FORM 10-Q

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

(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, 2006

OR

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

For the transition period from _____ to _____

Commission file number 1-10765

UNIVERSAL HEALTH SERVICES, INC.

(Exact name of registrant as specified in its charter)

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

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

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

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, an accelerated filer or a non-accelerated filer. See definition of "accelerated filer and large accelerated filer" in Rule 12b-2 or The Exchange Act (check one):

Large accelerated filer ☒ **Accelerated filer ☐** **Non-accelerated filer ☐**

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, 2006:

Class A	3,328,404
Class B	50,483,870
Class C	335,800
Class D	25,593

UNIVERSAL HEALTH SERVICES, INC.

I N D E X

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,	
	2006	2005
Net revenues	$1,034,289	$1,006,645
Operating charges:		
Salaries, wages and benefits	442,232	406,340
Other operating expenses	248,101	231,165
Supplies expense	128,513	126,536
Provision for doubtful accounts	75,007	82,408
Depreciation and amortization	39,030	39,696
Lease and rental expense	16,232	15,467
Hurricane related expenses	6,904	—
Hurricane insurance recoveries	(22,291)	—
	933,728	901,612
Income before interest expense, minority interests and income taxes	100,561	105,033
Interest expense, net	8,525	10,676
Minority interests in earnings of consolidated entities	11,177	7,919
Income before income taxes	80,859	86,438
Provision for income taxes	30,367	31,748
Income from continuing operations	50,492	54,690
Income from discontinued operations, net of income tax expense of $348 and $4.2 million during the three month periods ended March 31, 2006 and 2005, respectively	592	6,719
Net income	$ 51,084	$ 61,409
Basic earnings per share:		
From continuing operations	$ 0.94	$ 0.95
From discontinued operations	0.01	0.12
Total basic earnings per share	$ 0.95	$ 1.07
Diluted earnings per share:		
From continuing operations	$ 0.87	$ 0.89
From discontinued operations	0.01	0.10
Total diluted earnings per share	$ 0.88	$ 0.99
Weighted average number of common shares – basic	53,768	57,523
Add: Shares for conversion of convertible debentures	6,577	6,577
Other share equivalents	161	316
Weighted average number of common shares and equivalents—diluted	60,506	64,416

See accompanying notes to these consolidated financial statements.

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

	March 31, 2006	December 31, 2005
Assets		
Current assets:		
Cash and cash equivalents	$ 8,211	$ 7,963
Accounts receivable, net	547,800	499,726
Supplies	53,556	52,835
Other current assets	25,608	27,267
Deferred income taxes	23,404	20,507
Total current assets	658,579	608,298
Property and equipment	2,415,905	2,303,348
Less: accumulated depreciation	(905,712)	(873,695)
	1,510,193	1,429,653
Other assets:		
Goodwill	686,728	686,211
Deferred charges	9,799	10,152
Other	119,748	124,395
	816,275	820,758
	$2,985,047	$2,858,709
Liabilities and Stockholders' Equity		
Current liabilities:		
Current maturities of long-term debt	$ 3,999	$ 5,191
Accounts payable and accrued liabilities	481,776	421,286
Federal and state taxes	128,974	97,693
Total current liabilities	614,749	524,170
Other noncurrent liabilities	300,716	289,195
Minority interests	170,222	159,879
Long-term debt	603,533	637,654
Deferred income taxes	41,281	42,713
Commitments and contingencies		
Common stockholders' equity:		
Class A Common Stock, 3,328,404 shares outstanding in 2006 and 3,328,404 in 2005	33	33
Class B Common Stock, 50,472,015 shares outstanding in 2006 and 50,281,543 in 2005	505	503
Class C Common Stock, 335,800 shares outstanding in 2006 and 335,800 in 2005	3	3
Class D Common Stock, 25,619 shares outstanding in 2006 and 25,626 in 2005	—	—
Cumulative dividends	(45,443)	(41,157)
Retained earnings	1,310,169	1,256,437
Accumulated other comprehensive loss	(10,721)	(10,721)
	1,254,546	1,205,098
	$2,985,047	$2,858,709

See accompanying notes to these condensed consolidated financial statements.

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

	Three Months Ended March 31,	
	2006	2005
Cash Flows from Operating Activities:		
Net income	$ 51,084	$ 61,409
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation & amortization	39,030	45,506
Accretion of discount on convertible debentures	3,573	3,428
Hurricane insurance recoveries	(22,291)	—
Gains on sales of assets and businesses	—	(9,095)
Provision for asset impairment	—	3,105
Changes in assets & liabilities, net of effects from acquisitions and dispositions:		
Accounts receivable	(48,074)	(65,960)
Accrued interest	3,337	4,147
Accrued and deferred income taxes	27,118	32,084
Other working capital accounts	30,635	25,197
Other assets and deferred charges	1,039	15,451
Other	4,707	3,733
Minority interests in earnings of consolidated entities, net of distributions	10,343	5,293
Accrued insurance expense, net of commercial premiums paid	22,529	21,862
Payments made in settlement of self-insurance claims	(12,690)	(11,548)
Net cash provided by operating activities	110,340	134,612
Cash Flows from Investing Activities:		
Property and equipment additions, net of disposals	(83,203)	(57,920)
Acquisition of assets and businesses	(11,735)	(5,225)
Hurricane insurance recoveries received	28,000	—
Proceeds received from sales of assets and businesses	—	124,589
Net cash (used in) provided by investing activities	(66,938)	61,444
Cash Flows from Financing Activities:		
Reduction of long-term debt	(38,886)	(176,799)
Additional borrowings	—	8,114
Issuance of common stock	1,584	771
Repurchase of common shares	(1,566)	(1,255)
Dividends paid	(4,286)	(4,645)
Financing costs on new revolving credit facility	—	(1,179)
Net cash used in financing activities	(43,154)	(174,993)
Increase in cash and cash equivalents	248	21,063
Cash and cash equivalents, beginning of period	7,963	33,125
Cash and cash equivalents, end of period	$ 8,211	$ 54,188
Supplemental Disclosures of Cash Flow Information:		
Interest paid	$ 1,615	$ 4,422
Income taxes paid, net of refunds	$ 3,598	$ 4,272

See accompanying notes to these condensed consolidated financial statements.

(1) General

This Report on Form 10-Q is for the Quarterly period ended March 31, 2006. In this Quarterly Report, "we," "us," "our" and the "Company" refer to Universal Health Services, Inc. and its subsidiaries.

You should carefully review the information contained in this Quarterly Report, and should particularly consider any risk factors that we set forth in this Quarterly Report and in other reports or documents that we file from time to time with the SEC. In this Quarterly Report, we state our beliefs of future events and of our future financial performance. In some cases, you can identify those so-called "forward-looking statements" by words such as "may," "will," "should," "expects," "plans," "anticipates," "believes," "estimates," "predicts," "potential," or "continue" or the negative of those words and other comparable words. You should be aware that those statements are only our predictions. Actual events or results may differ materially. In evaluating those statements, you should specifically consider various factors, including the risks outlined in Item 2. Management's Discussion and Analysis of Results of Operations and Financial Condition – Forward Looking Statements and Risk Factors. Those factors may cause our actual results to differ materially from any of our forward-looking statements.

The condensed consolidated financial statements include the accounts of our majority-owned subsidiaries and partnerships controlled by us, or our subsidiaries, as managing general partner. The condensed consolidated financial statements included herein have been prepared by us, without audit, pursuant to the rules and regulations of the Securities and Exchange Commission and reflect all normal and recurring adjustments which, in our opinion, are necessary to fairly present results for the interim periods. Certain information and footnote disclosures normally included in financial statements prepared in accordance with accounting principles generally accepted in the United States of America have been condensed or omitted pursuant to such rules and regulations, although we believe that the accompanying disclosures are adequate to make the information presented not misleading. It is suggested that these condensed consolidated financial statements be read in conjunction with the consolidated financial statements, significant accounting policies and the notes thereto included in our Annual Report on Form 10-K for the year ended December 31, 2005. Certain prior year amounts have been reclassified to conform with current year financial statement presentation.

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

Relationship with Universal Health Realty Income Trust:

At March 31, 2006, we held approximately 6.7% 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 pursuant to the terms of which, we conduct the Trust's day-to-day affairs, provide administrative services and present investment opportunities. In addition, certain of our officers and directors are also officers and/or directors of the Trust. Management believes that it has the ability to exercise significant influence over the Trust, therefore we account for our investment in the Trust using the equity method of accounting. We earned an advisory fee from the Trust, which is included in net revenues in the accompanying condensed consolidated statements of income, of $347,000 and $355,000 during the three month periods ended March 31, 2006 and 2005, respectively. Our pre-tax share of income from the Trust was $331,000 and $300,000 during the three month periods ended March 31, 2006 and 2005, respectively, and is included in net revenues in the accompanying condensed consolidated statements of income. The carrying value of this investment was $9.5 million at March 31, 2006 and $9.7 million at December 31, 2005, and is included in other assets in the accompanying condensed consolidated balance sheets. The market value of this investment was $28.8 million at March 31, 2006 and $24.7 million at December 31, 2005.

