounting policies included in our Annual Report on Form 10-K for the year ended December 31, 2020. 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, and overhead expenses incurred on behalf of both segments are captured and allocated to each segment based upon each segment's respective percentage of total operating expenses.

	Three months ended March 31, 2021			
	Acute Care Hospital Services	Behavioral Health Services (a)	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 9,119,184	$ 2,473,565	$ -	$ 11,592,749
Gross outpatient revenues	$ 4,580,720	$ 246,764	$ -	$ 4,827,484
Total net revenues	$ 1,694,542	$ 1,315,337	$ 3,108	$ 3,012,987
Income/(loss) before allocation of corporate overhead and income taxes	$ 173,118	$ 231,325	$ (131,566)	$ 272,877
Allocation of corporate overhead	$ (58,107)	$ (42,950)	$ 101,057	$ 0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 115,011	$ 188,375	$ (30,509)	$ 272,877
Total assets as of March 31, 2021	$ 4,957,253	$ 7,090,291	$ 1,048,785	$ 13,096,329

	Three months ended March 31, 2020			
	Acute Care Hospital Services	Behavioral Health Services (a)	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 7,821,472	$ 2,525,539	$ 0	$ 10,347,011
Gross outpatient revenues	$ 4,681,741	$ 259,739	$ 0	$ 4,941,480
Total net revenues	$ 1,521,049	$ 1,306,109	$ 2,509	$ 2,829,667
Income/(loss) before allocation of corporate overhead and income taxes	$ 103,537	$ 237,683	$ (150,437)	$ 190,783
Allocation of corporate overhead	$ (55,973)	$ (42,730)	$ 98,703	$ 0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 47,564	$ 194,953	$ (51,734)	$ 190,783
Total assets as of March 31, 2020	$ 4,387,355	$ 6,871,852	$ 361,219	$ 11,620,426

(a) Includes net revenues generated from our behavioral health care facilities located in the U.K. amounting to approximately $165 million and $137 million for the three-month periods ended March 31, 2021 and 2020, respectively. Total assets at our U.K. behavioral health care facilities were approximately $1.355 billion and $1.197 billion as of March 31, 2021 and 2020, respectively.

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

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

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

	Three months ended March 31,	
	2021	2020
Basic and Diluted:		
Net income attributable to UHS	$ 209,091	$ 142,037
Less: Net income attributable to unvested restricted share grants	(552)	(373)
Net income attributable to UHS – basic and diluted	$ 208,539	$ 141,664
Weighted average number of common shares - basic	84,782	86,212
Net effect of dilutive stock options and grants based on the treasury stock method	1,014	243
Weighted average number of common shares and equivalents - diluted	85,796	86,455
Earnings per basic share attributable to UHS:	$ 2.46	$ 1.64
Earnings per diluted share attributable to UHS:	$ 2.43	$ 1.64

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 4.6 million for the three months ended March 31, 2021 and 5.9 million for the three months ended March 31, 2020. All classes of our common stock have the same dividend rights.

The decrease in our basic and diluted weighted number of common shares outstanding for the three months ended March 31, 2021, as compared to the comparable prior year three months, was due primarily to the impact of shares repurchased by us.

Stock-Based Compensation:

During the three-month periods ended March 31, 2021 and 2020, pre-tax compensation cost of $14.8 million and $15.3 million, respectively, was recognized related to outstanding stock options. In addition, during the three-month periods ended March 31, 2021 and 2020, pre-tax compensation cost of approximately $2.9 million and $2.4 million (net of cancellations), respectively, was recognized related to restricted stock. As of March 31, 2021 there was approximately $182.2 million of unrecognized compensation cost related to unvested options and restricted stock awards and units which is expected to be recognized over the remaining weighted average vesting period of 3.1 years. There were 2,389,902 stock options granted during the first three months of 2021 (including 406,982 stock options granted at a 10% market price premium) with a weighted-average grant date fair value of $39.65 per option. There were 150,860 shares of restricted shares and restricted units granted during the first three months of 2021 with a weighted-average grant date fair value of $138.80 per share.

The expense associated with stock-based compensation arrangements is a non-cash charge. In the Condensed Consolidated Statements of Cash Flows, stock-based compensation expense is an adjustment to reconcile net income to cash provided by operating activities and aggregated to $18.0 million during each of the three month periods ended March 31, 2021 and 2020.

(9) Dispositions and acquisitions

Three-month period ended March 31, 2021:

Acquisitions:

During the first three months of 2021, there were no acquisitions.

Divestitures:

During the first three months of 2021, there were no divestitures.

Three-month period ended March 31, 2020:

Acquisitions:

During the first three months of 2020, there were no acquisitions.

Divestitures:

During the first three months of 2020, there were no divestitures.

(10) Dividends

We declared and paid dividends of $17.0 million, or $.20 per share, during the first quarter of 2021 and $17.3 million, or $.20 per share during the first quarter of 2020.

(11) Income Taxes

Our effective income tax rates were 23.4% and 24.3% during the three-month periods ended March 31, 2021 and 2020, respectively. The decrease in our effective tax rate during the three months ended March 31, 2021, compared with the same period in 2020, was primarily due to a $2 million decrease in our provision for income taxes attributable to employee share-based payments which decreased our provision for income taxes by approximately $1 million during the first quarter of 2021 as compared to less than $1 million increase during the first quarter of 2020.

The global intangible low-taxed income (“GILTI”) provisions from the TCJA-17 require the inclusion of the earnings of certain foreign subsidiaries in excess of an acceptable rate of return on certain assets of the respective subsidiaries in our U.S. tax return for tax years beginning after December 31, 2017. An accounting policy election was made during 2018 to treat taxes related to GILTI as a period cost when the tax is incurred. We recorded a GILTI tax provision of zero for the three months ended March 31, 2021 and 2020.

As of January 1, 2021, our unrecognized tax benefits were approximately $2 million. The amount, if recognized, that would favorably

affect the effective tax rate is approximately $2 million. During the three months ended March 31, 2021, 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, 2021, we have less than $1 million of accrued interest and penalties. The U.S. federal statute of limitations remains open for 2017 and subsequent years. Foreign and U.S. state and local jurisdictions have statutes of limitations generally ranging from 3 to 4 years. The statute of limitations on certain jurisdictions could expire within the next twelve months. It is reasonably possible that the amount of uncertain tax benefits will change during the next 12 months, however, it is anticipated that any such change, if it were to occur, would not have a material impact on our results of operations.

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

(12) Revenue

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

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

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

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

The following table disaggregates our revenue by major source for the three-month periods ended March 31, 2021 and 2020 (in thousands):

	For the three months ended March 31, 2021							
	Acute Care		Behavioral Health		Other		Total	
Medicare	$ 335,513	20%	$ 88,492	7%			$ 424,005	14%
Managed Medicare	275,560	16%	57,542	4%			333,102	11%
Medicaid	111,641	7%	153,140	12%			264,781	9%
Managed Medicaid	135,498	8%	334,758	25%			470,256	16%
Managed Care (HMO and PPOs)	598,810	35%	348,744	27%			947,554	31%
UK Revenue	0	0%	164,666	13%			164,666	5%
Other patient revenue and adjustments, net	94,250	6%	120,283	9%			214,533	7%
Other non-patient revenue	143,270	8%	47,712	4%	3,108		194,090	6%
Total Net Revenue	$ 1,694,542	100%	$ 1,315,337	100%	$ 3,108		$ 3,012,987	100%

	For the three months ended March 31, 2020							
	Acute Care		Behavioral Health		Other		Total	
Medicare	$ 326,025	21%	$ 119,617	9%			$ 445,642	16%
Managed Medicare	221,991	15%	59,238	5%			281,229	10%
Medicaid	127,959	8%	175,018	13%			302,977	11%
Managed Medicaid	123,455	8%	302,557	23%			426,012	15%
Managed Care (HMO and PPOs)	540,737	36%	340,687	26%			881,424	31%
UK Revenue	0	0%	136,850	10%			136,850	5%
Other patient revenue and adjustments, net	64,599	4%	123,060	9%			187,659	7%
Other non-patient revenue	116,283	8%	49,082	4%	2,509		167,874	6%
Total Net Revenue	$ 1,521,049	100%	$ 1,306,109	100%	$ 2,509		$ 2,829,667	100%

(13) Lease Accounting

Our operating leases are primarily for real estate, including certain acute care facilities, off-campus outpatient facilities, medical office buildings, and corporate and other administrative offices. Our real estate lease agreements typically have initial terms of five to 10 years. These real estate leases may include one or more options to renew, with renewals that can extend the lease term from five to 10 years. The exercise of lease renewal options is at our sole discretion. When determining the lease term, we included options to extend or terminate the lease when it is reasonably certain that we will exercise that option.

Three of our hospital facilities are held under operating leases with Universal Health Realty Income Trust with two hospital terms expiring in 2021 and the third expiring in 2026 (see Note 2 for additional disclosure). We are also the lessee of the real property of certain facilities.

Supplemental cash flow information related to leases for the three-month periods ended March 31, 2021 and 2020 are as follows (in thousands):

	Three months ended March 31,	
	2021	2020
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from operating leases	$ 31,043	$ 28,227
Operating cash flows from finance leases	$ 1,184	$ 489
Financing cash flows from finance leases	$ 697	$ 628
Right-of-use assets obtained in exchange for lease obligations:		
Operating leases	$ 5,907	$ 29,112
Finance leases	$ 7,690	$ -

(14) Recent Accounting Standards

In June 2016, the FASB issued ASU 2016-13, "Financial Instruments - Credit Losses," which introduced new guidance for an approach based on expected losses to estimate credit losses on certain types of financial instruments. Instruments in scope include loans, held-to-maturity debt securities, and net investments in leases as well as reinsurance and trade receivables. In November 2018, the FASB issued ASU 2018-19, which clarifies that operating lease receivables are outside the scope of the new standard. The standard was be effective for us in fiscal years beginning after December 15, 2019. The adoption of this guidance did not have a material impact on our consolidated financial statements.

In January, 2017, the FASB issued ASU No. 2017-04, “Intangibles-Goodwill and Other (Topic 350): Simplifying the Accounting for Goodwill Impairment” (“ASU 2017-04”), which removes the requirement to perform a hypothetical purchase price allocation to measure goodwill impairment. A goodwill impairment will now be the amount by which a reporting unit’s carrying value exceeds its fair value, not to exceed the carrying amount of goodwill. ASU 2017-04 was effective for the annual and interim periods beginning January 1, 2020 with early adoption permitted, and applied prospectively. The adoption of this guidance did not have a material impact on our consolidated financial statements.

In August 2018, the FASB issued ASU 2018-15, Intangibles- Goodwill and Other- Internal Use Software (Topic 350): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract, ("ASU 2018-15"), which requires customers in a cloud computing arrangement (i.e., hosting arrangement) that is a service contract to follow the internal use software guidance in ASC 350-40 to determine which implementation costs to capitalize or expense. ASU 2018-15 was effective for fiscal years beginning after December 15, 2019, including interim periods within those fiscal years. The adoption of this guidance did not have a material impact on our consolidated financial statements.

In March 2020, the FASB issued ASU 2020-04, “Facilitation of the Effects of Reference Rate Reform on Financial Reporting.” The ASU is intended to provide temporary optional expedients and exceptions to the US GAAP guidance on contract modifications and hedge accounting to ease the financial reporting burdens related to the expected market transition from LIBOR and other interbank offered rates to alternative reference rates. This guidance was effective beginning on March 12, 2020, and the Company may elect to apply the amendments prospectively through December 31, 2022. The Company is currently evaluating the impact this guidance may have on our consolidated financial statements.

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

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

Overview

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

As of March 31, 2021, we owned and/or operated 361 inpatient facilities and 39 outpatient and other facilities including the following located in 38 states, Washington, D.C., the United Kingdom and Puerto Rico:

Acute care facilities located in the U.S.:

- 26 inpatient acute care hospitals;
- 17 free-standing emergency departments, and;
- 6 outpatient centers & 1 surgical hospital.

Behavioral health care facilities (335 inpatient facilities and 15 outpatient facilities):

Located in the U.S.:

- 186 inpatient behavioral health care facilities, and;
- 12 outpatient behavioral health care facilities.

Located in the U.K.:

- 146 inpatient behavioral health care facilities, and;
- 3 outpatient behavioral health care facilities.

Located in Puerto Rico:

- 3 inpatient behavioral health care facilities.

As a percentage of our consolidated net revenues, net revenues from our acute care hospitals, outpatient facilities and commercial health insurer accounted for 56% and 54% during the three-month periods ended March 31, 2021 and 2020, respectively. Net revenues from our behavioral health care facilities and commercial health insurer accounted for 44% and 46% of our consolidated net revenues during the three-month periods ended March 31, 2021 and 2020, respectively.

Our behavioral health care facilities located in the U.K. generated net revenues of approximately $165 million and $137 million during the three-month periods ended March 31, 2021 and 2020, respectively. Total assets at our U.K. behavioral health care facilities were approximately $1.355 billion as of March 31, 2021 and $1.334 billion as of December 31, 2020.

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

Forward-Looking Statements and Risk Factors

You should carefully review the information contained in this Quarterly Report, and should particularly consider any risk factors that we set forth in our Annual Report on Form 10-K for the year ended December 31, 2020, 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 set forth in *Item 1A. Risk Factors* and *Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations-Forward Looking Statements and Risk Factors* in our Annual Report on Form 10-K for the year ended December 31, 2020 ("Form 10-K") and in *Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations-Forward Looking Statements and Risk Factors,* as included herein.

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

- we are subject to risks associated with public health threats and epidemics, including the health concerns relating to the COVID-19 pandemic. In January 2020, the Centers for Disease Control and Prevention ("CDC") confirmed the spread of the disease to the United States. In March 2020, the World Health Organization declared the COVID-19 outbreak a pandemic. The federal government has declared COVID-19 a national emergency, as many federal and state authorities have implemented aggressive measures to "flatten the curve" of confirmed individuals diagnosed with COVID-19 in an attempt to curtail the spread of the virus and to avoid overwhelming the health care system;
- the COVID-19 pandemic has adversely impacted and is likely to further adversely impact us, our employees, our patients, our vendors and supply chain partners, and financial institutions, which could continue to have a material adverse effect on our business, results of operations and financial condition. In an effort to slow the spread of the disease, since March, 2020, at various times, most state and local governments mandated general "shelter-in-place" orders or other similar restrictions that require or strongly encourage social distancing and, face coverings, and that have closed or limited non-essential business activities. Some of these restrictions remain in place. Additionally, evidence suggests that individuals may be deciding to forego medical care delivered in traditional venues. These dynamics have manifested themselves in our hospitals in, among other ways, reduced emergency room visits, elective/scheduled procedures and acute and behavioral health patient days. While such measures are expected to assist in responding to the recent outbreak, self-quarantines, shelter-in-place orders, and suspension of voluntary procedures and surgeries have had, and will likely continue to have, an adverse impact on the operations and financial position of health care provider systems due to increased costs (including labor costs which have been pressured during the COVID-19 pandemic due to a shortage of clinicians and increased wage rates resulting from increased demand for those services), actual reduction and potential reduction in overall patient volume, and shifts in payor mix. Despite these measures, there have been waves of escalated COVID-19 cases at various times, including the fourth quarter of 2020 and into the first quarter of 2021, in many states in the U.S., including many states in which we operate hospitals. The COVID-19 vaccination process commenced during the first quarter of 2021 and, while we expect that the administration of vaccines will assist in easing the number of COVID-19 patients, the pace of distribution and the portion of the population that ultimately become vaccinated is difficult to predict. The extent to which the COVID-19 pandemic and measures taken in response thereto impact our business, results of operations and financial condition will depend on numerous factors and future developments, most of which are beyond our control or ability to predict. The ultimate impact of the COVID-19 pandemic is highly uncertain and subject to change. We are not able to fully quantify the impact that these factors will have on our future financial results, but expect developments related to the COVID-19 pandemic to materially affect our financial performance in 2021. Even after the COVID-19 pandemic has subsided, we may continue to experience materially adverse impacts on our financial condition and our results of operations as a result of its macroeconomic impact, including any recession that has occurred or may occur in the future, and many of our known risks described in the *Risk Factors* in our Form 10-K;
- the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"), a stimulus package signed into law on March 27, 2020, authorizes $100 billion in grant funding to hospitals and other healthcare providers to be distributed through the Public Health and Social Services Emergency Fund (the "PHSSEF"). These funds are not required to be repaid provided the recipients attest to and comply with certain terms and conditions, including limitations on balance billing and not using PHSSEF funds to reimburse expenses or losses that other sources are obligated to reimburse. However, since the expenses and losses will be ultimately measured over the life of the COVID-19 pandemic, potential retrospective unfavorable adjustments in future periods, of funds recorded as revenues in prior periods, could occur. The U.S. Department of Health and Human Services ("HHS") initially distributed $30 billion of this funding based on each provider's share of total Medicare fee-for-service reimbursement in 2019. Subsequently, HHS determined that CARES Act funding (including the $30 billion already distributed) would be allocated proportional to providers' share of 2018 net patient revenue. We have received payments from these initial distributions of the PHSSEF as disclosed herein. HHS has indicated that distributions of the remaining $50 billion will be targeted primarily to hospitals in COVID-19 high impact areas, to rural providers, safety net hospitals and certain Medicaid providers and to reimburse providers for COVID-19 related treatment of uninsured patients. We have received payments from these targeted distributions of the PHSSEF, as disclosed herein. The CARES Act also makes other forms of financial assistance available to healthcare providers, including through Medicare and Medicaid payment adjustments and an expansion of the Medicare Accelerated and Advance Payment Program, which made available accelerated payments of Medicare funds in order to increase cash flow to providers. On April 26, 2020, CMS announced it was reevaluating and temporarily suspending the Accelerated and Advance Payment Program in light of the availability of the PHSSEF and the significant funds available through other programs. We have received accelerated payments under this program during 2020, and early returned all of those funds

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

- our ability to comply with the existing laws and government regulations, and/or changes in laws and government regulations;
- an increasing number of legislative initiatives have been passed into law that may result in major changes in the health care delivery system on a national or state level. Legislation has already been enacted that has eliminated the penalty for failing to maintain health coverage that was part of the original Legislation. President Biden is expected to undertake executive actions that will strengthen the Legislation and may reverse the policies of the prior administration. To date, the Biden administration has issued executive orders implementing a special enrollment period permitting individuals to enroll in health plans outside of the annual open enrollment period and reexamining policies that may undermine the ACA or the Medicaid program. The ARPA's expansion of subsidies to purchase coverage through an exchange is anticipated to increase exchange enrollment. The Trump Administration had directed the issuance of final rules (i) enabling the formation of association health plans that would be exempt from certain Legislation requirements such as the provision of essential health benefits; (ii) expanding the availability of short-term, limited duration health insurance, (iii) eliminating cost-sharing reduction payments to insurers that would otherwise offset deductibles and other out-of-pocket expenses for health plan enrollees at or below 250 percent of the federal poverty level; (iv) relaxing requirements for state innovation waivers that could reduce enrollment in the individual and small group markets and lead to additional enrollment in short-term, limited duration insurance and association health plans, and; (v) incentivizing the use of health reimbursement arrangements by employers to permit employees to purchase health insurance in the individual market. The uncertainty resulting from these Executive Branch policies had led to reduced Exchange enrollment in 2018, 2019 and 2020. It is also anticipated that these policies, to the extent that they remain as implemented, may create additional cost and reimbursement pressures on hospitals, including ours. In addition, while attempts to repeal the entirety of the Legislation have not been successful to date, a key provision of the Legislation was eliminated as part of the Tax Cuts and Jobs Act and on December 14, 2018, a federal U.S. District Court Judge in Texas ruled the entire Legislation is unconstitutional.