Total rent expense under the operating leases on the hospital facilities with the Trust was $4.0 million and $4.1 million during the three month periods ended March 31, 2006 and 2005, respectively. In addition, certain of our subsidiaries are tenants in several medical office buildings owned by limited liability companies in which the Trust holds non-controlling ownership interests.

The Trust commenced operations in 1986 by purchasing certain subsidiaries from us and immediately leasing the properties back to our respective subsidiaries. Most of the leases were entered into at the time the Trust commenced operations and provided for initial terms of 13 to 15 years with up to six additional 5-year renewal terms. Each lease also provided for additional or bonus rental, as discussed below. In 1998, the lease for McAllen Medical Center was amended to provide that the last two renewal terms would also be fixed at the initial agreed upon rental. This lease amendment was in connection with certain concessions granted by us with respect to the renewal of other leases. The base rents are paid monthly and the bonus rents are computed and paid on a quarterly basis, based upon a computation that compares current quarter revenue to a corresponding quarter in the base year. The leases with our subsidiaries are unconditionally guaranteed by us and are cross-defaulted with one another.

Pursuant to the terms of the leases with the Trust, we have the option to renew the leases at the lease terms described above by providing notice to the Trust at least 90 days prior to the termination of the then current term. We also have the right to purchase the respective leased facilities at the end of the lease terms or any renewal terms at the appraised market value. 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.

During the third quarter of 2005, Chalmette Medical Center (“Chalmette”), our two story, 138-bed acute care hospital located in Chalmette, Louisiana was severely damaged and closed as a result of Hurricane Katrina. The majority of the real estate assets of Chalmette were leased from the Trust, by our subsidiary and, in accordance with the terms of the lease, and as part of an overall evaluation of the leases between our subsidiaries and the Trust, we elected to offer substitution properties to the Trust rather than exercise our right to rebuild the facility or offer cash for Chalmette. Independent appraisals were obtained by the Trust and us which indicated that the pre-hurricane fair market value of the leased facility was $24.0 million (“FMV of Chalmette”).

The Trust has agreed, subject to certain closing conditions, to terminate the lease between Chalmette and the Trust and to transfer the real property assets and all rights attendant thereto (including insurance proceeds) of Chalmette to us in exchange and substitution for newly constructed real property assets owned by us (“Capital Additions”) at Wellington Regional Medical Center (“Wellington”), The Bridgeway (“Bridgeway”) and Southwest Healthcare System-Inland Valley Campus (“Inland Valley”), in satisfaction of the obligations under the Chalmette lease. The estimated total value of this exchange and substitution package is approximately $25.2 million based upon the combined actual and estimated construction costs of the Capital Additions. Since the estimated total value of the substitution package is expected to exceed the FMV of Chalmette, the excess amount will be paid to us in cash upon completion of the Inland Valley Capital Additions. The total rent payable by us to the Trust on the Capital Additions included in the substitution package (excluding the rent on the Capital Additions in excess of the FMV of Chalmette) is expected to closely approximate the $1.6 million to $1.7 million total annual rent paid by us to the Trust under the Chalmette lease during the last three years. We will pay incremental rent on the Capital Additions in excess of the FMV of Chalmette at a rate equal to the prevailing five-year treasury rate plus 200 basis points at the time of funding (minimum rate 6.75%).

Also in April of 2006, as part of the overall arrangement, we agreed not to exercise our purchase options under the leases at the end of the current lease terms but rather, we agreed to early five year renewals of the leases between the Trust and each of Inland Valley, Wellington and McAllen Medical Center, which were scheduled to mature on December 31, 2006, and Bridgeway, which was scheduled to mature on December 31, 2009, on the same economic terms as the current leases. To reflect the lease renewals, on April 24, 2006, the Trust and each of the individual lessees entered into amended and restated leases relating to their respective, individual properties.

Pursuant to the Master Lease Document by and among the Trust and certain subsidiaries of ours, dated December 24, 1986 (the "Master Lease"), which governs all leases of properties with our subsidiaries, we have the right to purchase the leased properties at the end of each lease term at each property's fair market value purchase price. As part of the overall exchange and substitution proposal, as well as the early five year lease renewals on Inland Valley, Wellington, McAllen and Bridgeway, the Trust agreed to amend the Master Lease to include a change of control provision (as defined) and a provision granting us the right to purchase each of the leased properties, at their fair market value purchase price, on one month's notice to the Trust in the event of such change of control occurs.

After giving effect to the Asset Exchange and Substitution Agreement and the various lease renewals discussed above, subsidiaries of ours will lease four hospitals facilities owned by the Trust with terms expiring in 2011 through 2014. The table below details the renewal options and terms for each of our four hospital facilities:

Hospital Name	Type of Facility	Annual Minimum Rent	End of Lease Term	Renewal Term (years)
McAllen Medical Center	Acute Care	$ 5,485,000	December, 2011	20 (a)
Wellington Regional Medical Center	Acute Care	$ 3,030,000	December, 2011	20 (b)
Southwest Healthcare System, Inland Valley Campus	Acute Care	$ 2,597,000 (d)	December, 2011	20 (b)
The Bridgeway	Behavioral Health	$ 930,000	December, 2014	10 (c)

(a) We have four 5-year renewal options at existing lease rates (through 2031).
(b) We have two 5-year renewal options at existing lease rates (through 2021) and two 5-year renewal options at fair market value lease rates (2022 through 2031).
(c) We have two 5-year renewal options at fair market value lease rates (2015 through 2024).
(d) Excludes potential incremental rent on Capital Additions in excess of FMV of Chalmette.

Other Related Party Transactions:

Our Chairman and Chief Executive Officer is a member of the Board of Directors of Broadlane, Inc. In addition, the Company and certain Directors and members of our executive management team own approximately 6% of the outstanding shares of Broadlane, Inc. as of March 31, 2006. Broadlane, Inc. provides contracting and other supply chain services to us and various other healthcare organizations.

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

We invested $3.3 million for a 25% ownership interest in an information technology company that provides laboratory information system and order management technology to many of our acute care hospitals. We have also committed to pay this company a license fee totaling $25.3 million over a five-year period, of which $9.7 million has been paid as of March 31, 2006.

(3) Other Noncurrent and Minority Interest Liabilities

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

As of March 31, 2006 and December 31, 2005, the minority interest liability of $170.2 million and $159.9 million, respectively, consists primarily of: (i) a 27.5% outside ownership interest in four acute care facilities located in Las Vegas, Nevada; (ii) a 20% outside ownership in an acute care facility located in Washington D.C., and; (iii) a 10% outside ownership in two acute care facilities located in Louisiana.

In connection with the four acute care facilities located in Las Vegas, Nevada, the outside owners have certain "put rights" that may require the respective limited liabilities companies ("LLCs") to purchase the minority member's interests upon the occurrence of: (i) certain specified financial conditions falling below established thresholds; (ii) breach of the management contract by the managing member (a subsidiary of ours), or; (iii) if the minority member's ownership percentage is reduced to less than certain thresholds.

We own a 90% controlling interest in the two acute care facilities located in Louisiana and the remaining 10% is owned by an outside minority member. These facilities were severely damaged and closed as a result of Hurricane Katrina during the third quarter of 2005. Since the Hurricane, all facilities remain closed and non-operational and we continue to assess the damage and the likely recovery period for the facilities and surrounding communities. In connection with these facilities, the minority member has certain "put rights" which can be exercised at any time within 180 days of the third (January, 2007), fifth (January, 2009), tenth (January, 2014) or fifteenth (January, 2019) anniversary of the closing dates, or at any time if certain determinations are made as specified in the agreement. These put rights, if exercised, would require the LLC to purchase the minority member's interest at a price that is the greater of: (i) a fixed amount as stipulated in the agreement that approximates the minority member's initial contribution in each facility, or; (ii) the minority member's interest multiplied by the annualized net revenue of each facility for the 12 month period ending on the date of exercise of the put right. We also have certain "call rights" that would allow the LLC to purchase the minority member's shares which can be exercised at any time within 180 days of the third, fifth, tenth or fifteenth anniversary of the closing dates, or at any time if certain determinations are made as specified in the agreement. These call rights allow the LLC to purchase the minority member's interest at a price that is the greater of: (i) a fixed amount as stipulated in the agreement that approximates the minority member's initial contribution in each facility, plus a premium, or; (ii) the minority member's percentage interest multiplied by the annualized net revenue of each facility plus a premium for the 12 month period ending on the date of exercise of the call right.

(4) Commitments and Contingencies

Due to unfavorable pricing and availability trends in the professional and general liability insurance markets, our subsidiaries have assumed a greater portion of the hospital professional and general liability risk as the cost of commercial professional and general liability insurance coverage has risen significantly. Effective January 1, 2006, most of our subsidiaries were self-insured for malpractice exposure up to $20 million per occurrence. We purchased an umbrella excess policy for our subsidiaries through a commercial insurance carrier for coverage in excess of $20 million per occurrence with a $75 million aggregate limitation. Given these insurance market conditions, there can be no assurance that a continuation of these unfavorable trends, or a sharp increase in claims asserted against us, will not have a material adverse effect on our future results of operations.

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

For the period from January 1, 1998 through December 31, 2001, most of our subsidiaries were covered under commercial insurance policies with PHICO, a Pennsylvania based insurance company that was placed into liquidation during the first quarter of 2002. As a result of PHICO's liquidation, we recorded a $40 million pre-tax charge during 2001 to reserve for PHICO claims that became our liability. However, we continue to be entitled to receive reimbursement from state insurance guaranty funds and/or PHICO's estate for a portion of certain claims ultimately paid by us.

As of March 31, 2006, the total accrual for our professional and general liability claims was $232.3 million ($224.6 million net of expected recoveries), of which $24.0 million is included in other current liabilities. As of December 31, 2005, the total accrual for our professional and general liability claims was $225.2 million ($216.4 million net of expected recoveries), of which $24.0 million is included in other current liabilities. Included in other assets was $7.7 million as of March 31, 2006 and $8.8 million as of December 31, 2005, related to estimated expected recoveries from various state guaranty funds in connection with PHICO related professional and general liability claims payments.

Prior to 2006, we had commercial insurance policies for a large portion of our property loss exposure which provided coverage with varying sub-limits and aggregates for property and business interruption losses resulting from damage sustained from fire, flood, windstorm and earthquake. The specific amount of commercial insurance coverage was dependent on factors such as location of the facility and loss causation.

Due to a sharp increase in property losses experienced nationwide in recent years, the cost of commercial property insurance has increased significantly. As a result, catastrophic coverage for flood, earthquake and windstorm has been limited to annual aggregate losses (as opposed to per occurrence losses) and coverage has been limited to lower sub-limits for named windstorms, earthquakes in certain states such as Alaska, California, Puerto Rico and Washington and for floods in facilities located in designated flood zones. Given these insurance market conditions, there can be no assurance that a continuation of these unfavorable trends, or a sharp increase in uninsured property losses sustained by us, will not have a material adverse effect on our future results of operations.

As of March 31, 2006, we had outstanding letters of credit and surety bonds totaling $81 million consisting of: (i) $69 million related to our self-insurance programs; (ii) $6 million consisting primarily of collateral for outstanding bonds of an unaffiliated third party and public utility, and; (iii) $6 million of debt guarantees related to entities in which we own a minority interest.

We have a long-term contract with a third party that expires in 2012, to provide certain data processing services for our acute care and behavioral health facilities.

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

On August 5, 2004, we were named, together with our subsidiary, Valley Hospital Medical Center, Inc., as defendants in a lawsuit filed in Clark County, Nevada, under the caption Deborah Louise Poblocki v. Universal Health Services, Inc., et al., No. 04-A-489927-C. The plaintiff alleged that the hospital overcharged her and other similarly situated patients who lacked health insurance. The complaint sought class action treatment but no class was certified. The matter was settled in February, 2006 on terms favorable to us.

We and our South Texas Health System affiliates, which operate McAllen Medical Center, McAllen Heart Hospital, Edinburg Regional Medical Center and certain other affiliates, were served with a subpoena dated November 21, 2005, issued by the Office of Inspector General of the Department of Health and Human Services. The Civil Division of the U.S. Attorney's office in Houston, Texas has indicated that the subpoena is part of an investigation under the False Claims Act of compliance with Medicare and Medicaid rules and regulations pertaining to the employment of physicians and the solicitation of patient referrals from physicians from January 1, 1999 to the date of the subpoena related to the South Texas Health System. We are cooperating in the investigation and are producing documents responsive to the subpoena. We monitor all aspects of our business and have developed a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards. Because the law in this area is complex and constantly evolving, governmental investigation or litigation may result in interpretations that are inconsistent with industry practices, including ours. This matter is at an early stage and we are unable to evaluate the existence or extent of any potential financial exposure at this time.

On November 1, 2005, our management company and several of our facilities located in California, including Inland Valley Medical Center, Rancho Springs Medical Center, Del Amo Hospital and Corona Regional Medical Center ("Hospitals") were named as defendants in a wage and hour lawsuit filed in Los Angeles Superior Court under the caption Lasko-Hoellinger, et al v. UHS of Delaware, Inc., et al. While two of the four original plaintiffs in that case voluntarily requested that they be dismissed as plaintiffs from that lawsuit, the remaining two plaintiffs are seeking to have the matter certified as a class action. The remaining plaintiffs are alleging, among other things, that they are entitled to recover damages from the Hospitals for missed breaks and other alleged violations of various California Labor Code sections and applicable wage orders for a period of at least one year prior to the filing of the case. The Hospitals have denied liability and are defending the case, which has not yet been certified as a class action by the court. Although we are unable to evaluate the extent of any potential financial exposure at this time, this matter could have a material adverse effect on our future results of operations.

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

The healthcare industry is subject to numerous laws and regulations which include, among other things, matters such as government healthcare participation requirements, various licensure and accreditations,

reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government action has increased with respect to investigations and/or allegations concerning possible violations of fraud and abuse and false claims statutes and/or regulations by healthcare providers. Providers that are found to have violated these laws and regulations may be excluded from participating in government healthcare programs, subjected to fines or penalties or required to repay amounts received from government for previously billed patient services. While management believes its policies, procedures and practices comply with governmental regulations, no assurance can be given that we will not be subjected to governmental inquiries or actions.

(5) Segment Reporting

Our reportable operating segments consist of acute care hospital services and behavioral health care services. The "Other" segment column below includes centralized services including information services, purchasing, reimbursement, accounting, taxation, legal, advertising, design and construction, and patient accounting as well as the operating results for our other operating entities including outpatient surgery and radiation centers. Also included in the Other segment column for both periods presented are the combined assets of $5.0 million and $332.3 million as of March 31, 2006 and 2005, respectively, related to the acute care facilities and international acute care hospital services reflected as discontinued operations on our Consolidated Statements of Income. The chief operating decision making group for our acute care hospital services and behavioral health care services is comprised of the President and Chief Executive Officer, and the lead executives of each operating segment. The lead executive for each operating segment also manages 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, 2005.

Four of our acute care facilities were severely damaged and closed as a result of Hurricane Katrina during the third quarter of 2005. The resulting hurricane-related expenses and hurricane-related insurance recoveries are reflected in the Acute Care Hospital Services data shown below for the three months period ended March 31, 2006.

	Three Months Ended March 31, 2006			
	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Dollar amounts in thousands)			
Gross inpatient revenues	$1,941,155	$409,400	—	$2,350,555
Gross outpatient revenues	$ 708,511	$ 53,274	$ 20,721	$ 782,506
Total net revenues	$ 769,952	$253,628	$ 10,709	$1,034,289
Income/(loss) before income taxes	$ 74,555	$ 49,611	($ 43,307)	$ 80,859
Total assets as of 3/31/06	$2,020,202	$720,857	$ 243,988	$2,985,047
Licensed beds	4,989	6,397	—	11,386
Available beds	4,688	6,339	—	11,027
Patient days	283,248	451,885	—	735,133
Admissions	63,167	28,072	—	91,239
Average length of stay	4.5	16.1	—	8.1

	Three Months Ended March 31, 2005			
	Acute Care Hospital Services	Behavioral Health Services	Other	Total Consolidated
	(Dollar amounts in thousands)			
Gross inpatient revenues	$1,946,868	$325,897	—	$2,272,765
Gross outpatient revenues	$ 690,580	$ 48,515	$ 23,960	$ 763,055
Total net revenues	$ 806,624	$189,560	$ 10,461	$1,006,645
Income/(loss) before income taxes	$ 85,250	$ 39,846	($ 38,658)	$ 86,438
Total assets as of 3/31/05	$2,061,972	$429,134	$ 367,603	$2,858,709
Licensed beds	5,549	4,414	—	9,963
Available beds	5,126	4,356	—	9,482
Patient days	312,500	325,874	—	638,374
Admissions	67,091	25,045	—	92,136
Average length of stay	4.7	13.0	—	6.9

(6) 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 year. Diluted earnings per share are based on the weighted average number of common shares outstanding during the year adjusted to give effect to common stock equivalents.

The following table sets forth the computation of basic and diluted earnings per share for the three month periods ended March 31, 2006 and 2005 (in thousands, except per share data):

	Three Months Ended March 31, (amounts in thousands)	
	2006	2005
Basic:		
Income from continuing operations	$ 50,492	$ 54,690
Less: Dividends on unvested restricted stock, net of taxes	(23)	(27)
Income from continuing operations – basic	$ 50,469	$ 54,663
Income from discontinued operations	592	6,719
Net income – basic	$ 51,061	$ 61,382
Diluted:		
Income from continuing operations	$ 50,492	$ 54,690
Less: Dividends on unvested restricted stock, net of taxes	(23)	(27)
Add: Debenture interest, net of taxes	2,457	2,382
Income from continuing operations-diluted	$ 52,926	$ 57,045
Income from discontinued operations	592	6,719
Net income – diluted	$ 53,518	$ 63,764
Weighted average number of common shares	53,768	57,523
Net effect of dilutive stock options and grants based on the treasury stock method	161	316
Assumed conversion of discounted convertible debentures	6,577	6,577
Weighted average number of common shares and equivalents	60,506	64,416
Earnings Per Basic Share:		
From continuing operations	$ 0.94	$ 0.95
From discontinued operations	0.01	0.12
Total earnings per basic share	$ 0.95	$ 1.07
Earnings Per Diluted Share:		
From continuing operations	$ 0.87	$ 0.89
From discontinued operations	0.01	0.10
Total earnings per diluted share	$ 0.88	$ 0.99

Stock-Based Compensation: At March 31, 2006, we have a number of stock-based employee compensation plans. Effective January 1, 2006, we adopted SFAS No. 123R and related interpretations and began expensing the grant-date fair value of stock options. Prior to January 1, 2006, we accounted for these plans under the recognition and measurement principles of APB Opinion No. 25, "Accounting for Stock Issued to Employees," and related interpretations. Accordingly, no compensation expense was reflected in net income for stock option grants, as all options granted under the plan had an original exercise price equal to the market value of the underlying shares on the date of grant. The estimated impact of adopting SFAS No. 123R for the year ended December 31, 2006, assuming no stock options are granted during the year, is expected to reduce net income by $3.8 million ($6.1 million pre-tax), or approximately $.06 per diluted share. In accordance with SFAS No. 123, the pro forma impact of expensing stock options for the year ended December 31, 2005 would have been a reduction in net income by $3.9 million ($6.2 million pre-tax) for the year, or $.06 per diluted share.