That ruling was appealed and on December 18, 2019, the Fifth Circuit Court of Appeals voted 2-1 to strike down the Legislation individual mandate as unconstitutional and sent the case back to the U.S. District Court in Texas to determine which Legislation provisions should be stricken with the mandate or whether the entire law is unconstitutional without the individual mandate. On March 2, 2020, the U.S. Supreme Court agreed to hear, during the 2020-2021 term, two consolidated cases, filed by the State of California and the United States House of Representatives, asking the Supreme Court to review the ruling by the Fifth Circuit Court of Appeals. Oral argument was heard on November 10, 2020, and a ruling is expected in 2021. In a February 10, 2021 letter to the Supreme Court, the Department of Justice reversed its earlier position and stated that the Legislation is constitutional. The Legislation will remain law while the case proceeds through the appeals process; however, the case creates additional uncertainty as to whether any or all of the Legislation could be struck down, which creates operational risk for the health care industry. We are unable to predict the final outcome of this matter which has caused greater uncertainty regarding the future status of the Legislation. If all or any parts of the Legislation are ultimately found to be unconstitutional, it could have a material adverse effect on our business, financial condition and results of operations. See below in *Sources of Revenue and Health Care Reform* for additional disclosure;

- under the Legislation, hospitals are required to make public a list of their standard charges, and effective January 1, 2019, CMS has required that this disclosure be in machine-readable format and include charges for all hospital items and services and average charges for diagnosis-related groups. On November 27, 2019, CMS published a final rule on "Price Transparency Requirements for Hospitals to Make Standard Charges Public." This rule took effect on January 1, 2021 and requires all hospitals to also make public their payor-specific negotiated rates, minimum negotiated rates, maximum negotiated rates, and cash for all items and services, including individual items and services and service packages, that could be provided by a hospital to a patient. Failure to comply with these requirements may result in daily monetary penalties;
- as part of the CAA, Congress passed legislation aimed at preventing or limiting patient balance billing in certain circumstances. The CAA addresses surprise medical bills stemming from emergency services, out-of-network ancillary providers at in-network facilities, and air ambulance carriers. The legislation prohibits surprise billing when out-of-network emergency services or out-of-network services at an in-network facility are provided, unless informed consent is received. In these circumstances providers are prohibited from billing the patient for any amounts that exceed in-network cost-sharing requirements. The legislation requires HHS, as well as the Department of the Treasury, and Department of Labor to issue implementing regulations within a year of enactment;
- possible unfavorable changes in the levels and terms of reimbursement for our charges by third party payers or government based payers, including Medicare or Medicaid in the United States, and government based payers in the United Kingdom;
- our ability to enter into managed care provider agreements on acceptable terms and the ability of our competitors to do the same, including contracts with United/Sierra Healthcare in Las Vegas, Nevada. Effective January, 2020, United/Sierra Healthcare in Las Vegas, entered into an agreement with a competitor health system that was previously excluded from their contractual network in the area. As a result, we believe that our 6 acute care hospitals in the Las Vegas, Nevada market, will likely experience a decline in patient volumes. However, we have entered into an amended agreement with United/Sierra Healthcare related to our hospitals in the Las Vegas market that provide for various rate increases beginning in January, 2020. Although we estimate that the unfavorable impact of the projected declines in patient volumes should be largely offset by the favorable impact of the increased rates, we can provide no assurance that these developments, as well as the effect of COVID-19 on the Las Vegas market, will not have a material adverse impact on our future results of operations;
- the outcome of known and unknown litigation, government investigations, false claims act allegations, and liabilities and other claims asserted against us and other matters as disclosed in *Note 6 to the Consolidated Financial Statements - Commitments and Contingencies* and the effects of adverse publicity relating to such matters*;*
- the unfavorable impact on our business of the deterioration in national, regional and local economic and business conditions, including a worsening of unfavorable credit market conditions;
- competition from other healthcare providers (including physician owned facilities) in certain markets;
- technological and pharmaceutical improvements that increase the cost of providing, or reduce the demand for healthcare;
- our ability to attract and retain qualified personnel, nurses, physicians and other healthcare professionals and the impact on our labor expenses resulting from a shortage of nurses and other healthcare professionals;
- demographic changes;
- we experienced a cyberattack in September, 2020 that had an adverse effect on our operating results during the fourth quarter of 2020. Although we can provide no assurance or estimation related to the amount of the ultimate insurance

proceeds that we may receive in connection with this incident, we believe we are entitled to recovery of the majority of the unfavorable economic impact of the cyberattack pursuant to a commercial insurance policy. However, there is a heightened risk of future cybersecurity threats, including ransomware attacks targeting healthcare providers. If successful, future cyberattacks could have a material adverse effect on our business. Any costs that we incur as a result of a data security incident or breach, including costs to update our security protocols to mitigate such an incident or breach could be significant. Any breach or failure in our operational security systems can result in loss of data or an unauthorized disclosure of or access to sensitive or confidential member or protected personal or health information and could result in significant penalties or fines, litigation, loss of customers, significant damage to our reputation and business, and other losses;

- the availability of suitable acquisition and divestiture opportunities and our ability to successfully integrate and improve our acquisitions since failure to achieve expected acquisition benefits from certain of our prior or future acquisitions could result in impairment charges for goodwill and purchased intangibles;
- the impact of severe weather conditions, including the effects of hurricanes and climate change;
- as discussed below in *Sources of Revenue*, we receive revenues from various state and county based programs, including Medicaid in all the states in which we operate (we receive Medicaid revenues in excess of $100 million annually from each of California, Texas, Nevada, Washington, D.C., Pennsylvania, Illinois, Kentucky and Massachusetts); CMS-approved Medicaid supplemental programs in certain states including Texas, Mississippi, Illinois, Oklahoma, Nevada, Arkansas, California and Indiana, and; state Medicaid disproportionate share hospital payments in certain states including Texas and South Carolina. We are therefore particularly sensitive to potential reductions in Medicaid and other state based revenue programs as well as regulatory, economic, environmental and competitive changes in those states. We can provide no assurance that reductions to revenues earned pursuant to these programs, and the effect of the COVID-19 pandemic on state budgets, particularly in the above-mentioned states, will not have a material adverse effect on our future results of operations;
- our ability to continue to obtain capital on acceptable terms, including borrowed funds, to fund the future growth of our business;
- our inpatient acute care and behavioral health care facilities may experience decreasing admission and length of stay trends;
- our financial statements reflect large amounts due from various commercial and private payers and there can be no assurance that failure of the payers to remit amounts due to us will not have a material adverse effect on our future results of operations;
- the Budget Control Act of 2011 (the "2011 Act") imposed annual spending limits for most federal agencies and programs aimed at reducing budget deficits by $917 billion between 2012 and 2021, according to a report released by the Congressional Budget Office. Among its other provisions, the law established a bipartisan Congressional committee, known as the Joint Select Committee on Deficit Reduction (the "Joint Committee"), which was tasked with making recommendations aimed at reducing future federal budget deficits by an additional $1.5 trillion over 10 years. The Joint Committee was unable to reach an agreement by the November 23, 2011 deadline and, as a result, across-the-board cuts to discretionary, national defense and Medicare spending were implemented on March 1, 2013 resulting in Medicare payment reductions of up to 2% per fiscal year with a uniform percentage reduction across all Medicare programs. The Bipartisan Budget Act of 2015, enacted on November 2, 2015, continued the 2% reductions to Medicare reimbursement imposed under the 2011 Act. Recent legislation has suspended payment reductions through December 31, 2021 in exchange for extended cuts through 2030. We cannot predict whether Congress will restructure the implemented Medicare payment reductions or what other federal budget deficit reduction initiatives may be proposed by Congress going forward;
- uninsured and self-pay patients treated at our acute care facilities unfavorably impact our ability to satisfactorily and timely collect our self-pay patient accounts;
- changes in our business strategies or development plans;
- in June, 2016, the United Kingdom affirmatively voted in a non-binding referendum in favor of the exit of the United Kingdom ("U.K.") from the European Union (the "Brexit") and it was approved by vote of the British legislature. On March 29, 2017, the United Kingdom triggered Article 50 of the Lisbon Treaty, formally starting negotiations regarding its exit from the European Union. On January 31, 2020, the U.K. formally exited the European Union. On December 24, 2020, the United Kingdom and the European Union reached a post-Brexit trade and cooperation agreement that created new business and security requirements and preserved the United Kingdom's tariff- and quota-free access to the European Union member states. We do not know to what extent Brexit will ultimately impact the business and regulatory environment in the U.K., the European Union, or other countries. Any of these effects of Brexit, and others we cannot anticipate, could harm our business, financial condition and results of operations;

- fluctuations in the value of our common stock, and;
- other factors referenced herein or in our other filings with the Securities and Exchange Commission.

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

Critical Accounting Policies and Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires us to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes. 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, 2020. We consider our critical accounting policies to be those that require us to make significant judgments and estimates when we prepare our financial statements, including the following:

Revenue Recognition: On January 1, 2018, we adopted, using the modified retrospective approach, ASU 2014-09 and ASU 2016-08, “Revenue from Contracts with Customers (Topic 606)” and “Revenue from Contracts with Customers: Principal versus Agent Considerations (Reporting Revenue Gross versus Net)”, respectively, which provides guidance for revenue recognition. The standard’s core principle is that a company will recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods or services. The most significant change from the adoption of the new standard relates to our estimation for the allowance for doubtful accounts. Under the previous standards, our estimate for amounts not expected to be collected based upon our historical experience, were reflected as provision for doubtful accounts, included within net revenue. Under the new standard, our estimate for amounts not expected to be collected based on historical experience will continue to be recognized as a reduction to net revenue, however, not reflected separately as provision for doubtful accounts. Under the new standard, subsequent changes in estimate of collectability due to a change in the financial status of a payer, for example a bankruptcy, will be recognized as bad debt expense in operating charges. The adoption of this ASU in 2018, and amounts recognized as bad debt expense and included in other operating expenses, did not have a material impact on our consolidated financial statements.

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

Charity Care, Uninsured Discounts and Other Adjustments to Revenue: Collection of receivables from third-party payers and patients is our primary source of cash and is critical to our operating performance. Our primary collection risks relate to uninsured patients and the portion of the bill which is the patient’s responsibility, primarily co-payments and deductibles. We estimate our revenue adjustments for implicit price concessions based on general factors such as payer mix, the aging of the receivables and historical collection experience. We routinely review accounts receivable balances in conjunction with these factors and other economic conditions which might ultimately affect the collectability of the patient accounts and make adjustments to our allowances as warranted. At our acute care hospitals, third party liability accounts are pursued until all payment and adjustments are posted to the patient account. For those accounts with a patient balance after third party liability is finalized or accounts for uninsured patients, the patient receives statements and collection letters.

Historically, a significant portion of the patients treated throughout our portfolio of acute care hospitals are uninsured patients which, in part, has resulted from patients who are employed but do not have health insurance or who have policies with relatively high deductibles. Patients treated at our hospitals for non-elective services, who have gross income of various amounts, dependent upon the state, ranging from 200% to 400% of the federal poverty guidelines, are deemed eligible for charity care. The federal poverty guidelines are established by the federal government and are based on income and family size. Because we do not pursue collection of amounts that qualify as charity care, the transaction price is fully adjusted and there is no impact in our net revenues or in our accounts receivable, net.

A portion of the accounts receivable at our acute care facilities are comprised of Medicaid accounts that are pending approval from third-party payers but we also have smaller amounts due from other miscellaneous payers such as county indigent programs in certain states. Our patient registration process includes an interview of the patient or the patient’s responsible party at the time of registration. At that time, an insurance eligibility determination is made and an insurance plan code is assigned. There are various pre-established insurance profiles in our patient accounting system which determine the expected insurance reimbursement for each patient based on the insurance plan code assigned and the services rendered. Certain patients may be classified as Medicaid pending at registration based upon a screening evaluation if we are unable to definitively determine if they are currently Medicaid eligible. When a patient is registered as Medicaid-eligible or Medicaid-pending, our patient accounting system records net revenues for services provided to that

patient based upon the established Medicaid reimbursement rates, subject to the ultimate disposition of the patient's Medicaid eligibility. When the patient's ultimate eligibility is determined, reclassifications may occur which impacts net revenues in future periods. Although the patient's ultimate eligibility determination may result in adjustments to net revenues, these adjustments did not have a material impact on our results of operations during the three-month periods ended March 31, 2021 or 2020 since our facilities make estimates at each financial reporting period to adjust revenue based on historical collections.

We also provide discounts to uninsured patients (included in "uninsured discounts" amounts below) who do not qualify for Medicaid or charity care. Because we do not pursue collection of amounts classified as uninsured discounts, the transaction price is fully adjusted and there is no impact in our net revenues or in our net accounts receivable. In implementing the discount policy, we first attempt to qualify uninsured patients for governmental programs, charity care or any other discount program. If an uninsured patient does not qualify for these programs, the uninsured discount is applied.

The following tables show the amounts recorded at our acute care hospitals for charity care and uninsured discounts, based on charges at established rates, for the three-month periods ended March 31, 2021 and 2020:

Uncompensated care:

Amounts in millions	Three Months Ended			
	March 31, 2021	%	March 31, 2020	%
Charity care	$ 167	39%	$ 202	32%
Uninsured discounts	259	61%	432	68%
Total uncompensated care	$ 426	100%	$ 634	100%

Estimated cost of providing uncompensated care:

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

Amounts in millions	Three Months Ended	
	March 31, 2021	March 31, 2020
Estimated cost of providing charity care	$ 18	$ 23
Estimated cost of providing uninsured discounts related care	28	48
Estimated cost of providing uncompensated care	$ 46	$ 71

Self-Insured/Other Insurance Risks: We provide for self-insured risks including general and professional liability claims, workers' compensation claims and healthcare and dental claims. Our estimated liability for self-insured professional and general liability claims is based on a number of factors including, among other things, the number of asserted claims and reported incidents, estimates of losses for these claims based on recent and historical settlement amounts, estimate of incurred but not reported claims based on historical experience, and estimates of amounts recoverable under our commercial insurance policies. All relevant information, including our own historical experience is used in estimating the expected amount of claims. While we continuously monitor these factors, our ultimate liability for professional and general liability claims could change materially from our current estimates due to inherent uncertainties involved in making this estimate. Our estimated self-insured reserves are reviewed and changed, if necessary, at each reporting date and changes are recognized currently as additional expense or as a reduction of expense. In addition, we also: (i) own commercial health insurers headquartered in Reno, Nevada, and Puerto Rico and; (ii) maintain self-insured employee benefits programs for employee healthcare and dental claims. The ultimate costs related to these programs/operations include expenses for claims incurred and paid in addition to an accrual for the estimated expenses incurred in connection with claims incurred but not yet reported. Given our significant insurance-related exposure, there can be no assurance that a sharp increase in the number and/or severity of claims asserted against us will not have a material adverse effect on our future results of operations.

See *Note 6 to the Consolidated Financial Statements-Commitments and Contingencies*, for additional disclosure related to our professional and general liability, workers' compensation liability and property insurance.

The total accrual for our professional and general liability claims and workers' compensation claims was $386 million as of March 31, 2021, of which $129 million is included in current liabilities. The total accrual for our professional and general liability claims and workers' compensation claims was $369 million as of December 31, 2020, of which $129 million is included in current liabilities.

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

Results of Operations

COVID-19

The impact of the COVID-19 pandemic, which began during the second half of March, 2020, has had a material unfavorable effect on our operations and financial results since that time. The COVID-19 vaccination process commenced during the first quarter of 2021 and, while we expect the administration of vaccines will assist in easing the number of COVID-19 patients, the pace of distribution and the portion of the population that will ultimately become vaccinated is difficult to predict. The extent to which the COVID-19 pandemic and measures taken in response thereto impact our business, results of operations and financial condition will depend on numerous factors and future developments, most of which are beyond our control or ability to predict. The ultimate impact of the COVID-19 pandemic is highly uncertain and subject to change. We are not able to fully quantify the impact that these factors will have on our future financial results.

2021 CARES Act Grants and Medicare Accelerated Payments Receipts/Disbursements:

During the first quarter of 2021, we received approximately $188 million of additional funds from the federal government in connection with the CARES Act. We expect to return the $188 million of funds to the appropriate government agencies in May, 2021 utilizing a portion of our cash and cash equivalents held on deposit. Since our intent was to return these funds, our results of operations for the first quarter ended March 31, 2021 include no impact from the receipt of the funds.

Also, and as previously announced earlier this year, in March of 2021 we funded the early repayment of $695 million of funds received during 2020 pursuant to the Medicare Accelerated and Advance Payment Program. These funds were returned to the government utilizing a portion of our cash and cash equivalents held on deposit.

Please see *Sources of Revenue- 2019 Novel Coronavirus Disease Medicare and Medicaid Payment Related Legislation* below for additional disclosure regarding funds received and related recognition of revenues in our results of operations in connection with various governmental stimulus grant programs, most notably the CARES Act.

Financial results for the three-month periods ended March 31, 2021 and 2020:

The following table summarizes our results of operations and is used in the discussion below for the three-month periods ended March 31, 2021 and 2020 (dollar amounts in thousands):

	Three months ended March 31, 2021		Three months ended March 31, 2020	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 3,012,987	100.0%	$ 2,829,667	100.0%
Operating charges:				
Salaries, wages and benefits	1,497,773	49.7%	1,432,669	50.6%
Other operating expenses	709,708	23.6%	689,790	24.4%
Supplies expense	347,110	11.5%	317,827	11.2%
Depreciation and amortization	131,403	4.4%	124,394	4.4%
Lease and rental expense	31,324	1.0%	28,293	1.0%
Subtotal-operating expenses	2,717,318	90.2%	2,592,973	91.6%
Income from operations	295,669	9.8%	236,694	8.4%
Interest expense, net	21,957	0.7%	36,351	1.3%
Other (income) expense, net	835	0.0%	9,560	0.3%
Income before income taxes	272,877	9.1%	190,783	6.7%
Provision for income taxes	63,807	2.1%	46,323	1.6%
Net income	209,070	6.9%	144,460	5.1%
Less: Income attributable to noncontrolling interests	(21)	(0.0)%	2,423	0.1%
Net income attributable to UHS	$ 209,091	6.9%	$ 142,037	5.0%

Net revenues increased 6.5%, or $183 million, to $3.01 billion during the three-month period ended March 31, 2021 as compared to $2.83 billion during the first quarter of 2020. The net increase was primarily attributable to: (i) a $186 million or 6.7% increase in net revenues generated from our acute care hospital services and behavioral health services operated during both periods (which we refer to as “same facility”), and; (ii) $2 million of other combined net decreases.

Income before income taxes (before deduction for income attributable to noncontrolling interests) increased $82 million to $273 million during the three-month period ended March 31, 2021 as compared to $191 million during the comparable quarter of 2020. The $82 million net increase was due to:

- an increase of $70 million at our acute care facilities, as discussed below in *Acute Care Hospital Services*;

- a decrease of $6 million at our behavioral health care facilities, as discussed below in *Behavioral Health Services*;
- an increase of $14 million due to a decrease in interest expense due primarily to a decrease in the average cost of borrowings, and;
- $4 million of other combined net increases.

Net income attributable to UHS increased $67 million to $209 million during the three-month period ended March 31, 2021 as compared to $142 million during the comparable prior year quarter. This increase was attributable to:

- an $82 million increase in income before income taxes, as discussed above;
- an increase of $2 million due to a decrease in income attributable to noncontrolling interests, and;
- a decrease of $17 million resulting from an increase in the provision for income taxes due primarily to: (i) the income tax provision recorded in connection with the $84 million increase in pre-tax income, partially offset by; (ii) a $2 million decrease in the provision for income taxes recorded in connection with our adoption of ASU 2016-09.

Acute Care Hospital Services

Same Facility Basis Acute Care Hospital Services

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

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

The following table summarizes the results of operations for our acute care facilities on a same facility basis and is used in the discussion below for the three-month periods ended March 31, 2021 and 2020 (dollar amounts in thousands):

	Three months ended March 31, 2021		Three months ended March 31, 2020	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,671,836	100.0%	$ 1,497,123	100.0%
Operating charges:				
Salaries, wages and benefits	706,811	42.3%	658,929	44.0%
Other operating expenses	393,207	23.5%	375,531	25.1%
Supplies expense	296,478	17.7%	264,530	17.7%
Depreciation and amortization	81,184	4.9%	77,928	5.2%
Lease and rental expense	20,112	1.2%	16,020	1.1%
Subtotal-operating expenses	1,497,792	89.6%	1,392,938	93.0%
Income from operations	174,044	10.4%	104,185	7.0%
Interest expense, net	246	0.0%	618	0.0%
Other (income) expense, net	-	—	-	—
Income before income taxes	$ 173,798	10.4%	$ 103,567	6.9%

Three-month periods ended March 31, 2021 and 2020:

During the three-month period ended March 31, 2021, as compared to the comparable prior year quarter, net revenues from our acute care hospital services, on a same facility basis, increased $175 million or 11.7%. Income before income taxes (and before income attributable to noncontrolling interests) increased $70 million, or 68%, amounting to $174 million or 10.4% of net revenues during the first quarter of 2021 as compared to $104 million or 6.9% of net revenues during the first quarter of 2020.

During the three-month period ended March 31, 2021, net revenue per adjusted admission increased 26.3% while net revenue per adjusted patient day increased 11.8%, as compared to the comparable quarter of 2020. During the three-month period ended March 31, 2021, as compared to the comparable prior year quarter, inpatient admissions to our acute care hospitals decreased 6.2% and adjusted admissions (adjusted for outpatient activity) decreased 12.1%. Patient days at these facilities increased 5.9% and adjusted patient days decreased 0.7% during the three-month period ended March 31, 2021 as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities increased to 5.4 days during the first quarter of 2021 as compared to 4.8 days during the first quarter of 2020. The occupancy rate, based on the average available beds at these facilities, was 69% and 65% during the three-month periods ended March 31, 2021 and 2020, respectively.

All Acute Care Hospitals

The following table summarizes the results of operations for all our acute care operations during the three-month periods ended March 31, 2021 and 2020. These amounts include: (i) our acute care results on a same facility basis, as indicated above; (ii) the impact of provider tax assessments which increased net revenues and other operating expenses but had no impact on income before income taxes, and; (iii) certain other amounts including, if applicable, the results of recently acquired/opened ancillary facilities and businesses. Dollar amounts below are reflected in thousands.

	Three months ended March 31, 2021		Three months ended March 31, 2020	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,694,542	100.0%	$ 1,521,049	100.0%
Operating charges:				
Salaries, wages and benefits	707,218	41.7%	658,959	43.3%
Other operating expenses	416,007	24.5%	399,457	26.3%
Supplies expense	296,479	17.5%	264,530	17.4%
Depreciation and amortization	81,362	4.8%	77,928	5.1%
Lease and rental expense	20,112	1.2%	16,020	1.1%
Subtotal-operating expenses	1,521,178	89.8%	1,416,894	93.2%
Income from operations	173,364	10.2%	104,155	6.8%
Interest expense, net	246	0.0%	618	0.0%
Other (income) expense, net	-	—	-	—
Income before income taxes	$ 173,118	10.2%	$ 103,537	6.8%

Three-month periods ended March 31, 2021 and 2020:

During the three-month period ended March 31, 2021, as compared to the comparable prior year quarter, net revenues from our acute care hospital services increased $173 million or 11.4% to $1.69 billion as compared to $1.52 billion due primarily to the $175 million, or 11.7%, increase same facility revenues, as discussed above.

Income before income taxes increased $70 million, or 67%, to $173 million or 10.2% of net revenues during the first quarter of 2021 as compared to $104 million or 6.8% of net revenues during the first quarter of 2020. The $70 million increase in income before income taxes from our acute care hospital services resulted from the increase in income before income taxes at our hospitals, on a same facility basis, as discussed above.

Behavioral Health Services

Our Same Facility basis results (which is a non-GAAP measure), which include the operating results for facilities and businesses operated in both the current year and prior year period, neutralize (if applicable) the effect of items that are non-operational in nature including items such as, but not limited to, gains/losses on sales of assets and businesses, impact of the reserve established in connection with the civil aspects of the government's investigation of certain of our behavioral health care facilities, impacts of settlements, legal judgments and lawsuits, impairments of long-lived and intangible assets and other amounts that may be reflected in the current or prior year financial statements that relate to prior periods. Our Same Facility basis results reflected on the table below also excludes from net revenues and other operating expenses, provider tax assessments incurred in each period as discussed below *Sources of Revenue-Various State Medicaid Supplemental Payment Programs.* However, these provider tax assessments are included in net revenues and other operating expenses as reflected in the table below under *All Behavioral Health Care Services*. The provider tax assessments had no impact on the income before income taxes as reflected on the tables below since the amounts offset between net revenues and other operating expenses. To obtain a complete understanding of our financial performance, the Same Facility results should be examined in connection with our net income as determined in accordance with GAAP and as presented in the condensed consolidated financial statements and notes thereto as contained in this Quarterly Report on Form 10-Q.

The following table summarizes the results of operations for our behavioral health care facilities, on a same facility basis, and is used in the discussions below for the three-month periods ended March 31, 2021 and 2020 (dollar amounts in thousands):

Same Facility—Behavioral Health

	Three months ended March 31, 2021		Three months ended March 31, 2020	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,292,042	100.0%	$ 1,281,052	100.0%
Operating charges:				
Salaries, wages and benefits	701,567	54.3%	690,375	53.9%
Other operating expenses	245,373	19.0%	242,366	18.9%
Supplies expense	50,746	3.9%	51,561	4.0%
Depreciation and amortization	45,302	3.5%	42,715	3.3%
Lease and rental expense	11,274	0.9%	11,020	0.9%
Subtotal-operating expenses	1,054,262	81.6%	1,038,037	81.0%
Income from operations	237,780	18.4%	243,015	19.0%
Interest expense, net	338	0.0%	364	0.0%
Other (income) expense, net	413	0.0%	889	0.1%
Income before income taxes	$ 237,029	18.3%	$ 241,762	18.9%

Three-month periods ended March 31, 2021 and 2020:

On a same facility basis during the first quarter of 2021, net revenues generated from our behavioral health services increased $11 million, or 0.9%, to $1.29 billion, from $1.28 billion generated during the first quarter of 2020. Income before income taxes decreased $5 million, or 2%, to $237 million or 18.3% of net revenues during the three-month period ended March 31, 2021, as compared to $242 million or 18.9% of net revenues during the first quarter of 2020.

During the three-month period ended March 31, 2021, net revenue per adjusted admission increased 6.2% and net revenue per adjusted patient day increased 4.9%, as compared to the comparable quarter of 2020. On a same facility basis, inpatient admissions and adjusted admissions to our behavioral health facilities decreased 4.7% and 4.9%, respectively, during the three-month period ended March 31, 2021 as compared to the comparable quarter of 2020. Patient days and adjusted patient days at these facilities decreased 3.6% and 3.8% during the three-month period ended March 31, 2021, respectively, as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities was 13.3 days and 13.2 days during the three-month periods ended March 31, 2021 and 2020, respectively. The occupancy rate, based on the average available beds at these facilities, was 72% and 75% during the three-month periods ended March 31, 2021 and 2020, respectively.

All Behavioral Health Care Facilities

The following table summarizes the results of operations for all our behavioral health care services during the three-month periods ended March 31, 2021 and 2020. These amounts include: (i) our behavioral health care results on a same facility basis, as indicated above; (ii) the impact of provider tax assessments which increased net revenues and other operating expenses but had no impact on income before income taxes, and; (iii) certain other amounts including the results of facilities acquired or opened during the past year (if applicable) as well as the results of certain facilities that were closed or restructured during the past year. Dollar amounts below are reflected in thousands.

	Three months ended March 31, 2021		Three months ended March 31, 2020	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,315,337	100.0%	$ 1,306,109	100.0%
Operating charges:				
Salaries, wages and benefits	703,975	53.5%	693,272	53.1%
Other operating expenses	269,297	20.5%	266,182	20.4%
Supplies expense	51,009	3.9%	51,639	4.0%
Depreciation and amortization	46,482	3.5%	43,889	3.4%
Lease and rental expense	11,683	0.9%	12,158	0.9%
Subtotal-operating expenses	1,082,446	82.3%	1,067,140	81.7%
Income from operations	232,891	17.7%	238,969	18.3%
Interest expense, net	1,153	0.1%	397	0.0%
Other (income) expense, net	413	0.0%	889	0.1%
Income before income taxes	$ 231,325	17.6%	$ 237,683	18.2%

Three-month periods ended March 31, 2021 and 2020:

During the three-month period ended March 31, 2021, as compared to the comparable prior year quarter, net revenues generated from our behavioral health services increased $9 million or 0.7% due to: (i) the above-mentioned $11 million or 0.9% increase in net revenues on a same facility basis, and; (ii) $2 million other combined net decreases.

Income before income taxes decreased $6 million, or 3%, to $231 million or 17.6% of net revenues during the first quarter of 2021 as compared to $238 million or 18.2% of net revenues during the first quarter of 2020. The decrease in income before income taxes at our behavioral health facilities during the first quarter of 2021, as compared to the first quarter of 2020, was primarily attributable to the above-mentioned decrease in income before income taxes experienced at our behavioral health facilities on a same facility basis, 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.

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

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

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

Sources of Revenues and Health Care Reform: Given increasing budget deficits, the federal government and many states are currently considering additional ways to limit increases in levels of Medicare and Medicaid funding, which could also adversely affect future payments received by our hospitals. In addition, the uncertainty and fiscal pressures placed upon the federal government as a result of, among other things, impacts on state revenue and expenses resulting from the COVID-19 pandemic, economic recovery stimulus packages, responses to natural disasters, and the federal and state budget deficits in general may affect the availability of government funds to provide additional relief in the future. We are unable to predict the effect of future policy changes on our operations.

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

The Legislation revises reimbursement under the Medicare and Medicaid programs to emphasize the efficient delivery of high quality care and contains a number of incentives and penalties under these programs to achieve these goals. The Legislation provides for decreases in the annual market basket update for federal fiscal years 2010 through 2019, a productivity offset to the market basket update beginning October 1, 2011 for Medicare Part B reimbursable items and services and beginning October 1, 2012 for Medicare inpatient hospital services. The Legislation and subsequent revisions provide for reductions to both Medicare DSH and Medicaid DSH payments. The Medicare DSH reductions began in October, 2013 while the Medicaid DSH reductions are scheduled to begin in 2024. The Legislation implemented a value-based purchasing program, which will reward the delivery of efficient care. Conversely, certain facilities will receive reduced reimbursement for failing to meet quality parameters; such hospitals will include those with excessive readmission or hospital-acquired condition rates.

A 2012 U.S. Supreme Court ruling limited the federal government’s ability to expand health insurance coverage by holding unconstitutional sections of the Legislation that sought to withdraw federal funding for state noncompliance with certain Medicaid coverage requirements. Pursuant to that decision, the federal government may not penalize states that choose not to participate in the Medicaid expansion by reducing their existing Medicaid funding. Therefore, states can choose to expand or not to expand their

Medicaid program without risking the loss of federal Medicaid funding. As a result, many states, including Texas, have not expanded their Medicaid programs without the threat of loss of federal funding. CMS has previously granted section 1115 demonstration waivers providing for work and community engagement requirements for certain Medicaid eligible individuals. CMS has also released guidance to states interested in receiving their Medicaid funding through a block grant mechanism. The Biden administration has signaled its intent to withdraw previously issued section 1115 demonstrations aligned with these policies. However, if implemented, the previously issued section 1115 demonstrations are anticipated to lead to reductions in coverage, and likely increases in uncompensated care, in states where these demonstration waivers are granted.

On December 14, 2018, a Texas Federal District Court deemed the Legislation to be unconstitutional in its entirety. The Court concluded that the Individual Mandate is no longer permissible under Congress's taxing power as a result of the Tax Cut and Jobs Act of 2017 ("TCJA") reducing the individual mandate's tax to $0 (i.e., it no longer produces revenue, which is an essential feature of a tax), rendering the Legislation unconstitutional. The court also held that because the individual mandate is "essential" to the Legislation and is inseverable from the rest of the law, the entire Legislation is unconstitutional. Because the court issued a declaratory judgment and did not enjoin the law, the Legislation remains in place pending its appeal. The District Court for the Northern District of Texas ruling was appealed to the U.S. Court of Appeals for the Fifth Circuit. On December 18, 2019, the Fifth Circuit Court of Appeals' three-judge panel voted 2-1 to strike down the Legislation individual mandate as unconstitutional. The Fifth Circuit Court also sent the case back to the Texas district court to determine which Legislation provisions should be stricken with the mandate or whether the entire Legislation is unconstitutional. On March 2, 2020, the U.S. Supreme Court agreed to hear, during the 2020-2021 term, two consolidated cases, filed by the State of California and the United States House of Representatives, asking the Supreme Court to review the ruling by the Fifth Circuit Court of Appeals. Oral argument was heard on November 10, 2020, and a ruling is expected in 2021. On February 10, 2021, the Department of Justice announced that it has withdrawn support for the challenge before the Supreme Court. The Legislation will remain law while the case proceeds through the appeals process; however, the case creates additional uncertainty as to whether any or all of the Legislation could be struck down, which creates operational risk for the health care industry. We are unable to predict the final outcome of this legal challenge and its financial impact on our future results of operation.