We adopted SFAS No. 123R using the modified prospective transition method and therefore we have not restated prior periods. Under this transition method, compensation costs associated with stock options recognized in 2006 includes amortization related to the remaining unvested portion of stock option awards granted prior to January 1, 2006, and will include amortization expense related to new awards granted after January 1, 2006.

The expense associated with share-based compensation arrangements is a non-cash charge. In the Consolidated Statements of Cash Flows, share-based compensation expense is an adjustment to reconcile net income to cash provided by operating activities. Prior to the adoption of SFAS No. 123R, we presented tax benefits resulting from share-based compensation as operating cash flows in the Consolidated Statements of Cash Flows. SFAS No. 123R requires that cash flows resulting from tax deductions in excess of compensation cost recognized be classified as financing cash flows. For the first quarter of 2006, there were no excess tax benefits generated.

An aggregate of four million shares of Class B Common Stock have been reserved under the 2005 Stock Incentive Plan, and there have been 328,500 stock options, net of cancellations, granted under this plan as of March 31, 2006. There are 3,671,500 shares available for future grant under our 2005 Stock Incentive Plan.

For stock options granted prior to the adoption of SFAS No. 123R, the effect on net income and earnings per share if we had applied the fair value recognition provisions of SFAS No. 123, "Accounting for Stock-Based Compensation," to our stock option plan as of March 31, 2005, is shown in the table below (in thousands, except per share data):

	Three Months Ended March 31, 2005
Income from continuing operations	$ 54,690
Add: total stock-based compensation expenses included in net income (a)	565
Deduct: total stock-based employee compensation expenses determined under fair value based methods for all awards (b)	(1,365)
Pro forma net income from continuing operations	53,890
Income from discontinued operations, net of income taxes	6,719
Pro forma net income	$ 60,609
Basic earnings per share, as reported:	
From continuing operations	$ 0.95
From discontinued operations	$ 0.12
Total basic earnings per share, as reported	$ 1.07
Basic earnings per share, pro forma:	
From continuing operations	$ 0.94
From discontinued operations	$ 0.11
Total basic earnings per share, pro forma	$ 1.05
Diluted earnings per share, as reported:	
From continuing operations	$ 0.89
From discontinued operations	$ 0.10
Total diluted earnings per share, as reported	$ 0.99
Diluted earnings per share, pro forma:	
From continuing operations	$ 0.88
From discontinued operations	$ 0.10
Total diluted earnings per share, pro forma	$ 0.98

(a) Net of income tax effect of $331,000.
(b) Net of income tax effect of $800,000.

Under our stock option plan, the exercise price equals the market price of the company's stock on the date of grant. Options under the plan generally vest ratably over four years and expire five years after the date of grant.

Compensation cost related to stock options is generally recognized over the straight-line method over the stated vesting period of the award. As of January 1, 2006, there was $15.0 million of unrecognized compensation cost related to nonvested stock options expected to be recognized over a period of approximately four years. During the first quarter of 2006, compensation cost of $1.6 million ($1.0 million after-tax) was recognized related to outstanding stock options scheduled to vest post January 1, 2006. The fair value of the options granted or vesting after January 1, 2006 was estimated using the Black Scholes option valuation model with the following weighted average assumption ranges:

Expected volatility	44.7%
Expected dividend yield	0.4%
Expected life (in years)	3.97
Risk-free interest rate	3.7%

The risk-free rate is based on the U.S. Treasury zero coupon four year yield in effect at the time of grant. The expected life of stock options granted was estimated using the historical behavior of employees. Expected volatility was based on historical volatility for a period equal to the stock option's expected life. Expected dividend yield is based on our actual dividend yield at the time of grant.

The weighted-average grant-date fair value of options granted during the first quarter of 2006 was $14.07 per option.

A summary of stock option activity is presented below:

Outstanding Options	Number of Shares	Weighted Average Exercise Price	Range (High-Low)
Balance, January 1, 2006	1,506,325	$ 46.39	$54.88 -$37.82
Granted	39,500	$ 51.04	$51.04 -$51.04
Exercised	(54,600)	$ 41.42	$48.85 -$38.50
Cancelled	(30,500)	$ 48.36	$48.85 -$38.50
Balance, March 31, 2006	1,460,725	$ 46.66	$54.88 -$37.82
Exercisable, March 31, 2006	484,449	$ 43.57	$54.88 -$37.82

The aggregate intrinsic value of outstanding and exercisable stock options at March 31, 2006 is $6.0 million and $3.5 million, respectively. The total in-the-money value of all stock options exercised during the first quarter of 2006 was $350,000.

For restricted grant awards issued after January 1, 2006, the grant-date fair value of the restricted stock is generally estimated on the date of grant based on the market price of the stock, and compensation cost is generally amortized to expense on a straight-line basis over the vesting period during which employees perform related services.

A summary of restricted stock grant activity is presented below:

Outstanding Grants	Number of Shares	Weighted Average Grant-Date Fair Value
Balance, January 1, 2006	248,536	$ 49.66
Granted	200,000	$ 50.79
Paid Out	(39,780)	$ 48.05
Cancelled	(393)	$ 51.15
Balance, March 31, 2006	408,363	$ 50.42

The compensation cost charges against income in the first quarter of 2006 for restricted stock grants was approximately $1.1 million (or $680,000 after-taxes). As of March 31, 2006, there was approximately $12.1 million of unrecognized compensation cost related to restricted stock grants.

(7) Comprehensive Income

Comprehensive income or loss is recorded in accordance with the provisions of SFAS No.130, “Reporting Comprehensive Income”. SFAS No.130 establishes standards for reporting comprehensive income and its components in financial statements. Comprehensive income (loss) is comprised of net income, changes in unrealized gains or losses on derivative financial instruments and foreign currency translation adjustments.

(amounts in thousands)	Three Months Ended March 31, 2006	2005
Net income	$51,084	$61,409
Other comprehensive income (loss):		
Foreign currency translation adjustments (a)	—	(3,688)
Adjustment for losses reclassified into income (b)	—	732
Unrealized derivative gains/(losses) on cash flow hedges (c)	—	(183)
Comprehensive income	$51,084	$58,270

(a) Net of income tax benefit of $2.1 million during the three month period ended March 31, 2005.
(b) Net of income tax provision of $648 during the three month period ended March 31, 2005.
(c) Net of income tax benefit of $105 during the three month period ended March 31, 2005.

(8) Dispositions and Acquisitions

Acquisition during the three months ended March 31, 2006:

- We spent $12 million to acquire the assets of a closed behavioral health care facility located in Florida.

Acquisition during the three months ended March 31, 2005:

- During the first quarter of 2005, we acquired the membership interests of McAllen Medical Center Physicians, Inc. and Health Clinic P.L.L.C., a Texas professional limited liability company. In connection with this transaction, we paid $5.2 million in cash and assumed a $9.8 million purchase price payable, which is contingent on certain conditions as set forth in the purchase agreement.

Dispositions during the three months ended March 31, 2005:

During the first quarter of 2005, in conjunction with our strategic plan to sell certain acute care hospitals, as well as certain other under-performing assets, we sold the following hospitals and businesses for total cash proceeds of $125 million:

- a 430-bed hospital located in Bayamon, Puerto Rico;
- a 180-bed hospital located in Fajardo, Puerto Rico, and;
- a home health business in Bradenton, Florida.

The operating results of these facilities, as well as the gains resulting from the divestitures, are reflected as "Income from discontinued operations, net of income taxes" in the Consolidated Statements of Income for the three month periods ended March 31, 2006 and 2005. Also, subsequent to March 31, 2005, we sold our 81.5% ownership interest in Medi-Partenaires, an operating company that owned and managed 14 hospitals in France (sold during the second quarter of 2005) and we sold the assets of a closed women's hospital located in Edmond, Oklahoma (sold during the third quarter of 2005). The operating results of these facilities are also reflected as "Income from discontinued operations, net of income taxes" in the Consolidated Statements of Income for the three month periods ended March 31, 2006 and 2005.