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

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

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

The impact of the Legislation on each of our hospitals may vary. Because Legislation provisions are effective at various times over the next several years, we anticipate that many of the provisions in the Legislation may be subject to further revision. Initiatives to repeal the Legislation, in whole or in part, to delay elements of implementation or funding, and to offer amendments or supplements to modify its provisions have been persistent. The ultimate outcomes of legislative attempts to repeal or amend the Legislation and legal challenges to the Legislation are unknown. Legislation has already been enacted that eliminated the individual mandate penalty, effective January 1, 2019, related to the obligation to obtain health insurance that was part of the original Legislation. In addition, Congress previously considered legislation that would, in material part: (i) eliminate the large employer mandate to offer health insurance coverage to full-time employees; (ii) permit insurers to impose a surcharge up to 30 percent on individuals who go uninsured for more than two months and then purchase coverage; (iii) provide tax credits towards the purchase of health insurance, with a phase-out of tax credits accordingly to income level; (iv) expand health savings accounts; (v) impose a per capita cap on federal

funding of state Medicaid programs, or, if elected by a state, transition federal funding to block grants, and; (vi) permit states to seek a waiver of certain federal requirements that would allow such state to define essential health benefits differently from federal standards and that would allow certain commercial health plans to take health status, including pre-existing conditions, into account in setting premiums.

In addition to legislative changes, the Legislation can be significantly impacted by executive branch actions. President Biden is expected to undertake executive actions that will strengthen the Legislation and may reverse the policies of the prior administration. The Trump Administration had directed the issuance of final rules (i) enabling the formation of health plans that would be exempt from certain Legislation essential health benefits requirements; (ii) expanding the availability of short-term, limited duration health insurance; (iii) eliminating cost-sharing reduction payments to insurers that would otherwise offset deductibles and other out-of-pocket expenses for health plan enrollees at or below 250 percent of the federal poverty level; (iv) relaxing requirements for state innovation waivers that could reduce enrollment in the individual and small group markets and lead to additional enrollment in short-term, limited duration insurance and association health plans; and (vi) incentivizing the use of health reimbursement arrangements by employers to permit employees to purchase health insurance in the individual market. The uncertainty resulting from these Executive Branch policies led to reduced Exchange enrollment in 2018, 2019 and 2020. The recent and on-going COVID-19 pandemic and related U.S. National Emergency declaration may significantly increase the number of uninsured patients treated at our facilities extending beyond the most recent CBO published estimates due to increased unemployment and loss of group health plan health insurance coverage. It is also anticipated that these policies may create additional cost and reimbursement pressures on hospitals.

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

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

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

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

In April, 2021, CMS published its IPPS 2022 proposed payment rule which provides for a 2.5% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments, and adjustments mandated by the Legislation are considered, without consideration for the required Medicare DSH payments changes and increase to the Medicare Outlier threshold, the overall proposed increase in IPPS payments is approximately 2.5%. Including DSH payments and certain other adjustments, we estimate our overall increase from the proposed IPPS 2022 rule (covering the period of October 1, 2021 through September 30, 2022) will approximate 1.2%. This projected impact from the IPPS 2022 proposed rule includes an increase of approximately 0.5% to partially restore cuts made as a result of the American Taxpayer Relief Act of 2012 ("ATRA"), as required by the 21st Century Cures Act but excludes the impact of the sequestration reductions related to the 2011 Act, Bipartisan Budget Act of 2015, and Bipartisan Budget Act of 2018, as discussed below.

In September, 2020, CMS published its IPPS 2021 final payment rule which provides for a 2.4% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments, and adjustments mandated by the Legislation are considered, without consideration for the required Medicare DSH payments changes and increase to the Medicare Outlier threshold, the overall increase in IPPS payments is approximately 1.8%. Including DSH payments and certain other adjustments, we estimate our overall increase from the final IPPS 2021 rule (covering the period of October 1, 2020 through September 30, 2021) will approximate 2.3%. This projected impact from the IPPS 2021 final rule includes an increase of approximately 0.5% to partially restore cuts made as a result of the American Taxpayer Relief Act of 2012 ("ATRA"), as required by the 21st Century Cures Act but excludes the impact of the sequestration reductions related to the 2011 Act, Bipartisan Budget Act of 2015, and Bipartisan Budget Act of 2018, as discussed below.

In the final rule, CMS will require:

- Hospitals to report certain market-based payment rate information for Medicare Advantage organizations on their Medicare cost report for cost reporting periods ending on or after January 1, 2021, to be used in a potential change to the methodology for calculating the IPPS MS-DRG relative weights to reflect relative market-based pricing, beginning in FY 2024.
- Hospitals to report on the Medicare cost report of its median payer-specific negotiated charges with all of its MA organizations, by MS-DRG.
- As part of the FFY 2022 IPPS proposed rule published in April, 2021 and as outlined above, CMS has proposed to rescind this MA payer-specific negotiated charges reporting requirement.

In August, 2019, CMS published its IPPS 2020 final payment rule which provides 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 adjustments mandated by the Legislation are considered, without consideration for the required Medicare DSH payments changes and increase to the Medicare Outlier threshold, the overall increase in IPPS payments is approximately 2.8%. Including DSH payments and certain other adjustments, we estimate our overall increase from the final IPPS 2020 rule (covering the period of October 1, 2019 through September 30, 2020) will approximate 2.1%. This projected impact from the IPPS 2020 final rule includes an increase of approximately 0.5% to partially restore cuts made as a result ATRA, as required by the 21st Century Cures Act but excludes the impact of the sequestration reductions related to the 2011 Act, Bipartisan Budget Act of 2015, and Bipartisan Budget Act of 2018, as discussed below. CMS completed its full phase-in to use uncompensated care data from the 2015 Worksheet S-10 hospital cost reports to allocate approximately $8.5 billion in the DSH Uncompensated Care Pool.

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

The 2011 Act included the imposition of annual spending limits for most federal agencies and programs aimed at reducing budget deficits by $917 billion between 2012 and 2021, according to a report released by the Congressional Budget Office. Among its other provisions, the law established a bipartisan Congressional committee, known as the Joint Committee, which was responsible for developing recommendations aimed at reducing future federal budget deficits by an additional $1.5 trillion over 10 years. The Joint Committee was unable to reach an agreement by the November 23, 2011 deadline and, as a result, across-the-board cuts to discretionary, national defense and Medicare spending were implemented on March 1, 2013 resulting in Medicare payment reductions of up to 2% per fiscal year. Recent legislation suspended payment reductions through December 31, 2021, in exchange for extended cuts through 2030.

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

In April, 2021, CMS published its Psych PPS proposed rule for the federal fiscal year 2022. Under this proposed rule, payments to our psychiatric hospitals and units are estimated to increase by 2.3% compared to federal fiscal year 2021. This amount includes the effect of the 2.1% net market basket update which reflects the offset of a 0.2% productivity adjustment.

In July, 2020, CMS published its Psych PPS final rule for the federal fiscal year 2021. Under this final rule, payments to our psychiatric hospitals and units are estimated to increase by 2.2% compared to federal fiscal year 2020. This amount includes the effect of the 2.2% market basket update.

In July, 2019, CMS published its Psych PPS final rule for the federal fiscal year 2020. Under this final rule, payments to our psychiatric hospitals and units are estimated to increase by 1.7% compared to federal fiscal year 2019. This amount includes the effect of the 2.9% market basket update less a 0.75% adjustment as required by the ACA and a 0.4% productivity adjustment.

CMS's calendar year 2018 final OPPS rule, issued on November 13, 2017, substantially reduced Medicare Part B reimbursement for 340B Program drugs paid to hospitals. Beginning January 1, 2018, CMS reimbursement for certain separately payable drugs or biologicals that are acquired through the 340B Program by a hospital paid under the OPPS (and not excepted from the payment adjustment policy) is the average sales price of the drug or biological minus 22.5 percent, an effective reduction of 26.89% in payments for 340B program drugs. In December, 2018, the U.S. District Court for the District of Columbia ruled that HHS did not have statutory authority to implement the 2018 Medicare OPPS rate reduction related to hospitals that qualify for drug discounts under the federal 340B Program and granted a permanent injunction against the payment reduction. On July 31, 2020, the U.S. Court of Appeals for the D.C. Circuit reversed the District Court and held that HHS's decision to lower drug reimbursement rates for 340B hospitals rests on a reasonable interpretation of the Medicare statute. No further legal challenges are available to the plaintiffs and, as a result, we recognized $8 million of revenues during 2020 that were previously reserved in a prior year.

In December, 2020, CMS published its OPPS final rule for 2021. The hospital market basket increase is 2.4% and there is no productivity adjustment reduction to the 2021 OPPS market basket. When other statutorily required adjustments and hospital patient service mix are considered, we estimate that our overall Medicare OPPS update for 2021 will aggregate to a net increase of 3.3% which includes a 9.2% increase to behavioral health division partial hospitalization rates.

In November, 2019, CMS published its OPPS final rule for 2020. The hospital market basket increase is 3.0%. The Medicare statute requires a productivity adjustment reduction of 0.4% to the 2020 OPPS market basket resulting in a 2020 update to OPPS payment rates by 2.6%. When other statutorily required adjustments and hospital patient service mix are considered, we estimate that our overall Medicare OPPS update for 2020 will aggregate to a net increase of 2.7% which includes a 7.7% increase to behavioral health division partial hospitalization rates. When the behavioral health division's partial hospitalization rate impact is excluded, we estimate that our Medicare 2020 OPPS payments will result in a 1.9% increase in payment levels for our acute care division, as compared to 2019. For CY 2020, CMS will use the FY 2020 hospital IPPS post-reclassified wage index for urban and rural areas as the wage index for the OPPS to determine the wage adjustments for both the OPPS payment rate and the copayment standardized amount.

On November 15, 2019, CMS finalized its Hospital Price Transparency rule that implements certain requirements under the June 24, 2019 Presidential Executive Order related to Improving Price and Quality Transparency in American Healthcare to Put Patients First. Under this final rule, effective January 1, 2021, CMS will require: (1) hospitals make public their standard changes (both gross charges and payer-specific negotiated charges) for all items and services online in a machine-readable format, and; (2) hospitals to make public standard charge data for a limited set of "shoppable services" the hospital provides in a form and manner that is more consumer friendly. A lawsuit was filed by several hospital associations, health systems, and hospitals in the U.S. District court for the District of Columbia challenging the legal authority of HHS to implement the final rule. In June, 2020, the U.S. District Court issued a decision in favor of the federal government. The Plaintiffs in the case filed a notice of appeal to the Court of Appeals for the D.C. Circuit and oral argument was heard on October 15, 2020. On December 29, 2020, the Appeals Court ruled against the Plaintiffs challenge. As a result, the price transparency rule became effective January 1, 2021. We are unable to determine the impact, if any, this final rule will have on our future results of operations.

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

We receive revenues from various state and county based programs, including Medicaid in all the states in which we operate (we receive Medicaid revenues in excess of $100 million annually from each of California, Texas, Nevada, Washington, D.C., Pennsylvania, Illinois, Florida, Kentucky and Massachusetts); CMS-approved Medicaid supplemental programs in certain states including Texas, Mississippi, Illinois, Oklahoma, Nevada, Arkansas, California and Indiana, and; state Medicaid disproportionate share hospital payments in certain states including Texas and South Carolina. We are therefore particularly sensitive to potential reductions in Medicaid and other state based revenue programs as well as regulatory, economic, environmental and competitive changes in those states. We can provide no assurance that reductions to revenues earned pursuant to these programs, particularly in the above-mentioned states, will not have a material adverse effect on our future results of operations.

The Legislation substantially increases the federally and state-funded Medicaid insurance program, and authorizes states to establish federally subsidized non-Medicaid health plans for low-income residents not eligible for Medicaid starting in 2014. However, the Supreme Court has struck down portions of the Legislation requiring states to expand their Medicaid programs in exchange for increased federal funding. Accordingly, many states in which we operate have not expanded Medicaid coverage to individuals at 133% of the federal poverty level. Facilities in states not opting to expand Medicaid coverage under the Legislation may be additionally penalized by corresponding reductions to Medicaid disproportionate share hospital payments beginning in 2020, as discussed below. We can provide no assurance that further reductions to Medicaid revenues, particularly in the above-mentioned states, will not have a material adverse effect on our future results of operations.

On November 12, 2019, CMS issued the proposed Medicaid Fiscal Accountability Rule ("MFAR") which CMS believed would strengthen the fiscal integrity of the Medicaid program and help ensure that state supplemental payments and financing arrangements are transparent and value-driven. In January, 2021, CMS issued a formal notice of withdrawal of this proposed rule.

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

Various State Medicaid Supplemental Payment Programs:

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

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

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

On December 21, 2017, CMS approved the 1115 Waiver for the period January 1, 2018 to September 30, 2022. The Waiver continued to include UC and DSRIP payment pools with modifications and new state specific reporting deadlines that if not met by THHSC will result in material decreases in the size of the UC and DSRIP pools. For UC during the initial two years of this renewal, the UC program will remain relatively the same in size and allocation methodology. For year three of this waiver renewal, FFY 2020, and through FFY 2022, the size and distribution of the UC pool will be determined based on charity care costs reported to HHSC in accordance with Medicare cost report Worksheet S-10 principles. In September 2019, CMS approved the annual UC pool size in the amount of $3.9 billion for demonstration years ("DYs") 9, 10 and 11 (October 1, 2019 to September 30, 2022).

On April 16, 2021, CMS rescinded its January 15, 2021, 1115 Waiver ten year expedited renewal approval that was effective through September 30, 2030. HHSC will need to submit another 1115 Waiver renewal application in order to receive an extension beyond September 30, 2022.

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

estimate that this UHRIP pool increase will not have a material impact on the Company financial results due to CMS approved pool allocation methodology for the SFY 2021 program.

On March 26, 2021, HHSC published a final rule that will apply to program periods on or after September 1, 2021, and UHRIP will be re-named the Comprehensive Hospital Increase Reimbursement Program (“CHIRP”). CHIRP will be comprised of a UHRIP component and an Average Commercial Incentive Award (“ACIA”) component. HHSC has proposed a pool size of $5.0 billion subject to CMS approval. The Company is not able to estimate the financial impact of the program change.

On January 11, 2021, HHSC announced that CMS approved the pre-print modification that HHSC submitted for UHRIP period March 1, 2021 through August 31, 2021. CMS approved rate changes that will now increase rates for private Institutions of Mental Disease (“IMD”) for services provided to patients under age 21 or patients 65 years of age or older. We estimate that this payment policy change will increase our UHRIP reimbursement by $10 million in FY 2021 and this amount is included the aggregated FY 2021 Medicaid Supplemental Payment projection total below.

Texas Delivery System Reform Incentive Payments:
In addition, the Texas Medicaid Section 1115 Waiver includes a DSRIP pool to incentivize hospitals and other providers to transform their service delivery practices to improve quality, health status, patient experience, coordination, and cost-effectiveness. DSRIP pool payments are incentive payments to hospitals and other providers that develop programs or strategies to enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. In May, 2014, CMS formally approved specific DSRIP projects for certain of our hospitals for demonstration years 3 to 5 (our facilities did not materially participate in the DSRIP pool during demonstration years 1 or 2). DSRIP payments are contingent on the hospital meeting certain pre-determined milestones, metrics and clinical outcomes. Additionally, DSRIP payments are contingent on a governmental entity providing an IGT for the non-federal share component of the DSRIP payment. THHSC generally approves DSRIP reported metrics, milestones and clinical outcomes on a semi-annual basis in June and December. Under the CMS approval noted above, the Waiver renewal requires the transition of the DSRIP program to one focused on "health system performance measurement and improvement." THHSC must submit a transition plan describing "how it will further develop its delivery system reforms without DSRIP funding and/or phase out DSRIP funded activities and meet mutually agreeable milestones to demonstrate its ongoing progress." The size of the DSRIP pool will remain unchanged for the initial two years of the waiver renewal with unspecified decreases in years three and four of the renewal, FFY 2020 and 2021, respectively. In FFY 2022, DSRIP funding under the waiver is eliminated. For FFY 2020 and 2021, we estimate these changes will result in a $3 million and $4 million decrease in DSRIP payments, respectively. For FFY 2022, we will no longer receive DSRIP funds due to the elimination of this funding source by CMS in the Waiver renewals except for certain carryover DSRIP projects for which achievement of the required metrics will not be known until state fiscal year 2022. In March, 2020, HHSC submitted a DSRIP Transition Plan to CMS as required by the 1115 Waiver Special Terms and Conditions #37 that outlines a transition from the current DSRIP program to a Value-Based Purchasing (“VBP”) type payment model. As noted above, HHSC finalized a rule to make changes to existing UHRIP program. This rule change reflects HHSC’s effort to comply with federal regulations that require directed-payment programs to advance goals included in the state’s Medicaid managed care quality strategy and to align with the ongoing efforts to transition from the Delivery System Reform Incentive Payment program. We are unable to estimate the financial impact of this payment change.

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

The following table summarizes the revenues, Provider Taxes and net benefit related to each of the above-mentioned Medicaid supplemental programs for the three-month periods ended March 31, 2021 and 2020. The Provider Taxes are recorded in other operating expenses on the Condensed Consolidated Statements of Income as included herein.

	(amounts in millions)	
	Three Months Ended	
	March 31, 2021	March 31, 2020
Texas UC/UPL:		
Revenues	$ 26	$ 32
Provider Taxes	(6)	(13)
Net benefit	$ 20	$ 19
Texas DSRIP:		
Revenues	$ 0	$ 0
Provider Taxes	0	0
Net benefit	$ 0	$ 0
Various other state programs:		
Revenues	$ 85	$ 74
Provider Taxes	(40)	(33)
Net benefit	$ 45	$ 41
Total all Provider Tax programs:		
Revenues	$ 111	$ 106
Provider Taxes	(46)	(46)
Net benefit	$ 65	$ 60

We estimate that our aggregate net benefit from the Texas and various other state Medicaid supplemental payment programs will approximate $330 million (net of Provider Taxes of $211 million) during the year ending December 31, 2021. This amount includes approximately $60 million related to the Kentucky Hospital Rate Increase Program, as described below, which was approved and implemented during the second quarter of 2021. This estimate is based upon various terms and conditions that are out of our control including, but not limited to, the states'/CMS's continued approval of the programs and the applicable hospital district or county making IGTs consistent with 2020 levels. Future changes to these terms and conditions could materially reduce our net benefit derived from the programs which could have a material adverse impact on our future consolidated results of operations. In addition, Provider Taxes are governed by both federal and state laws and are subject to future legislative changes that, if reduced from current rates in several states, could have a material adverse impact on our future consolidated results of operations. As described below in *2019 Novel Coronavirus Disease Medicare and Medicaid Payment Related Legislation*, a 6.2% increase to the Medicaid Federal Matching Assistance Percentage ("FMAP") is included in the Families First Coronavirus Response Act. The impact of the enhanced FMAP Medicaid supplemental and DSH payments are reflected in our results for year ended December 31, 2020 and for the three months ended March 31, 2021. We are unable to estimate the prospective financial impact of this provision at this time as our financial impact is contingent on unknown state action during future eligible federal fiscal quarters.

Texas and South Carolina Medicaid Disproportionate Share Hospital Payments:

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

Upon meeting certain conditions and serving a disproportionately high share of Texas' and South Carolina's low income patients, five of our facilities located in Texas and one facility located in South Carolina received additional reimbursement from each state's DSH fund. The South Carolina and Texas DSH programs were renewed for each state's 2021 DSH fiscal year (covering the period of October 1, 2020 through September 30, 2021).

In connection with these DSH programs, included in our financial results was an aggregate of approximately $11 million and $9 million during the three-month periods ended March 31, 2021 and 2020, respectively. We expect the aggregate reimbursements to our hospitals pursuant to the Texas and South Carolina 2021 fiscal year programs to be approximately $47 million.

The Legislation and subsequent federal legislation provides for a significant reduction in Medicaid disproportionate share payments beginning in federal fiscal year 2024 (see above in *Sources of Revenues and Health Care Reform-Medicaid Revisions* for additional disclosure related to the delay of these DSH reductions). HHS is to determine the amount of Medicaid DSH payment cuts imposed on each state based on a defined methodology. As Medicaid DSH payments to states will be cut, consequently, payments to Medicaid-participating providers, including our hospitals in Texas and South Carolina, will be reduced in the coming years. Based on the CMS final rule published in September, 2019, beginning in fiscal year 2024 (as amended by the CARES Act and the CAA), annual Medicaid DSH payments in South Carolina and Texas could be reduced by approximately 74% and 44%, respectively, from 2020 DSH payment levels.

Our behavioral health care facilities in Texas have been receiving Medicaid DSH payments since FFY 2016. As with all Medicaid DSH payments, hospitals are subject to state audits that typically occur up to three years after their receipt. DSH payments are subject to a federal Hospital Specific Limit ("HSL") and are not fully known until the DSH audit results are concluded. In general, freestanding psychiatric hospitals tend to provide significantly less charity care than acute care hospitals and therefore are at more risk for retroactive recoupment of prior year DSH payments in excess of their respective HSL. In light of the retroactive HSL audit risk for freestanding psychiatric hospitals, we have established DSH reserves for our facilities that have been receiving funds since FFY 2016. These DSH reserves are also impacted by the resolution of federal DSH litigation related to Children's Hospital Association of Texas v. Azar ("CHAT"), No. 17-cv-844 (D.D.C. March 2, 2018), appeal docketed, No. 18-5135 (D.C. Cir. May 9, 2018) where the calculation of HSL was being challenged. In August, 2019, DC Circuit Court of Appeals issued a unanimous decision in CHAT and reversed the judgment of the district court in favor of CMS and ordered that CMS's "2017 Rule" (regarding Medicaid DSH Payments—Treatment of Third Party Payers in Calculating Uncompensated Care Costs) be reinstated. CMS has not issued any additional guidance post the ruling. In April 2020, the plaintiffs in the case have petitioned the Supreme Court of the United States to hear their case. Additionally, there have been separate legal challenges on this same issue in the Fifth and Eight Circuits. On November 4, 2019, the United States Court of Appeals for the Eighth Circuit issued an opinion upholding the 2017 Rule. Missouri Hosp. Ass'n v. Azar, No. 18-1778 (8th Cir. Nov. 4, 2019) (i.e. reversing a district court order enjoining the 2017 rule). On April 20, 2020, the United States Court of Appeals of the Fifth Circuit issued a decision also upholding the 2017 Rule. Baptist Memorial Hospital v. Azar, No. 18-60592 (5th Cir. April 20, 2020). In light of these court decisions, we continue to maintain reserves in the financial statements for cumulative Medicaid DSH and UC reimbursements related to our behavioral health hospitals located in Texas that amounted to $35 million and $36 million as of March 31, 2021 and 2020, respectively.

Nevada SPA:

In Nevada, CMS approved a state plan amendment ("SPA") in August, 2014 that implemented a hospital supplemental payment program retroactive to January 1, 2014. This SPA has been approved for additional state fiscal years including the 2021 fiscal year covering the period of July 1, 2020 through June 30, 2021.

In connection with this program, included in our financial results was approximately $6 million and $7 million during the three months ended March 31, 2021 and 2020, respectively. We estimate that our reimbursements pursuant to this program will approximate $18 million during the year ended December 31, 2021.

California SPA:

In California, CMS issued formal approval of the 2017-19 Hospital Fee Program in December, 2017 retroactive to January 1, 2017 through September 30, 2019. In September, 2019, the state submitted a request to renew the Hospital Fee Program for the period July 1, 2019 to December 31, 2021. On February 25, 2020, CMS approved this renewed program. These approvals include the Medicaid inpatient and outpatient fee-for-service supplemental payments and the overall provider tax structure but did not yet include the approval of the managed care rate setting payment component for certain rate periods (see table below). The managed care payment component consists of two categories of payments, "pass-through" payments and "directed" payments. The pass-through payments are similar in nature to the prior Hospital Fee Program payment method whereas the directed payment method will be based on actual concurrent hospital Medicaid managed care in-network patient volume.

California Hospital Fee Program CMS Approval Status:

Hospital Fee Program Component	CMS Methodology Approval Status	CMS Rate Setting Approval Status
Fee For Service Payment	Approved through December 31, 2021	Approved through December 31, 2021; Paid through December 31, 2020
Managed Care-Pass-Through Payment	Approved through December 31, 2020	Approved through June 30, 2017; Paid in advance of approval through December 31, 2020
Managed Care-Directed Payment	Approved through December 31, 2020	Approved through June 30, 2017; Paid in advance of approval through June 30, 2019

In connection with the existing program, included in our financial results was approximately $14 million and $7 million for the three month period ending March 31, 2021 and 2020, respectively. We estimate that our reimbursements pursuant to this program will approximate $46 million during the year ended December 31, 2021. The aggregate impact of the California supplemental payment program, as outlined above, is included in the above *State Medicaid Supplemental Payment Program* table.

In April, 2020, the California Department of Health Care Services (“DHCS”) notified hospital providers that participate in the Medicaid managed care directed payment program that DHCS would recalculate directed payments for the period of July 1, 2017 through September 30, 2018 (“SFY 2018”) to remedy an identified data error. In August, 2020, as a follow-up to that notification, DHCS issued its corrected directed payment calculations. The updated calculation resulted in a favorable adjustment to the above program year and also resulted in increased expected supplemental payment amount for program years subsequent to the recalculated SFY 2018 rate period. The California Hospital Fee amounts noted above include our portion of the state corrected data.

Kentucky Hospital Rate Increase Program (“HRIP”):

In January, 2021, CMS approved the Medicaid Managed Care Hospital Rate Increase Program (“HRIP”) for state fiscal year (”SFY”) 2021 (covering the period of July 1, 2020 to June 30, 2021). The CMS approval increased the program statewide net benefit to eligible Kentucky hospitals to approximately $1.1 billion from the original HRIP CMS-approved pool size of $86 million. The state has subsequently enacted legislation that authorizes increased HRIP payments to hospitals and CMS has approved the applicable HRIP rate add-on amount for SFY 2021 retroactive to July 1, 2020. We estimate that this program change will increase our reimbursement for SFY 2021 by approximately $60 million, which we expect to record during the second quarter of 2021. Medicaid directed payment programs, such as HRIP, authorized under 42 CFR §438.6 require an annual state submission and approval by CMS. We expect that the state will submit a request to CMS during the second quarter of 2021 in order to continue the HRIP program for SFY 2022 with a similar payment methodology and payment level. However, we are unable predict if CMS will approve the HRIP for SFY 2022, and if approved, if the rates will be comparable to the recently approved SFY 2021 HRIP rates.

Risk Factors Related To State Supplemental Medicaid Payments:

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

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

HITECH Act: In July 2010, 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 Medicare and Medicaid incentive payments started in federal fiscal year 2011 and can end as late as 2016 for Medicare and 2021 for the state Medicaid programs. State Medicaid program participation in this federally

funded incentive program is voluntary but all of the states in which our eligible hospitals operate have chosen to participate. Our acute care hospitals qualified for these EHR incentive payments upon implementation of the EHR application assuming they meet the "meaningful use" criteria. The government's ultimate goal is to promote more effective (quality) and efficient healthcare delivery through the use of technology to reduce the total cost of healthcare for all Americans and utilizing the cost savings to expand access to the healthcare system.

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

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

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

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

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

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

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

Implemented Medicare Reductions and Reforms:

- The Legislation reduced the market basket update for inpatient and outpatient hospitals and inpatient behavioral health facilities by 0.25% in each of 2010 and 2011, by 0.10% in each of 2012 and 2013, 0.30% in 2014, 0.20% in each of 2015 and 2016 and 0.75% in each of 2017, 2018 and 2019.
- The Legislation implemented certain reforms to Medicare Advantage payments, effective in 2011.
- A Medicare shared savings program, effective in 2012.
- A hospital readmissions reduction program, effective in 2012.
- A value-based purchasing program for hospitals, effective in 2012.
- A national pilot program on payment bundling, effective in 2013.
- Reduction to Medicare DSH payments, effective in 2014, as discussed above.

Medicaid Revisions:

- Expanded Medicaid eligibility and related special federal payments, effective in 2014.

- The Legislation (as amended by subsequent federal legislation) requires annual aggregate reductions in federal DSH funding from federal fiscal year ("FFY") 2024 through FFY 2027. Medicaid DSH reductions have been delayed several times. Commencing in federal fiscal year 2024, and continuing through 2027, DSH payments will be reduced by $8 billion annually.

Health Insurance Revisions:

- Large employer insurance reforms, effective in 2015.
- Individual insurance mandate and related federal subsidies, effective in 2014. As noted above in *Health Care Reform*, the Tax Cuts and Jobs Act enacted into law in December, 2017 eliminated the individual insurance federal mandate penalty beginning January 1, 2019.
- Federally mandated insurance coverage reforms, effective in 2010 and forward.

The Legislation seeks to increase competition among private health insurers by providing for transparent federal and state insurance exchanges. The Legislation also prohibits private insurers from adjusting insurance premiums based on health status, gender, or other specified factors. We cannot provide assurance that these provisions will not adversely affect the ability of private insurers to pay for services provided to insured patients, or that these changes will not have a negative material impact on our results of operations going forward.

Value-Based Purchasing:

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

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

Hospital Acquired Conditions:

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

Readmission Reduction Program:

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

Accountable Care Organizations:

The Legislation requires HHS to establish a Medicare Shared Savings Program that promotes accountability and coordination of care through the creation of accountable care organizations ("ACOs"). The ACO program allows providers (including hospitals), physicians and other designated professionals and suppliers to voluntarily work together to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS will be eligible to share in a portion of the amounts saved by the Medicare program. CMS is also developing and implementing more advanced ACO

payment models, such as the Next Generation ACO Model, which require ACOs to assume greater risk for attributed beneficiaries. On December 21, 2018, CMS published a final rule that, in general, requires ACO participants to take on additional risk associated with participation in the program. On April 30, 2020, CMS issued an interim final rule with comment in response to the COVID-19 national emergency permitting ACOs with current agreement periods expiring on December 31, 2020 the option to extend their existing agreement period by one year, and permitting certain ACOs to retain their participation level through 2021. It remains unclear to what extent providers will pursue federal ACO status or whether the required investment would be warranted by increased payment.

Bundled Payments for Care Improvement Advanced:

The Center for Medicare & Medicaid Innovation ("CMMI") implemented a new, second generation voluntary episode payment model, Bundled Payments for Care Improvement Advanced ("BPCI-Advanced" or the "Program"), with the first performance period beginning October 1, 2018. BPCI-Advanced is designed to test a new iteration of bundled payments with an aim to align incentives among participating health care providers to reduce expenditures and improve quality of care for traditional Medicare beneficiaries.

During the fourth quarter of 2020, CMS restructured the FY2021 to FY2023 program and required participants to select from eight Clinical Episode Service Line Groups instead of individual clinical episodes. CMS also announced that the now voluntary program would become mandatory in 2024.

For our hospitals that participated in the program, the CMS BPCI-A reconciliation for the period October 1, 2018 through June 30, 2020 did not have a material impact on our financial results.

The ultimate success and financial impact of the BPCI-Advanced program is contingent on multiple variables so we are unable to estimate the future impact. However, given the breadth and scope of participation of our acute care hospitals in BPCI-Advanced, the impact could be significant (either favorably or unfavorably) depending on actual program results.

2019 Novel Coronavirus Disease Medicare and Medicaid Payment Related Legislation

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

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

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

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

- Medicaid FMAP Enhancement
  - The FMAP was increased by 6.2% retroactive to the federal fiscal quarter beginning January 1, 2020 and each subsequent federal fiscal quarter for all states and U.S. territories during the declared public health emergency, in accordance with specified conditions.
- Public Health Emergency Declaration
  - The HHS Secretary renewed the public health emergency ("PHE") effective April 21, 2021 for ninety (90) days. As a result, states would be eligible for the enhanced FMAP through the end of federal fiscal year 2021 should the PHE not be rescinded by the Secretary before the end of the ninety day period.
- Creation of a $250 billion Public Health and Social Services Emergency Fund ("PHSSEF")
  - Makes grants available to hospitals and other healthcare providers to cover unreimbursed healthcare related expenses or lost revenues attributable to the public health emergency resulting from the coronavirus.
  - During the first quarter of 2021, we received approximately $188 million in PHSSEF grants from the federal government as provided for by the CARES Act. As mentioned above, we expect to return these funds to HHS in May, 2021. Since our intent was to return these funds, our results of operations for the first quarter of 2021 include

no impact from the receipt of the funds. Included in our results of operations for the three-month period ended March 31, 2021 was approximately $11 million of revenues recognized in connection with funds received from various state and local governmental stimulus grant programs.

- During the year ended December 31, 2020, we received approximately $417 million of funds from various governmental stimulus programs, most notably the PHSSEF as provided for by the CARES Act. Included in our results of operations for the year ended December 31, 2020 was approximately $413 million of revenues recognized in connection with funds received from these federal, state and local governmental stimulus programs. Our results of operations for the first quarter of 2020 did not include any revenues recorded in connection with these governmental stimulus programs.
- All PHSSEF receipts are pursuant to meeting the applicable the terms and conditions of the various distribution programs as of March 31, 2021. The Consolidated Appropriations Act, 2021 (H.R. 133) enacted on December 27, 2020 includes language that provides specific instructions on: (1) the redistribution of PHSSEF grant payments by a parent company among its subsidiaries, and; (2) the calculation of lost revenue in a PHSSEF grant entitlement determination. The HHS terms and conditions for all grant recipients and specific fund distributions are located at https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/for-providers/index.html

- Reimburse hospitals at Medicare rates for uncompensated COVID-19 care for the uninsured
  - Our operating results for the three-month period ended March 31, 2021 included $17 million of revenues in connection with this program. In 2020, we recorded $29 million in connection with this program, none of which was recorded during the first quarter of 2020. Revenue for the eligible patient encounters is recorded in the period in which the encounter is deemed eligible for this program net of any normal accounting reserves.

- Medicare Sequestration Relief
  - Suspension of the 2% Medicare sequestration offset for Medicare services provided from May 1, 2020 through December 31, 2021 by various legislative extensions.
  - We estimate that this provision had a favorable impact of approximately $11 million during the three-month period ending March 31, 2021; and will have a favorable impact of approximately $33 million over the remaining nine months of 2021. We estimate that this provision had a favorable impact of $30 million during 2020, none of which was included in our results of operations during the first quarter of 2020.

- Medicare add-on for inpatient hospital COVID-19 patients
  - Increases the payment that would otherwise be made to a hospital for treating a Medicare patient admitted with COVID-19 by twenty percent (20%) for the duration of the COVID-19 public health emergency.
  - For the three-month period ending March 31, 2021, we estimate that additional payments under this provision were approximately $16 million. For 2020, we estimate that additional payments under this provision were approximately $32 million, although the amounts included in our results of operations during the first quarter of 2020 were not significant. These payments offset the increased expenses associated with the treatment of Medicare COVID-19 patients.

- Expansion of the Medicare Accelerated and Advance Payment Program (“MAAPP”)
  - In March, 2021, we have fully repaid the $695 million of Medicare Accelerated payments received during 2020.