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

Income from discontinued operations, net of income taxes	Three Months Ended March 31,	
	2006	2005
Net revenues	$ 204	$119,549
Income from operations	940	4,936
Gain on divestitures	—	9,096
Provision for asset impairment	—	(3,105)
Income from discontinued operations, pre-tax	940	10,927
Income tax provision	(348)	(4,208)
Income from discontinued operations, net of income taxes	$ 592	$ 6,719

(9) Dividends

A dividend of $.08 per share or $4.3 million in the aggregate was declared by the Board of Directors on January 18, 2006 and was paid on March 15, 2006 to shareholders of record as of March 1, 2006.

(10) Pension Plan

The following table shows the components of net periodic pension cost for our defined benefit pension plan as of March 31, 2006 and 2005 (amounts in thousands):

	Three Months Ended March 31,	
	2006	2005
Service cost	$ 348	$ 247
Interest cost	1,100	1,072
Expected return on assets	(935)	(957)
Recognized actuarial loss	444	415
Net periodic pension cost	$ 957	$ 777

During the three months ended March 31, 2006 there were no employer contributions paid.

Item 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF RESULTS OF OPERATIONS AND FINANCIAL CONDITION

Overview

Our principal business is owning and operating, through our subsidiaries, acute care hospitals, behavioral health centers and ambulatory surgery and radiation oncology centers. As of March 31, 2006, we owned and/or operated 28 acute care hospitals and 101 behavioral health centers located in 32 states, Washington, DC and Puerto Rico. Since the third quarter of 2005, four of our acute care facilities in Louisiana were severely damaged and remain closed and non-operational as a result of Hurricane Katrina. As part of our ambulatory treatment centers division, we managed and/or owned outright or in partnership with physicians, 13 surgical hospitals, surgery centers and radiation oncology centers located in 6 states and Puerto Rico.

Net revenues from our acute care hospitals, surgical hospitals, surgery centers and radiation oncology centers accounted for 75% and 81% of our consolidated net revenues during the three month periods ended March 31, 2006 and 2005, respectively. Net revenues from our behavioral health care facilities accounted for 25% and 19% of our consolidated net revenues during the three month periods ended March 31, 2006 and 2005, respectively.

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

Forward-Looking Statements and Risk Factors

This 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.

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

- our ability to comply with existing laws and government regulations and/or changes in laws and government regulations;
- possible unfavorable changes in the levels and terms of reimbursement for our charges by third party payors or government programs, including Medicare or Medicaid;
- our ability to enter into managed care provider agreements on acceptable terms;
- the outcome of known and unknown litigation, government investigations, and liabilities and other claims asserted against us;
- national, regional and local economic and business conditions
- competition from other healthcare providers, including physician owned facilities in certain markets, including McAllen, Texas, the site of one of our largest acute care facilities;
- technological and pharmaceutical improvements that increase the cost of providing, or reduce the demand for healthcare;

- our ability to attract and retain qualified personnel, nurses, physicians and other healthcare professionals and the impact on our labor expenses resulting from a shortage of nurses and other healthcare professionals;
- demographic changes;
- our ability to successfully integrate and improve our recent acquisitions and the availability of suitable acquisitions and divestiture opportunities;
- a significant portion of our revenues is produced by a small number of our facilities;
- the availability and terms of capital to fund the growth of our business;
- some of our acute care facilities continue to experience decreasing inpatient admission trends;
- an increase in the number of uninsured and self-pay patients treated at our acute care facilities that unfavorably impacts our ability to satisfactorily and timely collect our self-pay patient accounts;
- our financial statements reflect large amounts due from various commercial and private payors and there can be no assurance that failure of the payors to remit amounts due to us will not have a material adverse effect on our future results of operations;
- the ability to obtain adequate levels of general and professional liability insurance on current terms;
- changes in our business strategies or development plans;
- the continuing impact of Hurricane Katrina upon us;
- fluctuations in the value of our common stock;
- other factors referenced herein or in our other filings with the Securities and Exchange Commission.

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

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

Critical Accounting Policies and Estimates

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

Revenue recognition: We record revenues and related receivables for health care services at the time the services are provided. Medicare and Medicaid revenues represented 35% and 36% of our net patient revenues during the three month periods ended March 31, 2006 and 2005, respectively. Revenues from managed care entities, including health maintenance organizations and managed Medicare and Medicaid programs accounted for 41% of our net patient revenues during each of the three month periods ended March 31, 2006 and 2005.

We report net patient service revenue at the estimated net realizable amounts from patients and third-party payors and others for services rendered. We have agreements with third-party payors that provide for payments to us at amounts different from our established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments. Estimates of contractual allowances under managed care plans are based upon the payment terms specified in the related contractual agreements. We closely monitor our historical collection rates, as well as changes in applicable laws, rules and regulations and contract terms, to assure that provisions are made using the most accurate information available. However, due to the complexities involved in these estimations, actual payments from payors may be different from the amounts we estimate and record.

We estimate our Medicare and Medicaid revenues using the latest available financial information, patient utilization data, government provided data and in accordance with applicable Medicare and Medicaid payment

rules and regulations. The laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation and as a result, there is at least a reasonable possibility that recorded estimates will change by material amounts in the near term. Certain types of payments by the Medicare program and state Medicaid programs (e.g. Medicare Disproportionate Share Hospital, Medicare Allowable Bad Debts and Inpatient Psychiatric Services) are subject to retroactive adjustment in future periods as a result of administrative review and audit and our estimates may vary from the final settlements. Such amounts are included in accounts receivable, net, on our Condensed Consolidated Balance Sheets. The funding of both federal Medicare and state Medicaid programs are subject to legislative and regulatory changes. As such, we can not make any assurance that future legislation and regulations, if enacted, will not have a material impact on our future Medicare and Medicaid reimbursements.

We provide care to patients who meet certain financial or economic criteria without charge or at amounts substantially less than our established rates. Because we do not pursue collection of amounts determined to qualify as charity care, they are not reported in net revenues or in accounts receivable, net. Our acute care hospitals provided charity care, based on charges at established rates, amounting to $96 million and $76 million during the three month periods ended March 31, 2006 and 2005, respectively.

On January 1, 2006, we implemented a formal company-wide uninsured discount policy which has had the effect of lowering both net revenues and the provision for doubtful accounts by approximately $15 million during the three months ended March 31, 2006. The implementation of this discount policy did not have a significant impact on net income during the first quarter of 2006.

Provision for Doubtful Accounts: Collection of receivables from third-party payors and patients is our primary source of cash and is critical to our operating performance. Our primary collection risks relate to uninsured patients and the portion of the bill which is the patient's responsibility, primarily co-payments and deductibles. We estimate our provisions for doubtful accounts based on general factors such as payor mix, the agings of the receivables and historical collection experience. We routinely review accounts receivable balances in conjunction with these factors and other economic conditions which might ultimately affect the collectibility of the patient accounts and make adjustments to our allowances as warranted. At our acute care hospitals, third party liability accounts are pursued until all payment and adjustments are posted to the patient account. For those accounts with a patient balance after third party liability is exhausted, the patient is sent at least two statements followed by a series of three collection letters. If the patient is deemed unwilling to pay, the account is written-off as bad debt and transferred to an outside collection agency for additional collection effort.

Uninsured receivables are outsourced to several early out collection agencies under contract with the hospital. The collection vendor must document at least three attempts to contact the patient and send three statements from the date of placement. If the patient fails to respond or expresses an unwillingness to pay, the account is returned to the hospital and subsequently written-off as bad debt and transferred to an outside agency for additional collection effort. Uninsured patients that express an inability to pay are reviewed for write-off as potential charity care.

During the collection process the hospital establishes a partial reserve in the allowance for doubtful accounts for self-pay balances outstanding for greater than 60 days from the date of discharge. All self-pay accounts at the hospital level are fully reserved if they become outstanding for greater than 90 days from the date of discharge. Third party liability accounts are fully reserved in the allowance for doubtful accounts when the balance ages past 180 days from the date of discharge. Potential charity accounts are fully reserved when the patient expresses an inability to pay.

On a consolidated basis, we monitor our total self-pay receivables to ensure that the total allowance for doubtful accounts provides adequate coverage based on historical collection experience. At March 31, 2006 and December 31, 2005, accounts receivable are recorded net of allowance for doubtful accounts of $94 million and $105 million, respectively.

Self-Insured Risks: We provide for self-insured risks, primarily general and professional liability claims and workers' compensation claims, based on estimates of the ultimate costs for both reported claims and claims incurred but not reported. Estimated losses from asserted and incurred but not reported claims are

accrued based on our estimates of the ultimate costs of the claims, which includes costs associated with litigating or settling claims, and the relationship of past reported incidents to eventual claims payments. All relevant information, including our own historical experience, the nature and extent of existing asserted claims and reported incidents, and independent actuarial analyses of this information, is used in estimating the expected amount of claims. We also consider amounts that may be recovered from excess insurance carriers, state guaranty funds and other sources in estimating our ultimate net liability for such risk. We also maintain a self-insured workers' compensation program. The ultimate costs related to these programs includes expenses for claims incurred and reported in addition to an accrual for the estimated expenses incurred in connection with claims incurred but not yet reported. 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 maintain self-insured employee benefits programs for employee healthcare and dental claims. The ultimate costs related to these programs include expenses for claims incurred and paid in addition to an accrual for the estimated expenses incurred in connection with claims incurred but not yet reported.

Long-Lived Assets: In accordance with SFAS No.144, "Accounting for the Impairment or Disposal of Long-Lived Assets", we review our long-lived assets, including amortizable intangible assets, for impairment whenever events or circumstances indicate that the carrying value of these assets may not be recoverable. The assessment of possible impairment is based on our ability to recover the carrying value of our asset based on our estimate of its undiscounted future cash flow. If the analysis indicates that the carrying value is not recoverable from future cash flows, the asset is written down to its estimated fair value and an impairment loss is recognized. Fair values are determined based on estimated future cash flows using appropriate discount rates.

Goodwill: In accordance with SFAS No. 142, "Goodwill and Other Intangible Assets", goodwill is reviewed for impairment at the reporting unit level as, defined by SFAS No. 142, on an annual basis or sooner if the indicators of impairment arise. Our judgments regarding the existence of impairment indicators are based on market conditions and operational performance of each reporting unit. We have designated September 1st as our annual impairment assessment date and performed an impairment assessment as of September 1, 2005, which indicated no impairment of goodwill. Future changes in the estimates used to conduct the impairment review, including profitability and market value projections, could indicate impairment in future periods potentially resulting in a write-off of a portion or all of our goodwill.

Income Taxes: Deferred tax assets and liabilities are recognized for the amount of taxes payable or deductible in future years as a result of differences between the tax bases of assets and liabilities and their reported amounts in the financial statements. We believe that future income will enable us to realize our deferred tax assets net of recorded valuation allowances relating to state net operating loss carryforwards.

We operate in multiple jurisdictions with varying tax laws. We are subject to audits by any of these taxing authorities. Our tax returns have been examined by the Internal Revenue Service through the year ended December 31, 2002. We believe that adequate accruals have been provided for federal, foreign and state taxes.

Recent Accounting Pronouncements

Stock-Based Compensation: In December 2004, the FASB issued SFAS No. 123R, "Share-Based Payment," a revision of SFAS No. 123. SFAS No. 123R requires a public entity to measure the cost of employee services received in exchange for an award of equity instruments based on the grant date fair value of the award (with limited exceptions), eliminating the alternative previously allowed by SFAS No. 123 to use the intrinsic value method of accounting. The grant date fair value is required to be estimated using option-pricing models adjusted for the unique characteristics of the instruments using methods similar to those required by SFAS No. 123 and used by us in prior years to calculate pro forma net income and earnings per share disclosures. The cost is required to be recognized ratably over the period during which the employee is required to provide services in exchange for the award.

The SEC deferred the effective date for SFAS 123R for public companies from the interim to the first annual period beginning after December 15, 2005. Accordingly, we adopted SFAS No. 123R as of January 1, 2006.

As a result of adopting SFAS No. 123R, we are recognizing as compensation cost in our financial statements the unvested portion of existing options granted prior to the effective date and the cost of stock options granted to employees after the effective date based on the fair value of the stock options at grant date. We are utilizing Black-Scholes as our option pricing model for applying SFAS 123R. The transition alternatives include a modified prospective and retroactive methods. Under the retroactive method, all prior periods presented would be restated. The modified prospective method requires that compensation expense be recorded for all unvested stock options and share awards that subsequently vest or are modified after the beginning of the first period restated. We adopted SFAS No. 123(R) using the modified prospective method for transition purposes. Using the Black-Scholes option pricing model, we would expect to record expense related to stock options outstanding as of December 31, 2005 of approximately $6.1 million ($3.8 million after-tax) for the year ended December 31, 2006. The stock-based compensation expense determined under a fair value method, specifically related to stock options, was $6.2 million for the year ended December 31, 2005. These pro forma amounts may not be representative of future expense amounts since the estimated fair value of the stock options is amortized to expense over the vesting period, and additional options may be granted in future years.

Physician Guarantees and Commitments: On November 10, 2005, the FASB issued Interpretation No. 45-3, “Application of FASB Interpretation No. 45 to Minimum Revenue Guarantees Granted to a Business or Its Owners” (“FIN 45-3”). FIN 45-3 amends FIN 45, Guarantor’s Accounting and Disclosure Requirements for Guarantees, Including Indirect Guarantees of Indebtedness of Others, to expand the scope to include guarantees granted to a business, such as a physician’s practice, or its owner(s), that the revenue of the business for a period will be at least a specified amount. Under FIN 45-3, the accounting requirements of FIN 45 are effective for any new revenue guarantees issued or modified on or after January 1, 2006 and the disclosure of all revenue guarantees, regardless of whether they were recognized under FIN 45, is required for all interim and annual periods beginning after January 1, 2006. The adoption of FIN 45-3 did not have a material impact on our consolidated results of operations or consolidated financial position for the three months ended March 31, 2006. We have $20.1 million of potential future financial obligations pursuant to contractual guarantees outstanding as of March 31, 2006 of which $12.0 million is committed during the remainder of 2006 and $8.1 million is committed during 2007.

Results of Operations

The following table summarizes our results of operations, and is used in the discussion below, for the three months ended March 31, 2006 and 2005 (dollar amounts in thousands):

	Three months ended March 31, 2006		Three months ended March 31, 2005	
	Amount	% of Revenues	Amount	% of Revenues
Net revenues	$1,034,289	100.0%	$1,006,645	100.0%
Operating charges:				
Salaries, wages and benefits	442,232	42.8%	406,340	40.4%
Other operating expenses	248,101	24.0%	231,165	23.0%
Supplies expense	128,513	12.4%	126,536	12.6%
Provision for doubtful accounts	75,007	7.3%	82,408	8.2%
Depreciation and amortization	39,030	3.8%	39,696	3.9%
Lease and rental expense	16,232	1.6%	15,467	1.5%
Hurricane related expenses	6,904	0.7%	—	—
Hurricane insurance recoveries	(22,291)	-2.2%	—	—
Subtotal operating expenses	933,728	90.3%	901,612	89.6%
Income before interest expense, minority interests and income taxes	100,561	9.7%	105,033	10.4%
Interest expense, net	8,525	0.8%	10,676	1.1%
Minority interests in earnings of consolidated entities	11,177	1.1%	7,919	0.8%
Income before income taxes	80,859	7.8%	86,438	8.6%
Provision for income taxes	30,367	2.9%	31,748	3.2%
Income from continuing operations	50,492	4.9%	54,690	5.4%
Income from discontinued operations, net of income taxes	592	0.0%	6,719	0.7%
Net income	$ 51,084	4.9%	$ 61,409	6.1%

Net revenues increased 3% or $28 million to $1.03 billion during the three month period ended March 31, 2006 as compared to $1.01 billion during the comparable prior year quarter. The increase was attributable to:

- a $42 million or 4% increase in net revenues generated at acute care hospitals and behavioral health care facilities owned during both periods (which we refer to as "same facility");
- $61 million of combined decreases in revenues resulting from the closure of our acute care facilities located in Louisiana that were severely damaged by Hurricane Katrina in late August, 2005 (amount represents revenue generated by these facilities during the first quarter of 2005), and;
- $47 million of other combined increases in revenues resulting from the revenues generated at behavioral health care facilities acquired during 2005 (consists primarily of revenues generated at the 46 behavioral health facilities acquired as part of the KEYS Group Holdings, LLC acquisition during the fourth quarter of 2005).

Income before income taxes decreased $5 million to $81 million during the three months ended March 31, 2006 as compared to $86 million during the comparable prior year quarter due primarily to:

- an increase of $21 million ($22 million pre-minority interest) resulting from the recording of Hurricane insurance recoveries, as discussed below;
- a decrease of $6 million ($7 million pre-minority interest) resulting from charges recorded in connection with the damage sustained from Hurricane Katrina, as discussed below;
- a decrease of $25 million (exclusive of Hurricane related expenses and recoveries) at our acute care facilities (as discussed below in Acute Care Hospital Services);
- an increase of $10 million in income before income taxes generated at our behavioral health care facilities (as discussed below in Behavioral Health Services);
- a decrease of $5 million in income before income taxes resulting from other combined net unfavorable changes.

Net income decreased $10 million to $51 million during the three month period ended March 31, 2006, as compared to $61 million during the comparable prior year quarter due primarily to:

- a $6 million after-tax decrease in income from discontinued operations, net of income taxes, resulting primarily from a $6 million after-tax gain ($9 million pre-tax) recorded during the first quarter of 2005 on the sale of two acute care facilities located in Puerto Rico and a home health business located in Florida;
- the $5 million decrease in income before income taxes, as discussed above;
- a favorable $1 million decrease in income taxes resulting from the tax benefit on the $5 million decrease in income before income taxes.

Acute Care Hospital Services

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 months ended March 31, 2006 and 2005 (dollar amounts in thousands):

Same Facility – Acute Care	Three Months Ended March 31,			
	2006	%	2005	%
Net revenues	$ 769,655	100.0	$ 746,157	100.0
Salaries, wages and benefits	291,088	37.8	267,802	35.9
Other operating expenses	184,053	23.9	167,753	22.5
Supplies expense	111,636	14.5	104,767	14.0
Provision for doubtful accounts	69,737	9.1	73,548	9.9
Depreciation and amortization	31,452	4.1	30,714	4.1
Lease and rental	11,027	1.4	10,631	1.4
Subtotal operating expenses	698,993	90.8	655,215	87.8
Income before interest expense, minority interests and income taxes	70,662	9.2	90,942	12.2
Interest expense, net	247	0.0	149	0.0
Minority interests in earnings of consolidated entities	9,826	1.3	7,058	1.0
Income before income taxes	$ 60,589	7.9	$ 83,735	11.2

On a same facility basis during the three month period ended March 31, 2006, as compared to the comparable prior year quarter, net revenues at our acute care hospitals increased $23 million or 3%. Income before income taxes decreased $23 million or 28% to $61 million during the 2006 first quarter as compared to $84 million during the 2005 comparable quarter. The factors contributing to the decrease in income before income taxes at these facilities are discussed below.