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

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

Other Operating Results

Interest Expense:

As reflected on the schedule below, interest expense was $22 million and $36 million during the three-month periods ended March 31, 2021 and 2020, respectively (amounts in thousands):

	Three Months Ended March 31, 2021	Three Months Ended March 31, 2020
Revolving credit & demand notes (a.)	$ 496	$ 716
$700 million, 4.75% Senior Notes due 2022, net (b.)	0	8,069
$400 million, 5.00% Senior Notes due 2026 (c.)	5,000	5,000
$800 million, 2.65% Senior Notes due 2030 (d.)	5,400	-
Term loan facility A (a.)	7,117	14,365
Term loan facility B (a.)	2,298	4,284
Accounts receivable securitization program (e.)	760	2,043
Subtotal-revolving credit, demand notes, Senior Notes, term loan facilities and accounts receivable securitization program	21,071	34,477
Amortization of financing fees	1,092	1,282
Other combined interest expense	1,337	1,671
Capitalized interest on major projects	(639)	(1,049)
Interest income	(904)	(30)
Interest expense, net	$ 21,957	$ 36,351

(a.) In October, 2018, we entered into a sixth amendment to our credit agreement dated November 15, 2010 to, among other things: (i.) increase the aggregate amount of the revolving commitments by $200 million to $1 billion; (ii) increase the aggregate amount of the term loan facility A by approximately $290 million to $2 billion, and; (iii) extend the maturity date of the credit agreement from August 7, 2019 to October 23, 2023. On October 31, 2018, we added a seven-year, Tranche B term loan facility in the aggregate amount of $500 million pursuant to our credit agreement. The Tranche B term loan matures on October 31, 2025.

The credit agreement, as amended in October, 2018, consists of: (i) an $1 billion revolving credit facility with no outstanding borrowings as of March 31, 2021; (ii) a term loan A facility with $1.875 billion of outstanding borrowings as of March 31, 2021, and; (iii) a term loan B facility with $489 million of outstanding borrowings as of March 31, 2021.

(b.) In September, 2020, we redeemed the entire $700 million aggregate principal amount of our previously outstanding 4.75% Senior Secured Notes that were scheduled to mature in 2022 (“2022 Notes”) at a cash redemption price equal to the sum of: (i) 100% of the aggregate principal amount of the 2022 Notes redeemed, and; (ii) accrued and unpaid interest on the 2022 Notes to the redemption date.

(c.) In June, 2016, we completed the offering of $400 million aggregate principal amount of 5.00% Senior Notes due in 2026.

(d.) In September, 2020, we completed the offering of $800 million aggregate principal amount of 2.65% Senior Notes due in 2030. The net proceeds of this offering were primarily used to redeem all of the $700 million, 2022 Notes as discussed above.

(e.) On March 18, 2021, we provided notice to the group of conduit lenders, liquidity banks, and PNC Bank, National Association, as administrative agent, in connection with our $450 million accounts receivable securitization program, expressing our intent to terminate the aggregate borrowing commitments under the facility effective as of March 31, 2021. There are no outstanding borrowings as of March 31, 2021.

Interest expense decreased $14 million during the three-month period ended March 31, 2021, as compared to the comparable period of 2020, due primarily to: (i) a net $13 million decrease in aggregate interest expense on our revolving credit, demand notes, senior notes, term loan facilities and accounts receivable securitization program resulting from a decrease in our aggregate average cost of borrowings pursuant to these facilities (2.2% during the three months ended March 31, 2021 as compared to 3.6% in the comparable quarter of 2020), as well as a decrease in the aggregate average outstanding borrowings ($3.81 billion during the three months ended March 31, 2021 as compared to $3.85 billion in the comparable 2020 quarter), and; (ii) $1 million of other combined net decreases in interest expense.

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, 2021 and 2020 (dollar amounts in thousands):

	Three months ended	
	March 31, 2021	March 31, 2020
Provision for income taxes	$ 63,807	$ 46,323
Income before income taxes	272,877	190,783
Effective tax rate	23.4%	24.3%

The provision for income taxes increased $17 million during the three-month period ended March 31, 2021, as compared to the first quarter of 2020, due primarily to: (i) the income tax provision recorded in connection with the $84 million increase in pre-tax income, partially offset by; (ii) a $2 million decrease in the provision for income taxes recorded in connection with our adoption of ASU 2016-09.

Liquidity

Net cash provided by operating activities

Net cash provided by operating activities was $72 million during the three-month period ended March 31, 2021 and $502 million during the first quarter of 2020. The net decrease of $430 million was attributable to the following:

- an unfavorable change of $509 million resulting primarily from the above-mentioned, early return of the $695 million of Medicare accelerated payments which were repaid during the first quarter of 2021, net of the $188 million of CARES Act grants received during the first quarter of 2021 (which we expect to repay in May, 2021);
- a favorable change of $72 million resulting from an increase in net income plus depreciation and amortization expense and stock-based compensation expense, and;
- $7 million of other combined net favorable changes.

Days sales outstanding ("DSO"): Our DSO are calculated by dividing our net revenue by the number of days in the three-month periods. The result is divided into the accounts receivable balance at March 31st of each year to obtain the DSO. Our DSO were 50 days and 48 days at March 31, 2021 and 2020, respectively.

Net cash used in investing activities

During the first three months of 2021, we used $262 million of net cash in investing activities as follows:

- $247 million spent on capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities;
- $14 million spent in connection with net cash outflows from forward exchange contracts that hedge our investment in the U.K. against movements in exchange rates, and;
- $1 million spent on the purchase and implementation of information technology applications.

During the first three months of 2020, we used $135 million of net cash in investing activities as follows:

- $184 million spent on capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities;
- $52 million received in connection with net cash inflows from forward exchange contracts that hedge our investment in the U.K. against movements in exchange rates;
- $2 million spent on the purchase and implementation of information technology applications, and;
- $1 million spent to fund investments in and advances to joint ventures and other.

Net cash used in financing activities

During the first three months of 2021, we used $270 million of net cash in financing activities as follows:

- spent $252 million on net repayments of debt as follows: (i) $225 million in connection with our accounts receivable securitization program; (ii) $25 million related to our term loan A facility; (iii) $1 million related to our term loan B facility, and; (iv) $1 million related to other debt facilities;
- spent $17 million to pay cash dividends of $.20 per share during the first quarter;

- received $8 million in connection with the sale of ownership interest to minority members;
- spent $7 million to repurchase shares of our Class B Common Stock in connection with income tax withholding obligations related to stock-based compensation programs;
- spent $5 million to pay profit distributions related to noncontrolling interests in majority owned businesses, and;
- generated $3 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans;

During the first three months of 2020, we used $372 million of net cash in financing activities as follows:

- spent $185 million on net repayments of debt as follows: (i) $13 million related to our term loan A facility; (ii) $140 million related to our accounts receivable securitization program; (iii) $1 million related to our term loan B facility, and; (iv) $31 million related to a short-term credit facility.
- generated $5 million of proceeds related to other debt facilities;
- spent $172 million to repurchase shares of our Class B Common Stock in connection with: (i) open market purchases pursuant to our $2.7 billion stock repurchase program ($170 million), and; (ii) income tax withholding obligations related to stock-based compensation programs ($3 million);
- spent $6 million to pay profit distributions related to noncontrolling interests in majority owned businesses;
- spent $17 million to pay quarterly cash dividends of $.20 per share, and;
- generated $3 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

Expected capital expenditures during remainder of 2021

Our estimated capital expenditures for the full year of 2021 are projected to be approximately $850 million to $1.0 billion. During the first three months of 2021, we spent approximately $247 million on capital expenditures. During the remaining nine months of 2021, we expect to spend approximately $603 million to $753 million which includes expenditures for capital equipment, renovations and new projects at existing hospitals.

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

Cash and Cash Equivalents

As of March 31, 2021, we had approximately $765 million of cash and cash equivalents consisting primarily of short-term cash accounts on which interest is being earned at various annual rates ranging from 0.20% to 0.35%.

Credit Facilities and Outstanding Debt Securities

On October 23, 2018, we entered into a Sixth Amendment (the “Sixth Amendment”) to our credit agreement dated as of November 15, 2010, as amended on March 15, 2011, September 21, 2012, May 16, 2013, August 7, 2014 and June 7, 2016, among UHS, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders, JPMorgan Chase Bank, N.A., as administrative agent, and the other agents party thereto (the “Senior Credit Agreement”).

The Sixth Amendment to the Senior Credit Agreement, among other things: (i) increased the aggregate amount of the revolving credit facility to $1 billion; (ii) increased the aggregate amount of the tranche A term loan commitments to $2 billion, and; (iii) extended the maturity date of the revolving credit and tranche A term loan facilities to October 23, 2023 from August 7, 2019.

On October 31, 2018, we added a seven-year tranche B term loan facility in the aggregate principal amount of $500 million pursuant to the Senior Credit Agreement. The tranche B term loan matures on October 31, 2025. We used the proceeds to repay borrowings under the revolving credit facility, the Securitization (as defined below), to redeem our $300 million, 3.75% Senior Notes that were scheduled to mature in 2019 and for general corporate purposes.

As of March 31, 2021, we had no borrowings outstanding pursuant to our $1 billion revolving credit facility and we had $997 million of available borrowing capacity net of $3 million of outstanding letters of credit.

Pursuant to the terms of the Sixth Amendment, the tranche A term loan, which had $1.875 billion of borrowings outstanding as of March 31, 2021, provides for installment payments of $25 million per quarter until maturity in October of 2023, when all outstanding amounts will be due.

The tranche B term loan, which had approximately $489 million of borrowings outstanding as of March 31, 2021, provides for installment payments of $1.25 million per quarter which are scheduled to continue until maturity in October of 2025, when all outstanding amounts will be due.

Borrowings under the Senior Credit Agreement bear interest at our election at either (1) the ABR rate which is defined as the rate per annum equal to the greatest of (a) the lender's prime rate, (b) the weighted average of the federal funds rate, plus 0.5% and (c) one month LIBOR rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.375% to 0.625% for revolving credit and term loan A borrowings and 0.75% for tranche B borrowings, or (2) the one, two, three or six month LIBOR rate (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.375% to 1.625% for revolving credit and term loan A borrowings and 1.75% for the tranche B term loan. As of March 31, 2021, the applicable margins were 0.375% for ABR-based loans and 1.375% for LIBOR-based loans under the revolving credit and term loan A facilities. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Senior Credit Agreement is secured by certain assets of the Company and our material subsidiaries (which generally excludes asset classes such as substantially all of the patient-related accounts receivable of our acute care hospitals, and certain real estate assets and assets held in joint-ventures with third parties) and is guaranteed by our material subsidiaries.

The Senior Credit Agreement includes a material adverse change clause that must be represented at each draw. The Senior Credit Agreement contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens and indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage. We are in compliance with all required covenants as of March 31, 2021 and December 31, 2020.

In March, 2021, we provided notice to the group of conduit lenders, liquidity banks, and PNC Bank, National Association, as administrative agent, in connection with our $450 million accounts receivable securitization program ("Securitization"), expressing our intent to terminate the aggregate borrowing commitments under the facility, which occurred effective as of March 31, 2021. The Securitization was amended as of April 26, 2021 (the eighth amendment) to: (i) reduce the aggregate borrowing commitments to $20 million; (ii) slightly reduce the borrowing rates and commitment fee, and; (iii) extend the maturity date to April 25, 2022. Substantially all other material terms and conditions remained unchanged.

As of March 31, 2021, we had combined aggregate principal of $1.2 billion from the following senior secured notes:

- $800 million aggregate principal amount of 2.65% senior secured notes due in October, 2030 ("2030 Notes") which were issued on September 21, 2020.
- $400 million aggregate principal amount of 5.00% senior secured notes due in June, 2026 ("2026 Notes") which were issued on June 3, 2016.

Interest on the 2026 Notes is payable on June 1 and December 1 until the maturity date of June 1, 2026. Interest on the 2030 Notes payable on April 15 and October 15, commencing April 15, 2021, until the maturity date of October 15, 2030. The 2026 Notes and 2030 Notes were offered only to qualified institutional buyers under Rule 144A and to non-U.S. persons outside the United States in reliance on Regulation S under the Securities Act of 1933, as amended (the "Securities Act"). The 2026 Notes and 2030 Notes have not been registered under the Securities Act and may not be offered or sold in the United States absent registration or an applicable exemption from registration requirements.

The 2030 Notes are guaranteed (the "*Guarantees*") on a senior secured basis by all of our existing and future direct and indirect subsidiaries (the "*Subsidiary Guarantors*") that guarantee our Senior Credit Agreement, dated as of November 15, 2010, as amended, restated or supplemented from time to time, or other first lien obligations or any junior lien obligations. The 2030 Notes and the Guarantees are secured by first-priority liens, subject to permitted liens, on certain of the Company's and the Subsidiary Guarantors' assets now owned or acquired in the future by the Company or the Subsidiary Guarantors (other than real property, accounts receivable sold pursuant to the Company's Existing Receivables Facility (as defined in the Indenture pursuant to which the 2030 Notes were issued (the "Indenture")), and certain other excluded assets). The Company's obligations with respect to the 2030 Notes, the obligations of the Subsidiary Guarantors under the Guarantees, and the performance of all of the Company's and the Subsidiary Guarantors' other obligations under the Indenture are secured equally and ratably with the Company's and the Subsidiary Guarantors' obligations under the Senior Credit Agreement and the Company's 2026 Notes by a perfected first-priority security interest, subject to permitted liens, in the collateral owned by the Company and its Subsidiary Guarantors, whether now owned or hereafter acquired. However, the liens on the collateral securing the 2030 Notes and the Guarantees will be released if: (i) the 2030 Notes have investment grade ratings; (ii) no default has occurred and is continuing, and; (iii) the liens on the collateral securing all first lien obligations (including the Senior Credit Agreement and the 2026 Notes) and any junior lien obligations are released or the collateral under the Senior Credit Agreement, any other first lien obligations and any junior lien obligations is released or no longer required to be pledged. The liens on any collateral securing the 2030 Notes and the Guarantees will also be released if the liens on that collateral securing the Senior Credit Agreement, other first lien obligations and any junior lien obligations are released.

In connection with the issuance of the 2030 Notes, the Company, the Subsidiary Guarantors and the representatives of the several initial purchasers, entered into a Registration Rights Agreement (the "*Registration Rights Agreement*"), whereby the Company and the Subsidiary Guarantors have agreed, at their expense, to use commercially reasonable best efforts to: (i) cause to be filed a registration statement enabling the holders to exchange the 2030 Notes and the Guarantees for registered senior secured notes issued by the

Company and guaranteed by the then Subsidiary Guarantors under the Indenture (the "*Exchange Securities*"), containing terms identical to those of the 2030 Notes (except that the Exchange Securities will not be subject to restrictions on transfer or to any increase in annual interest rate for failure to comply with the Registration Rights Agreement); (ii) cause the registration statement to become effective; (iii) complete the exchange offer not later than 60 days after such effective date and in any event on or prior to a target registration date of March 21, 2023, and; (iv) file a shelf registration statement for the resale of the 2030 Notes if the exchange offer cannot be effected within the time periods listed above. The interest rate on the 2030 Notes will increase and additional interest thereon will be payable if the Company does not comply with its obligations under the Registration Rights Agreement.

On September 28, 2020, we redeemed the entire $700 million aggregate principal amount of our previously outstanding 4.75% Senior Secured Notes due 2022 (the "2022 Notes"), at a cash redemption price equal to the sum of: (i) 100% of the aggregate principal amount of the 2022 Notes redeemed, and; (ii) accrued and unpaid interest on the 2022 Notes to the redemption date.

At March 31, 2021, the carrying value and fair value of our debt were each approximately $3.6 billion. At December 31, 2020, the carrying value and fair value of our debt were each approximately $3.9 billion. The fair value of our debt was computed based upon quotes received from financial institutions. We consider these to be "level 2" in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with debt instruments.

Our total debt as a percentage of total capitalization was approximately 36% at March 31, 2021 and 38% at December 31, 2020.

We expect to finance all capital expenditures and acquisitions and pay dividends and potentially repurchase shares of our common stock utilizing internally generated and additional funds. Additional funds may be obtained through: (i) borrowings under our existing revolving credit facility, which had $997 million of available borrowing capacity as of March 31, 2021, or through refinancing the existing Senior Credit Agreement; (ii) the issuance of other long-term debt, and/or; (iii) the issuance of equity. We believe that our operating cash flows, cash and cash equivalents, as well as access to the capital markets, provide us with sufficient capital resources to fund our operating, investing and financing requirements for the next twelve months. However, in the event we need to access the capital markets or other sources of financing, there can be no assurance that we will be able to obtain financing on acceptable terms or within an acceptable time. Our inability to obtain financing on terms acceptable to us could have a material unfavorable impact on our results of operations, financial condition and liquidity.

Off-Balance Sheet Arrangements

During the three months ended March 31, 2021, there have been no material changes in the off-balance sheet arrangements consisting of standby letters of credit and surety bonds.

As of March 31, 2021 we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds which totaled $168 million consisting of: (i) $159 million related to our self-insurance programs, and; (ii) $9 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, 2021. 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, 2020.

Item 4. Controls and Procedures

As of March 31, 2021, 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 other changes in our internal control over financial reporting or in other factors during the first quarter of 2021 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II. OTHER INFORMATION

Item 1. Legal Proceedings

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

Item 1A. Risk Factors

Our Annual Report on Form 10-K for the year ended December 31, 2020 includes a listing of risk factors to be considered by investors in our securities. During the first quarter of 2021, 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, 2020.

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

On July 25, 2019, our Board of Directors authorized a $1.0 billion increase to our stock repurchase program, which increased the aggregate authorization to $2.7 billion from the previous $1.7 billion authorization approved in various increments since 2014. Pursuant to this program, which currently had an aggregate available repurchase authorization of $559.6 million as of March 31, 2021, shares of our Class B Common Stock may be repurchased, from time to time as conditions allow, on the open market or in negotiated private transactions. There is no expiration date for our stock repurchase program.

During the second quarter of 2021, our Board of Directors approved a resumption of our stock repurchase program which had been previously suspended in April, 2020 as part of various COVID-19 initiatives. The schedule below provides information related to our stock repurchase program during the three-month period ended March 31, 2021. No shares were repurchased pursuant to the terms of our stock repurchase program during the first quarter of 2021, since as mentioned above, our stock repurchase program was suspended during that period. During the three-month period ended March 31, 2021, 53,997 shares were repurchased in connection with income tax withholding obligations resulting from stock-based compensation programs.