Inpatient admissions to these facilities increased 1.2% during the first quarter of 2006, as compared to the comparable 2005 quarter, while patient days increased 0.2%. The average length of patient stay at these facilities was 4.5 days in each of the three month periods ended March 31, 2006 and 2005. The occupancy rate, based on the average available beds at these facilities, was 67% during each of the quarters ended March 31, 2006 and 2005. Our same facility net revenues were favorably impacted by an increase in prices charged to private payors including health maintenance organizations and preferred provider organizations. On a same facility basis, net revenue per adjusted admission (adjusted for outpatient activity) at these facilities increased 1.3% and net revenue per adjusted patient day increased 2.0% during the first quarter of 2006 over the comparable prior year quarter. On January 1, 2006, we implemented a formal company-wide uninsured discount policy which has had the effect of lowering both net revenues and the provision for doubtful accounts by approximately $15 million during the three months ended March 31, 2006. The implementation of this discount policy did not have a significant impact on net income during the first quarter of 2006. Excluding the impact of the uninsured discount policy, on a same facility basis, net revenue per adjusted admission at these facilities would have increased 3.2% and net revenue per adjusted patient day would have increased 3.9% during the first quarter of 2006 as over the comparable prior year quarter.

Contributing to the decline in income before income taxes at our acute care facilities during the 2006 first quarter, as compared to the comparable 2005 quarter, was an increase in the level of uninsured patients at our acute care facilities and a continued decline in the operating performance of certain of our acute care facilities in Texas, including the McAllen/Edinburg market, and other selected markets. We have experienced an increase in uninsured patients throughout our portfolio of acute care hospitals which in part, has resulted from an increase in the number of patients who are employed but do not have health insurance. During the first quarter of 2006, combined admissions and patient days at our two acute care hospitals located in the McAllen/Edinburg, Texas market decreased 6.4% and 18.1%, respectively, as compared to the first quarter of 2005. Combined income before income taxes at these two facilities decreased $10 million during the three month period ended March 31, 2006 as compared to the comparable prior year period. These declines were due primarily to continued intense hospital and physician competition as a physician-owned hospital in the market has eroded a portion of our higher margin business, including cardiac procedures. A continuation of increased provider competition in this market, as well as additional capacity under construction by us and others, could result in additional erosion of the net revenues and financial operating results of our acute care facilities in this market. We expect the competitive pressures in the market to continue and potentially intensify if additional capacity is added to the market in future periods by our competitors.

As competition in the market has increased, wage rates and physician recruiting costs have risen increasing the continued pressure on operating margins and profitability. In response to these competitive pressures, we have recruited a number of new physicians to the market, are working with many of our managed care plans for greater exclusivity and have undertaken significant capital investment in the market, including Edinburg

Children's Hospital, a new dedicated 120-bed children's facility, which was completed and opened during the first quarter of 2006, as well as South Texas Behavioral Health Center, a 134-bed replacement behavioral facility, which is scheduled to be completed and opened during the third quarter of 2006. We can not guarantee, however, that such investments will be successful in minimizing the impact of competition in this market.

The operating factors mentioned above have resulted in a certain degree of volatility in our income from continuing operations. Although we have undertaken actions in regards to physician recruitment and other measures as mentioned above in the McAllen/Edinburg market, the ultimate impact and timing of potential improvements in the operating results of the facilities in the market are beyond our ability to predict. A continuation of the unfavorable operating results experienced in this market and/or a continuation of the increased level of uninsured patients to our facilities and the resulting adverse trends in the provision for doubtful accounts and charity care provided, could have a material unfavorable impact on our future operating results.

The following table summarizes the results of operations for all our acute care operations during the three months ended March 31, 2006 and 2005. Included in these results, in addition to the same facility results shown above, are the financial results for the period of January 1, 2005 through March 31, 2005 for our Louisiana hospitals damaged by Hurricane Katrina as well as the hurricane related expenses and insurance recoveries recorded during the first quarter of 2006.

All Acute Care Facilities	**dollar amounts in thousands Three Months Ended March 31,**			
	2006	**%**	**2005**	**%**
Net revenues	$ 769,952	100.0	$ 806,624	100.0
Salaries, wages and benefits	291,146	37.8	293,967	36.4
Other operating expenses	184,173	23.9	183,634	22.8
Supplies expense	111,649	14.5	113,267	14.0
Provision for doubtful accounts	69,745	9.1	78,299	9.7
Depreciation and amortization	31,524	4.1	33,053	4.1
Lease and rental	11,486	1.5	11,989	1.5
Hurricane related expenses	6,904	0.9	—	—
Hurricane insurance recoveries	(22,291)	-2.9	—	—
Subtotal operating expenses	684,336	88.9	714,209	88.5
Income before interest expense, minority interest and income taxes	85,616	11.1	92,415	11.5
Interest expense, net	247	0.0	153	0.0
Minority interests in earnings of consolidated entities	10,814	1.4	7,012	0.9
Income before income taxes	$ 74,555	9.7	$ 85,250	10.6

During the three months ended March 31, 2006, as compared to the comparable prior year quarter, net revenues at our acute care hospitals decreased 5% or $37 million. The decrease in net revenues was primarily attributable to:

- a $23 million increase at same facility revenues, as discussed above, and;
- combined decreases in revenue of $61 million resulting from the closure of our acute care facilities located in Louisiana that were severely damaged and closed as a result of Hurricane Katrina in late August, 2005 (amount represents revenue generated by these facilities during the period of January 1, 2005 through March 31, 2005).

Income before income taxes decreased $10 million or 13% to $75 million or 9.7% of net revenues during the first quarter of 2006 as compared to $85 million or 10.6% of net revenues during the comparable prior year quarter. The decrease in income before income taxes at our acute care facilities resulted from:

- a $23 million decrease at our acute care facilities owned for more than a year, as discussed above;

- a $21 million increase ($22 million pre-minority interest) resulting from the recording of Hurricane Katrina related insurance recoveries, as discussed below;
- a $6 million decrease ($7 million pre-minority interest) resulting from charges recorded in connection with the damage sustained from Hurricane Katrina, and;
- $3 million of combined decreases caused by the cessation of the income/loss at our acute care facilities that were severely damaged and closed as a result of Hurricane Katrina in late August, 2005.

Behavioral Health Services

The following table summarizes the results of operations for our behavioral health care facilities, on a same facility basis, and is used in the discussion below for the three months ended March 31, 2006 and 2005 (dollar amounts in thousands):

Same Facility – Behavioral Health	Three Months Ended March 31,			
	2006	%	2005	%
Net revenues	$207,591	100.0	$189,560	100.0
Salaries, wages and benefits	98,575	47.5	91,083	48.0
Other operating expenses	39,073	18.8	36,626	19.3
Supplies expense	12,163	5.9	11,298	6.0
Provision for doubtful accounts	5,357	2.6	3,893	2.1
Depreciation and amortization	3,885	1.9	4,220	2.2
Lease and rental	2,613	1.3	2,442	1.3
Subtotal operating expenses	161,666	77.9	149,562	78.9
Income before interest expense, minority interests and income taxes	45,925	22.1	39,998	21.1
Interest expense, net	3	0.0	3	0.0
Minority interests in earnings of consolidated entities	181	0.1	149	0.1
Income before income taxes	$ 45,741	22.0	$ 39,846	21.0

On a same facility basis during the first quarter of 2006, as compared to the comparable 2005 quarter, net revenues at our behavioral health care facilities increased 10% or $18 million. Income before income taxes increased $6 million or 15% to $46 million or 22.0% of net revenues during the three months ended March 31, 2006 as compared to $40 million or 21.0% of net revenues during the comparable prior year quarter. Inpatient admissions to these facilities increased 5.9% during the first quarter of 2006, as compared to the comparable 2005 quarter, while patient days increased 3.4%. The average length of patient stay at these facilities was 12.7 days during the first quarter of 2006 and 13.0 days during the first quarter of 2005. The occupancy rate, based on the average available beds at these facilities, was 85.1% during the three months ended March 31, 2006, as compared to 83.1% during the comparable prior year period. On a same facility basis, net revenue per adjusted admission (adjusted for outpatient activity) at these facilities increased 3.4% and net revenue per adjusted patient day increased 6.1% during the first quarter of 2006, as compared to the first quarter of 2005.