During the period of January 1, 2021 through March 31, 2021, we repurchased the following shares:

	Additional Dollars Authorized For Repurchase (in thousands)	Total number of shares purchased	Total number of shares cancelled	Average price paid per share for forfeited restricted shares	Total Number of shares purchased as part of publicly announced programs	Average price paid per share for shares purchased as part of publicly announced program	Aggregate purchase price paid for shares purchased as part of publicly announced program (in thousands)	Maximum number of shares that may yet be purchased under the program	Maximum number of dollars that may yet be purchased under the program (in thousands)
January, 2021	$ -	5,419	1,274	$ 0.01	—	—	—	—	$ 559,563
February, 2021	—	2,095	—	$ 0.01	—	—	—	—	$ 559,563
March, 2021	—	46,483	955	$ 0.01	—	—	—	—	$ 559,563
Total January through March, 2021	$ -	53,997	2,229	$ 0.01	—	N/A	$ —		

Dividends

During the quarter ended March 31, 2021, we declared and paid dividends of $.20 per share.

Item 6. Exhibits

10.1	Eighth Amendment to Amended and Restated Credit and Security Agreement, dated as of April 26, 2021.
31.1	Certification of the Company's Chief Executive Officer pursuant to Rule 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934.
31.2	Certification of the Company's Chief Financial Officer pursuant to Rule 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934.
32.1	Certification of the Company's Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of the Company's Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	Inline XBRL Instance Document –the instance document does not appear in the Interactive Data file because its XBRL tags are embedded within the Inline XBRL document.
101.SCH	Inline XBRL Taxonomy Extension Schema Document
101.CAL	Inline XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase Document
101.LAB	Inline XBRL Taxonomy Extension Label Linkbase Document
101.PRE	Inline XBRL Taxonomy Extension Presentation Linkbase Document
104	The cover page from the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2021, has been formatted in Inline XBRL.

Signatures

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

Universal Health Services, Inc.
(Registrant)

Date: May 7, 2021

/s/ MARC D. MILLER

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

/s/ STEVE FILTON

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

Exhibit 10.1
EXECUTION VERSION

EIGHTH AMENDMENT TO
AMENDED AND RESTATED CREDIT AND SECURITY AGREEMENT

This EIGHTH AMENDMENT TO AMENDED AND RESTATED CREDIT AND SECURITY AGREEMENT (this "Amendment"), dated as of April 26, 2021, is entered into by and among the following parties:

(i) the Borrowers identified on the signature pages hereto;
(ii) UHS Receivables Corp., as Collection Agent;
(iii) UHS of Delaware, Inc., as Servicer;

(iv) Universal Health Services, Inc., as Performance Guarantor; and

(v) PNC Bank, National Association ("PNC"), as Liquidity Bank, LC Participant for PNC's Lender Group, Co-Agent for PNC's Lender Group, LC Bank, and Administrative Agent.

Capitalized terms used but not otherwise defined herein have the respective meanings set forth in the Credit and Security Agreement defined below.

BACKGROUND

1. The parties hereto have entered into that certain Amended and Restated Credit and Security Agreement, dated as of October 27, 2010 (as amended, supplemented and otherwise modified from time to time, the "Credit and Security Agreement").

2. Pursuant to that certain letter agreement, dated as of March 31, 2021, among the parties to the Credit and Security Agreement at that time, (i) each of Victory Receivables Corporation, MUFG Bank, Ltd., Truist Bank, Atlantic Asset Securitization LLC and Credit Agricole Corporate and Investment Bank ceased to be parties to the Credit and Security Agreement, (ii) the Aggregate Principal was repaid in full, (iii) the Aggregate Commitment was reduced to zero ($0), (iv) notwithstanding the foregoing, neither the Final Payout Date nor the Termination Date occurred, and all Transaction Documents survived the transactions contemplated by such letter agreement, and (v) PNC remains a party to the Credit and Security Agreement as a Liquidity Bank, LC Participant for PNC's Lender Group, Co-Agent for PNC's Lender Group, LC Bank and Administrative Agent.

3. The parties hereto desire to amend the Credit and Security Agreement as set forth herein.

4. Concurrently with this Amendment, the parties hereto (other than the Performance Guarantor) are entering into an amended and restated Fee Letter (the "A&R Fee Letter").

NOW, THEREFORE, for good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, the parties hereto agree as follows:

SECTION 1. Amendments to the Credit and Security Agreement. The Credit and Security Agreement is hereby amended as follows:

(a) Section 1.3 is amended by deleting the second paragraph thereof in its entirety.

(b) New Section 4.5 (*Benchmark Replacement Setting*) set forth on Exhibit A attached hereto is added immediately after existing Section 4.4 (*Default Rate*).

(c) The following new paragraph is added to the end of Section 6.2 (*Conditions Precedent to All Advances and Letter of Credit Issuances*):

In addition, the first Advance made or Letter of Credit issued after April 26, 2021 shall be subject to the further condition precedent that the Servicer shall have delivered to the Administrative Agent a Monthly Report reflecting data with respect to the Receivables in the Collateral as of the last day of the most recently ended calendar month.

(d) The following new paragraph is added to the end of Section 7.1(d) (*Audits*):

No later than ninety (90) days after the first Advance made or Letter of Credit issued after April 26, 2021, such Loan Party shall deliver to the Administrative Agent the results of an audit or field exam of the Receivables and the servicing and origination practices of the Originators from a third-party consultant selected by the Administrative Agent (in consultation with the Servicer).

(e) Section 9.1(s) is replaced in its entirety with the following:

(s) The Consolidated Leverage Ratio, as at the last day of any period of four consecutive fiscal quarters of the Parent exceeds 3.75:1.0.

(f) The following new paragraph is added to the end of Section 8.5 (*Monthly Reports*):

Notwithstanding the foregoing, the Servicer shall not be required to deliver any Monthly Report or listing of all Receivables pursuant to this Section 8.5 unless and until the first Advance is made or Letter of Credit is issued after April 26, 2021.

(g) The definition of "Aggregate Commitment" in Exhibit I is replaced in its entirety with the following:

"Aggregate Commitment" means, on any date of determination, the aggregate amount of the Lender Group Commitments of all Lender Groups (excluding the Lender Group Commitment of any Defaulting Lender's Lender Group). As of April 26, 2021, the Aggregate Commitment is $20,000,000.

(h) The definition of "Facility Termination Date" in Exhibit I is replaced in its entirety with the following:

"Facility Termination Date" means the earlier of (i) April 25, 2022 and (ii) the Amortization Date.

(i) Existing Schedule A is replaced with new Schedule A attached hereto. SECTION 2. Amended and Restated Administrative Agent Fee Letter. Each party hereto agrees that no fees shall accrue or be payable under that certain Amended and Restated Administrative Agent Fee Letter, dated as of April 26, 2018, by and among the Administrative Agent, the Collection Agent, the Servicer and the Borrowers, until otherwise agreed among the parties thereto.

SECTION 3. Representations and Warranties. Each Borrower, the Collection Agent, the Servicer and the Performance Guarantor hereby represents and warrants to the Lenders, the Co-Agents and the Administrative Agent as follows:

(a) Representations and Warranties. The representations and warranties made by such Person in the Transaction Documents are true and correct as of the date hereof and after giving effect to this Amendment (unless stated to relate solely to an earlier date, in which case such representations or warranties were true and correct as of such earlier date).

(b) Enforceability. The execution and delivery by such Person of this Amendment, and the performance of each of its obligations under this Amendment and the other Transaction Documents to which such Person is a party, as amended hereby, are within each of its organizational powers and have been duly authorized by all necessary organizational action on its part. This Amendment and the other Transaction Documents to which such Person is a party, as amended hereby, are such Person's valid and legally binding obligations, enforceable in accordance with its terms.

(c) No Amortization Event. After giving effect to this Amendment and the transactions contemplated hereby, no Amortization Event or Unmatured Amortization Event has occurred and is continuing.

SECTION 4. Effectiveness. This Amendment shall become effective on the date hereof (the "Effective Date") upon receipt by the Administrative Agent of the counterparts to this Amendment and the A&R Fee Letter executed by each of the parties hereto and thereto.

SECTION 5. CHOICE OF LAW; CONSENT TO JURISDICTION.

(a) THIS AMENDMENT SHALL BE GOVERNED AND CONSTRUED IN ACCORDANCE WITH THE LAWS OF THE STATE OF NEW YORK, WITHOUT REGARD TO ANY PRINCIPLES OF CONFLICTS OF LAWS THEREOF.

(b) EACH PARTY TO THIS AMENDMENT HEREBY IRREVOCABLY SUBMITS TO THE NON-EXCLUSIVE JURISDICTION OF ANY UNITED STATES FEDERAL OR NEW YORK STATE COURT SITTING IN THE BOROUGH OF MANHATTAN, NEW YORK, IN ANY ACTION OR PROCEEDING ARISING OUT OF OR RELATING TO THIS AMENDMENT OR ANY DOCUMENT EXECUTED BY SUCH PERSON PURSUANT TO THIS AMENDMENT, AND EACH SUCH PARTY HEREBY IRREVOCABLY AGREES THAT ALL CLAIMS IN RESPECT OF SUCH ACTION OR PROCEEDING MAY BE HEARD AND DETERMINED IN ANY SUCH COURT AND IRREVOCABLY WAIVES ANY OBJECTION IT MAY NOW OR HEREAFTER HAVE AS TO THE VENUE OF ANY SUCH SUIT, ACTION OR PROCEEDING BROUGHT IN SUCH A COURT OR THAT SUCH COURT IS AN INCONVENIENT FORUM. NOTHING HEREIN SHALL LIMIT THE RIGHT OF ANY AGENT OR ANY LENDER TO BRING PROCEEDINGS AGAINST ANY LOAN PARTY IN THE COURTS OF ANY OTHER JURISDICTION. ANY JUDICIAL PROCEEDING BY ANY LOAN PARTY AGAINST THE AGENT OR ANY LENDER OR ANY AFFILIATE OF THE AGENT OR ANY LENDER INVOLVING, DIRECTLY OR INDIRECTLY, ANY MATTER IN ANY WAY ARISING OUT OF, RELATED TO, OR CONNECTED WITH THIS AMENDMENT OR ANY DOCUMENT EXECUTED BY SUCH LOAN PARTY PURSUANT TO THIS AMENDMENT SHALL BE BROUGHT ONLY IN A COURT IN THE BOROUGH OF MANHATTAN, NEW YORK.

SECTION 6. Effect of Amendment. All provisions of the Credit and Security Agreement, as expressly amended and modified by this Amendment, shall remain in full force and effect. After this Amendment becomes effective, all references in the Credit and Security Agreement (or in any other Transaction Document) to "this Agreement", "hereof", "herein" or words of similar effect referring to the Credit and Security Agreement shall be deemed to be references to the Credit and Security Agreement as amended by this Amendment. This Amendment shall not be deemed, either expressly or impliedly, to waive, amend or supplement any provision of the Credit and Security Agreement other than as set forth herein.

SECTION 7. Counterparts. This Amendment may be executed in any number of counterparts and by different parties on separate counterparts, each counterpart shall be deemed to be an original, and all such counterparts shall together constitute but one and the same agreement. Delivery of an executed counterpart of a signature page to this Amendment by facsimile or other electronic means shall be effective as delivery of a manually executed counterpart of this Amendment.

SECTION 8. Transaction Document. This Amendment shall constitute a Transaction Document for all purposes.

SECTION 9. Section Headings. The various headings of this Amendment are included for convenience only and shall not affect the meaning or interpretation of this Amendment, the Credit and Security Agreement or any provision hereof or thereof.

SECTION 10. Severability. If any one or more of the agreements, provisions or terms of this Amendment shall for any reason whatsoever be held invalid or unenforceable, then such agreements, provisions or terms shall be deemed severable from the remaining agreements, provisions and terms of this Amendment and shall in no way affect the validity or enforceability of the provisions of this Amendment or the Credit and Security Agreement.

SECTION 11. Ratification. After giving effect to this Amendment and each of the other agreements, documents and instruments contemplated in connection herewith, the Performance Undertaking, along with each of the provisions thereof, remains in full force and effect and is hereby ratified and reaffirmed by the Performance Guarantor and each of the other parties hereto.

[Signature pages follow.]

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date first written above.

AIKEN REGIONAL RECEIVABLES, L.L.C.,
DISTRICT HOSPITAL PARTNERS RECEIVABLES, L.L.C.,
FORT DUNCAN MEDICAL RECEIVABLES, L.L.C., LANCASTER HOSPITAL RECEIVABLES, L.L.C., LAREDO REGIONAL RECEIVABLES, L.L.C., MANATEE MEMORIAL RECEIVABLES, L.L.C., MCALLEN HOSPITALS RECEIVABLES, L.L.C.,
NORTHWEST TEXAS HEALTHCARE RECEIVABLES, L.L.C., SPARKS FAMILY HOSPITAL RECEIVABLES, L.L.C., SUMMERLIN HOSPITAL RECEIVABLES, L.L.C., TEMECULA VALLEY HOSPITAL RECEIVABLES, L.L.C.,
TEXOMA HEALTHCARE SYSTEM RECEIVABLES, L.L.C., UHS OF OKLAHOMA RECEIVABLES, L.L.C.,
UHS-CORONA RECEIVABLES, L.L.C., RANCHO SPRINGS RECEIVABLES, L.L.C.,
VALLEY HEALTH SYSTEM RECEIVABLES, L.L.C. AND WELLINGTON REGIONAL RECEIVABLES, L.L.C.,
AS BORROWERS

By: /s/ Cheryl Ramagano
Name: Cheryl Ramagano
Title: Treasurer

UHS RECEIVABLES CORP.,
AS COLLECTION AGENT

By: /s/ Cheryl Ramagano
Name: Cheryl Ramagano
Title: Treasurer

UHS OF DELAWARE, INC.,
AS SERVICER

By: /s/ Cheryl Ramagano
Name: Cheryl Ramagano
Title: Senior Vice President and Treasurer

UNIVERSAL HEALTH SERVICES, INC.,
AS PERFORMANCE GUARANTOR

By: /s/ Cheryl Ramagano
Name: Cheryl Ramagano
Title: Senior Vice President and Treasurer

PNC BANK, NATIONAL ASSOCIATION,
AS LC PARTICIPANT, LIQUIDITY BANK AND AS LC BANK

By: /s/ Eric Bruno
Name: Eric Bruno
Title: Senior Vice President

PNC BANK, NATIONAL ASSOCIATION,
AS CO-AGENT AND ADMINISTRATIVE AGENT

By: /s/ Eric Bruno
Name: Eric Bruno
Title: Senior Vice President

EXHIBIT A

Section 4.5 Benchmark Replacement Setting.

(a) *Benchmark Replacement*. Notwithstanding anything to the contrary herein or in any other Transaction Document, if a Benchmark Transition Event or an Early Opt-in Election, as applicable, and its related Benchmark Replacement Date have occurred prior to the Reference Time in respect of any setting of the then-current Benchmark, then (x) if a Benchmark Replacement is determined in accordance with clause (1) or (2) of the definition of "Benchmark Replacement" for such Benchmark Replacement Date, such Benchmark Replacement will replace such Benchmark for all purposes hereunder and under any Transaction Document in respect of such Benchmark setting and subsequent Benchmark settings without any amendment to, or further action or consent of any other party to, this Agreement or any other Transaction Document and (y) if a Benchmark Replacement is determined in accordance with clause (3) of the definition of "Benchmark Replacement" for such Benchmark Replacement Date, such Benchmark Replacement will replace such Benchmark for all purposes hereunder and under any Transaction Document in respect of any Benchmark setting at or after 5:00 p.m. (New York City time) on the fifth (5th) Business Day after the date notice of such Benchmark Replacement is provided to the Co-Agents without any amendment to, or further action or consent of any other party to, this Agreement or any other Transaction Document so long as the Administrative Agent has not received, by such time, written notice of objection to such Benchmark Replacement from Co-Agents comprising the Required Co-Agents.

(b) *Benchmark Replacement Conforming Changes*. In connection with the implementation of a Benchmark Replacement, the Administrative Agent will have the right to make Benchmark Replacement Conforming Changes from time to time and, notwithstanding anything to the contrary herein or in any other Transaction Document, any amendments implementing such Benchmark Replacement Conforming Changes will become effective without any further action or consent of any other party to this Agreement or any other Transaction Document.

(c) *Notices; Standards for Decisions and Determinations*. The Administrative Agent will promptly notify the Collection Agent (on behalf of the Borrowers) and the Co-Agents of (i) any occurrence of a Benchmark Transition Event, a Term SOFR Transition Event or an Early Opt-in Election, as applicable, and its related Benchmark Replacement Date, (ii) the implementation of any Benchmark Replacement, (iii) the effectiveness of any Benchmark Replacement Conforming Changes, (iv) the removal or reinstatement of any tenor of a Benchmark pursuant to clause (d) below and (v) the commencement or conclusion of any Benchmark Unavailability Period. Any determination, decision or election that may be made by the Administrative Agent or, if applicable, any Co-Agent (or group of Co-Agents) pursuant to this Section 4.5, including any determination with respect to a tenor, rate or adjustment or of the occurrence or non-occurrence of an event, circumstance or date and any decision to take or refrain from taking any action or any selection, will be conclusive and binding absent manifest error and may be made in its or their sole discretion and without consent from any other party to this Agreement or any other Transaction Document, except, in each case, as expressly required pursuant to this Section 4.5.

(d) *Unavailability of Tenor of Benchmark*. Notwithstanding anything to the contrary herein or in any other Transaction Document, at any time (including in connection with the implementation of a Benchmark Replacement), (i) if the then-current Benchmark is a term rate (including Term SOFR or LIBO Rate) and either (A) any tenor for such Benchmark is not displayed on a screen or other information service that publishes such rate from time to time as selected by the Administrative Agent in its reasonable discretion or (B) the regulatory supervisor for the administrator of such Benchmark has provided a public statement or publication of information announcing that any tenor for such Benchmark is or will be no longer representative, then the Administrative Agent may modify the definition of "Interest Period" for any Benchmark settings at or after such time to remove such unavailable or non-representative tenor and (ii) if a tenor that was removed pursuant to clause (i) above either (A) is subsequently displayed on a screen or information service for a Benchmark (including a Benchmark Replacement) or (B) is not, or is no longer, subject to an announcement that it is or will no longer be representative for a Benchmark (including a Benchmark Replacement), then the Administrative Agent may modify the definition of "Interest Period" for all Benchmark settings at or after such time to reinstate such previously removed tenor.

(e) *Benchmark Unavailability Period*. Upon the Collection Agent's receipt of notice of the commencement of a Benchmark Unavailability Period, the Collection Agent (on behalf of the Borrowers) may revoke any request for a Loan bearing interest based on LIBO Rate, conversion to or continuation of Loans bearing interest based on LIBO Rate to be made, converted or continued during any Benchmark Unavailability Period and, failing that, the Borrowers will be deemed to have converted any such request into a request for a Loan of or conversion to Loans bearing interest at the Alternate Base Rate. During any Benchmark Unavailability Period or at any time that a tenor for the then-current Benchmark is not an Available Tenor, the component (if any) of the Alternate Base Rate based upon the then-current Benchmark or such tenor for such Benchmark, as applicable, will not be used in any determination of the Alternate Base Rate.

(f) Secondary Term SOFR Conversion. Notwithstanding anything to the contrary herein or in any other Transaction Document and subject to the proviso below in this paragraph, if a Term SOFR Transition Event and its related Benchmark Replacement Date have occurred prior to the Reference Time in respect of any setting of the then-current Benchmark, then (i) the applicable Benchmark Replacement will replace the then-current Benchmark for all purposes hereunder or under any Transaction Document in respect of such Benchmark setting (the ***"Secondary Term SOFR Conversion Date"***) and subsequent Benchmark settings, without any amendment to, or further action or consent of any other party to, this Agreement or any other Transaction Document; and (ii) Loans outstanding on the Secondary Term SOFR Conversion Date bearing interest based on the then-current Benchmark shall be deemed to have been converted to Loans bearing interest at the Benchmark Replacement with a tenor approximately the same length as the interest payment period of the then-current Benchmark; provided that, this clause (f) shall not be effective unless the Administrative Agent has delivered to the Co-Agents and the Collection Agent (on behalf of the Borrowers) a Term SOFR Notice.

(g) *LIBOR Notification*. This Section 4.5 provides a mechanism for determining an alternative rate of interest in the event that the London interbank offered rate is no longer available or in certain other circumstances. The Administrative Agent does not warrant or accept

any responsibility for and shall not have any liability with respect to, the administration, submission or any other matter related to the London interbank offered rate or other rates in the definition of "LIBOR Rate" or with respect to any alternative or successor rate thereto, or replacement rate therefor.

(h) *Certain Defined Terms*. As used in this Section 4.5:

"Available Tenor" means, as of any date of determination and with respect to the then- current Benchmark, as applicable, (x) if the then current Benchmark is a term rate or is based on a term rate, any tenor for such Benchmark that is or may be used for determining the length of an Interest Period pursuant to this Agreement as of such date and not including, for the avoidance of doubt, any tenor for such Benchmark that is then-removed from the definition of "Interest Period" pursuant to clause (d) of this Section 4.5, or (y) if the then current Benchmark is not a term rate nor based on a term rate, any payment period for interest calculated with reference to such Benchmark pursuant to this Agreement as of such date. For the avoidance of doubt, the Available Tenor for the LIBO Rate determined pursuant to clause (y)(A) of the definition thereof is one month.

"Benchmark" means, initially, LIBO Rate; provided that if a Benchmark Transition Event a Term SOFR Transition Event or an Early Opt-in Election, as applicable, and its related Benchmark Replacement Date have occurred with respect to LIBO Rate or the then-current Benchmark, then "Benchmark" means the applicable Benchmark Replacement to the extent that such Benchmark Replacement has replaced such prior benchmark rate pursuant to paragraph (a) of this Section 4.5.

"Benchmark Replacement" means, for any Available Tenor, the first alternative set forth in the order below that can be determined by the Administrative Agent for the applicable Benchmark Replacement Date:

(1) the sum of: (a) Term SOFR and (b) the related Benchmark Replacement Adjustment;

(2) the sum of: (a) Daily Simple SOFR and (b) the related Benchmark Replacement Adjustment;

(3) the sum of: (a) the alternate benchmark rate that has been selected by the Administrative Agent and the Borrowers as the replacement for the then-current Benchmark for the applicable Corresponding Tenor giving due consideration to (i) any selection or recommendation of a replacement benchmark rate or the mechanism for determining such a rate by the Relevant Governmental Body or (ii) any evolving or then-prevailing market convention for determining a benchmark rate as a replacement for the then-current Benchmark for U.S. dollar- denominated syndicated credit facilities at such time and (b) the related Benchmark Replacement Adjustment;

provided that, in the case of clause (1), such Unadjusted Benchmark Replacement is displayed on a screen or other information service that publishes such rate from time to time as selected by the Administrative Agent in its reasonable discretion; provided, further, that, with respect to a Term

SOFR Transition Event, on the applicable Benchmark Replacement Date, the "Benchmark Replacement" shall revert to and shall be determined as set forth in clause (1) of this definition. If the Benchmark Replacement as determined pursuant to clause (1), (2) or (3) above would be less than the Floor, the Benchmark Replacement will be deemed to be the Floor for the purposes of this Agreement and the other Transaction Documents.

"Benchmark Replacement Adjustment" means, with respect to any replacement of the then-current Benchmark with an Unadjusted Benchmark Replacement for any applicable Available Tenor for any setting of such Unadjusted Benchmark Replacement:

(1) for purposes of clauses (1) and (2) of the definition of "Benchmark Replacement," the first alternative set forth in the order below that can be determined by the Administrative Agent:

(a) the spread adjustment, or method for calculating or determining such spread adjustment, (which may be a positive or negative value or zero) as of the Reference Time such Benchmark Replacement is first set for such Available Tenor that has been selected or recommended by the Relevant Governmental Body for the replacement of such Benchmark with the applicable Unadjusted Benchmark Replacement for the applicable Corresponding Tenor;

(b) the spread adjustment (which may be a positive or negative value or zero) as of the Reference Time such Benchmark Replacement is first set for such Available Tenor that would apply to the fallback rate for a derivative transaction referencing the ISDA Definitions to be effective upon an index cessation event with respect to such Benchmark for the applicable Corresponding Tenor; and

(2) for purposes of clause (3) of the definition of "Benchmark Replacement," the spread adjustment, or method for calculating or determining such spread adjustment, (which may be a positive or negative value or zero) that has been selected by the Administrative Agent and the Borrowers for the applicable Corresponding Tenor giving due consideration to (i) any selection or recommendation of a spread adjustment, or method for calculating or determining such spread adjustment, for the replacement of such Benchmark with the applicable Unadjusted Benchmark Replacement by the Relevant Governmental Body on the applicable Benchmark Replacement Date or (ii) any evolving or then-prevailing market convention for determining a spread adjustment, or method for calculating or determining such spread adjustment, for the replacement of such Benchmark with the applicable Unadjusted Benchmark Replacement for U.S. dollar-denominated syndicated credit facilities;

provided that, (x) in the case of clause (1) above, such adjustment is displayed on a screen or other information service that publishes such Benchmark Replacement Adjustment from time to time as selected by the Administrative Agent in its reasonable discretion and (y) if the then- current Benchmark is a term rate, more than one tenor of such Benchmark is available as of the applicable Benchmark Replacement Date and the applicable Unadjusted Benchmark Replacement will not be a term rate, the Available Tenor of such Benchmark for purposes of this definition of "Benchmark Replacement Adjustment" shall be deemed to be the Available Tenor

that has approximately the same length (disregarding business day adjustments) as the payment period for interest calculated with reference to such Unadjusted Benchmark Replacement.

"Benchmark Replacement Conforming Changes" means, with respect to any Benchmark Replacement, any technical, administrative or operational changes (including changes to the definition of "Alternate Base Rate," the definition of "Business Day," the definition of "Interest Period," timing and frequency of determining rates and making payments of interest, timing of borrowing requests or prepayment, conversion or continuation notices, length of lookback periods, the applicability of breakage provisions, and other technical, administrative or operational matters) that the Administrative Agent decides may be appropriate to reflect the adoption and implementation of such Benchmark Replacement and to permit the administration thereof by the Administrative Agent in a manner substantially consistent with market practice (or, if the Administrative Agent decides that adoption of any portion of such market practice is not administratively feasible or if the Administrative Agent determines that no market practice for the administration of such Benchmark Replacement exists, in such other manner of administration as the Administrative Agent decides is reasonably necessary in connection with the administration of this Agreement and the other Transaction Documents).

"Benchmark Replacement Date" means the earliest to occur of the following events with respect to the then-current Benchmark:

(1) in the case of clause (1) or (2) of the definition of "Benchmark Transition Event," the later of (a) the date of the public statement or publication of information referenced therein and (b) the date on which the administrator of such Benchmark (or the published component used in the calculation thereof) permanently or indefinitely ceases to provide all Available Tenors of such Benchmark (or such component thereof);

(2) in the case of clause (3) of the definition of "Benchmark Transition Event," the date determined by the Administrative Agent, which date shall promptly follow the date of the public statement or publication of information referenced therein;

(3) in the case of a Term SOFR Transition Event, the date that is set forth in the Term SOFR Notice provided to the Co-Agents and the Collection Agent (on behalf of the Borrowers) pursuant to this Section 4.5, which date shall be at least 30 days from the date of the Term SOFR Notice; or

(4) in the case of an Early Opt-in Election, the sixth (6th) Business Day after the date notice of such Early Opt-in Election is provided to the Co-Agents, so long as the Administrative Agent has not received, by 5:00 p.m. (New York City time) on the fifth (5th) Business Day after the date notice of such Early Opt-in Election is provided to the Co-Agents, written notice of objection to such Early Opt-in Election from Co- Agents comprising the Required Co-Agents.

For the avoidance of doubt, (i) if the event giving rise to the Benchmark Replacement Date occurs on the same day as, but earlier than, the Reference Time in respect of any determination, the Benchmark Replacement Date will be deemed to have occurred prior to the Reference Time

for such determination and (ii) the "Benchmark Replacement Date" will be deemed to have occurred in the case of clause (1) or (2) with respect to any Benchmark upon the occurrence of the applicable event or events set forth therein with respect to all then-current Available Tenors of such Benchmark (or the published component used in the calculation thereof).

"Benchmark Transition Event" means the occurrence of one or more of the following events with respect to the then-current Benchmark:

(1) a public statement or publication of information by or on behalf of the administrator of such Benchmark (or the published component used in the calculation thereof) announcing that such administrator has ceased or will cease to provide all Available Tenors of such Benchmark (or such component thereof), permanently or indefinitely, provided that, at the time of such statement or publication, there is no successor administrator that will continue to provide any Available Tenor of such Benchmark (or such component thereof);

(2) a public statement or publication of information by a Governmental Authority having jurisdiction over the Administrative Agent, the regulatory supervisor for the administrator of such Benchmark (or the published component used in the calculation thereof), the Federal Reserve Board, the Federal Reserve Bank of New York, an insolvency official with jurisdiction over the administrator for such Benchmark (or such component), a resolution authority with jurisdiction over the administrator for such Benchmark (or such component) or a court or an entity with similar insolvency or resolution authority over the administrator for such Benchmark (or such component), which states that the administrator of such Benchmark (or such component) has ceased or will cease to provide all Available Tenors of such Benchmark (or such component thereof) permanently or indefinitely, provided that, at the time of such statement or publication, there is no successor administrator that will continue to provide any Available Tenor of such Benchmark (or such component thereof); or

(3) a public statement or publication of information by the regulatory supervisor for the administrator of such Benchmark (or the published component used in the calculation thereof) or a Governmental Authority having jurisdiction over the Administrative Agent announcing that all Available Tenors of such Benchmark (or such component thereof) are no longer representative.

For the avoidance of doubt, a "Benchmark Transition Event" will be deemed to have occurred with respect to any Benchmark if a public statement or publication of information set forth above has occurred with respect to each then-current Available Tenor of such Benchmark (or the published component used in the calculation thereof).

"Benchmark Unavailability Period" means the period (if any) (x) beginning at the time that a Benchmark Replacement Date pursuant to clauses (1) or (2) of that definition has occurred if, at such time, no Benchmark Replacement has replaced the then-current Benchmark for all purposes hereunder and under any Transaction Document in accordance with this Section 4.5 and (y) ending at the time that a Benchmark Replacement has replaced the then-current

Benchmark for all purposes hereunder and under any Transaction Document in accordance with this Section 4.5.

"Corresponding Tenor" with respect to any Available Tenor means, as applicable, either a tenor (including overnight) or an interest payment period having approximately the same length (disregarding business day adjustment) as such Available Tenor.

"Daily Simple SOFR" means, for any day, SOFR, with the conventions for this rate (which will include a lookback) being established by the Administrative Agent in accordance with the conventions for this rate selected or recommended by the Relevant Governmental Body for determining "Daily Simple SOFR" for business loans; provided, that if the Administrative Agent decides that any such convention is not administratively feasible for the Administrative Agent, then the Administrative Agent may establish another convention in its reasonable discretion.

"Early Opt-in Election" means, if the then-current Benchmark is LIBO Rate, the occurrence of:

(1) a notification by the Administrative Agent to (or the request by the Borrowers to the Administrative Agent to notify) each of the other parties hereto that at least five currently outstanding U.S. dollar-denominated syndicated credit facilities at such time contain (as a result of amendment or as originally executed) a SOFR-based rate (including SOFR, a term SOFR or any other rate based upon SOFR) as a benchmark rate (and such syndicated credit facilities are identified in such notice and are publicly available for review), and

(2) the joint election by the Administrative Agent and the Borrowers to trigger a fallback from LIBO Rate and the provision by the Administrative Agent of written notice of such election to the Co-Agents.

"Floor" means the benchmark rate floor, if any, provided in this Agreement initially (as of the execution of this Agreement, the modification, amendment or renewal of this Agreement or otherwise) with respect to LIBO Rate or, if no floor is specified, zero.

"ISDA Definitions" means the 2006 ISDA Definitions published by the International Swaps and Derivatives Association, Inc. or any successor thereto, as amended or supplemented from time to time, or any successor definitional booklet for interest rate derivatives published from time to time by the International Swaps and Derivatives Association, Inc. or such successor thereto.

"Reference Time" with respect to any setting of the then-current Benchmark means (1) if such Benchmark is LIBO Rate, 11:00 a.m. (London time) on the day that is two London banking days preceding the date of such setting, and (2) if such Benchmark is not LIBO Rate, the time determined by the Administrative Agent in its reasonable discretion.

"Relevant Governmental Body" means the Federal Reserve Board or the Federal Reserve Bank of New York, or a committee officially endorsed or convened by the Federal Reserve Board or the Federal Reserve Bank of New York, or any successor thereto.

"SOFR" means, with respect to any Business Day, a rate per annum equal to the secured overnight financing rate for such Business Day published by the SOFR Administrator on the SOFR Administrator's Website on the immediately succeeding Business Day.

"SOFR Administrator" means the Federal Reserve Bank of New York (or a successor administrator of the secured overnight financing rate).

"SOFR Administrator's Website" means the website of the Federal Reserve Bank of New York, currently at http://www.newyorkfed.org, or any successor source for the secured overnight financing rate identified as such by the SOFR Administrator from time to time.

"Term SOFR" means, for the applicable Corresponding Tenor as of the applicable Reference Time, the forward-looking term rate based on SOFR that has been selected or recommended by the Relevant Governmental Body.

"Term SOFR Notice" means a notification by the Administrative Agent to the Co- Agents and the Collection Agent (on behalf of the Borrowers) of the occurrence of a Term SOFR Transition Event.

"Term SOFR Transition Event" means the determination by the Administrative Agent that (a) Term SOFR has been recommended for use by the Relevant Governmental Body, and is determinable for each Available Tenor, (b) the administration of Term SOFR is administratively feasible for the Administrative Agent and (c) a Benchmark Transition Event has previously occurred resulting in a Benchmark Replacement in accordance with this Section 4.5 that is not Term SOFR.

"Unadjusted Benchmark Replacement" means the applicable Benchmark Replacement excluding the related Benchmark Replacement Adjustment.

SCHEDULE A
COMMITMENTS

PNC'S LENDER GROUP	**COMMITMENT**
Lender Group Commitment	$20,000,000
PNC's Commitment as a Liquidity Bank	$20,000,000
PNC's Commitment as an LC Participant	$20,000,000

Exhibit 31.1

CERTIFICATION—Chief Executive Officer

I, Marc D. Miller, certify that:

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

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

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

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

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

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

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

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

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

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

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

Date: May 7, 2021

/s/ Marc D. Miller
Chief Executive Officer

Exhibit 31.2

CERTIFICATION—Chief Financial Officer

I, Steve Filton, certify that:

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

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

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

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

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

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

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

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

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

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

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

Date: May 7, 2021

/s/ Steve Filton
Executive Vice President and Chief Financial Officer

Exhibit 32.1

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

In connection with the Quarterly Report of Universal Health Services, Inc. (the "Company") on Form 10-Q for the quarter ended March 31, 2021, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Marc D. Miller, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, and to the best of my knowledge, that:

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

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

/s/ Marc D. Miller
Chief Executive Officer
May 7, 2021

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, 2021, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Steve Filton, Executive Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, and to the best of my knowledge, that:

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

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

/s/ Steve Filton
Executive Vice President and Chief Financial Officer
May 7, 2021

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.