The following table summarizes the results of operations for our behavioral health care facilities, including newly acquired facilities, for the three months ended March 31, 2006 and 2005 (dollar amounts in thousands):

All Behavioral Health Care Facilities	Three Months Ended March 31,			
	2006	%	2005	%
Net revenues	$253,628	100.0	$189,560	100.0
Salaries, wages and benefits	127,183	50.1	91,083	48.0
Other operating expenses	47,617	18.8	36,626	19.3
Supplies expense	14,622	5.8	11,298	6.0
Provision for doubtful accounts	5,289	2.1	3,893	2.1
Depreciation and amortization	5,660	2.2	4,220	2.2
Lease and rental	3,855	1.5	2,442	1.3
Subtotal operating expenses	204,226	80.5	149,562	78.9
Income before interest expense, minority interests and income taxes	49,402	19.5	39,998	21.1
Interest expense, net	101	0.0	3	0.0
Minority interests in earnings of consolidated entities	(310)	-0.1	149	0.1
Income before income taxes	$ 49,611	19.6	$ 39,846	21.0

During the first quarter of 2006, as compared to the comparable prior year quarter, net revenues at our behavioral health care facilities (including newly acquired facilities listed below), increased 34% or $64 million. The increase in net revenues was attributable to

- an $18 million increase in same facility revenues, as discussed above, and;
- $46 million of revenues generated at facilities acquired during 2005, as discussed below.

Income before income taxes increased $10 million or 25% to $50 million or 19.6% of net revenues during the first quarter of 2006, as compared to $40 million or 21.0% of net revenues during the first quarter of 2005. The increase in income before income taxes at our behavioral health facilities was attributable to:

- a $6 million increase at our behavioral health facilities owned for more than a year, as discussed above, and;
- $4 million of combined income, net of losses, generated at facilities acquired during 2005.

During 2005, we acquired the following behavioral health care facilities:

- the stock of KEYS Group Holdings, LLC, including Keystone Education and Youth Services, LLC. Through this acquisition, we added a total of 46 facilities in 10 states including 21 residential treatment facilities with 1,280 beds, 21 non-public therapeutic day schools and four detention facilities;
- the assets of five therapeutic boarding schools located in Idaho and Vermont, four of which were closed at the date of acquisition. Three of these facilities reopened during the 4th quarter of 2005;
- a 58-bed behavioral health facility in Orem, Utah, and;
- a 72-bed behavioral health facility in Casper, Wyoming.

Sources of Revenue

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

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

outpatient basis. We believe that our experience with respect to our increased outpatient levels mirrors the general trend occurring in the health care industry and we are unable to predict the rate of growth and resulting impact on our future revenues.

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

The following table shows the approximate percentages of net patient revenue on a combined basis for our acute care and behavioral health facilities during the three month periods ended March 31, 2006 and 2005 (excludes sources of revenues for all periods presented for divested facilities which reflected as discontinued operations in our Consolidated Financial Statements). Net patient revenue is defined as revenue from all sources after deducting contractual allowances and discounts from established billing rates, which we derived from various sources of payment for the years indicated. The tables below exclude sources of revenue for all periods presented for divested facilities which are reflected as discontinued operations in our Consolidated Financial Statements.

Acute Care and Behavioral Health Facilities Combined	**Percentage of Net Patient Revenues Three Months Ended March 31,**	
	2006	**2005**
Third Party Payors:		
Medicare	26%	28%
Medicaid	9%	8%
Managed Care (HMO and PPOs)	41%	41%
Other Sources	24%	23%
Total	100%	100%

The following table shows the approximate percentages of net patient revenue for our acute care facilities:

Acute Care Facilities	**Percentage of Net Patient Revenues Three Months Ended March 31,**	
	2006	**2005**
Third Party Payors:		
Medicare	30%	31%
Medicaid	4%	5%
Managed Care (HMO and PPOs)	41%	40%
Other Sources	25%	24%
Total	100%	100%

The following table shows the approximate percentages of net patient revenue for our behavioral health facilities:

Behavioral Health Facilities	Percentage of Net Patient Revenues Three Months Ended March 31,	
	2006	2005
Third Party Payors:		
Medicare	14%	16%
Medicaid	24%	24%
Managed Care (HMO and PPOs)	43%	49%
Other Sources	19%	11%
Total	100%	100%

Note 5 to our Consolidated Financial Statements included in this quarterly report contains our revenues, income and other operating information for each reporting segment of our business.

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.

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

DRG rates are adjusted by an update factor each federal fiscal year, which begins on October 1. The index used to adjust the DRG rates, known as the "hospital market basket index," gives consideration to the inflation experienced by hospitals in purchasing goods and services. Generally, however, the percentage increases in the DRG payments have been lower than the projected increase in the cost of goods and services purchased by hospitals. For federal fiscal years 2005, 2004 and 2003, the update factors were 3.3%, 3.4% and 2.3%, respectively. For 2006, the update factor is 3.7% and the proposed increase for the 2007 federal fiscal year is 3.4%. Hospitals are allowed to receive the full basket update if they provide the Centers for Medicare and Medicaid Services ("CMS") with specific data relating to the quality of services provided. We have complied fully with this requirement and intend to comply fully in future periods.

In April 2006, CMS proposed a significant change in the manner in which it determines the underlying relative weights used to calculate the DRG payment amount. For federal fiscal year 2007, CMS has proposed using hospital costs rather than hospital charges for the DRG relative weight determination. This proposal, if enacted, would have a material adverse impact on our acute care hospitals' Medicare reimbursements.

In this same proposed rule, CMS has also proposed expanding the number of Medicare DRGs from 526 to 861. As part of this DRG expansion, CMS would utilize a new consolidated-severity DRG methodology aimed at more accurately aligning the Medicare DRG payment with the resources expended in treating Medicare beneficiaries in a hospital setting. CMS has proposed implementing this new DRG methodology in federal fiscal year 2008 or possibly in 2007. CMS has requested public comment on this proposal from the health care industry which would be considered in their finalization on the new DRG methodology.

For the majority of outpatient services, both general acute and behavioral health hospitals are paid under an outpatient PPS according to ambulatory procedure codes ("APC") that group together services that are clinically related and use similar resources. Depending on the service rendered during an encounter, a patient

may be assigned to a single or multiple groups. Medicare pays a set price or rate for each group, regardless of the actual costs incurred in providing care. Medicare sets the payment rate for each APC based on historical median cost data, subject to geographic modification. The APC payment rates are updated each federal fiscal year. For 2005, 2004 and 2003, the payment rate update factors were 3.3%, 3.4% and 2.3%, respectively. For 2006, the update factor is 3.7%.

We operate inpatient rehabilitation hospital units that treat Medicare patients with specific medical conditions which are excluded from the Medicare PPS DRG payment methodology. Inpatient rehabilitation facilities ("IRFs") must meet a certain volume threshold each year for the number of patients with these specific medical conditions, often referred to as the "75 Percent Rule". Medicare payment for IRF patients is based on a prospective case rate based on a CMS determined Case-Mix Group classification and is updated annually by CMS. CMS has temporarily reduced the IRF qualifying threshold from 75% to 50% in 2005, 60% in 2006 and 65% in 2007 before returning to the 75% threshold in 2008.

Psychiatric hospitals have traditionally been excluded from the inpatient services PPS. However, on January 1, 2005, CMS implemented a new PPS ("Psych PPS") for inpatient services furnished by psychiatric hospitals under the Medicare program. This system replaced the cost-based reimbursement guidelines with a per diem PPS with adjustments to account for certain facility and patient characteristics. 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. The new system is being phased-in over a three-year period. Also, CMS has included a stop-loss provision to ensure that hospitals avoid significant losses during the transition. We believe the continued phase-in of Psych PPS will have a favorable effect on our future results of operations, however, due to the three-year phase in period, we do not believe the favorable effect will have a material impact on our 2006 results of operations. In May 2006, CMS published its annual increase to the federal component of the Psych PPS per diem rate. This increase includes the effects of market basket updates resulting in a 4.5% increase in total payments for Rate Year 2007, covering the period of July 1, 2006 to June 30, 2007.

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

We receive a large concentration of our Medicaid revenues from Texas and significant amounts from Pennsylvania, Washington, DC and Illinois. We can provide no assurance that reductions to Medicaid revenues, particularly in the above-mentioned states, will not have a material adverse effect on our future results of operations. Furthermore, the federal government and many states are currently working to effectuate significant reductions in the level of Medicaid funding, which could adversely affect future levels of Medicaid reimbursement received by our hospitals.

In February 2005, a Texas Medicaid State Plan Amendment went into effect that expands the supplemental inpatient reimbursement methodology for the state's Medicaid program. In connection with this program, we earned $3 million in each of the three month periods ended March 31, 2006 and 2005. For the remainder of the state fiscal year 2006 (covering the period of April 1, 2006 through August 31, 2006), our total supplemental payments pursuant to the provisions of this program are estimated to be approximately $6 million.

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

Also included in our financial results during 2005 was $6 million in non-recurring Medicaid payments from Texas for a State Fiscal Year 2005 state-wide upper payment limit ("UPL") Medicaid payment program. This UPL program has not been renewed by Texas for SFY2006.

The State of Texas submitted to CMS, an amendment to its Medicaid State Plan seeking approval to make supplemental payments to certain hospitals located in Hidalgo, Maverick and Webb counties. If approved, our four acute care hospital facilities located in these counties may be eligible to receive supplemental Medicaid payments. There can be no assurance these additional reimbursements will be approved, however, if approved, we may be entitled to additional reimbursements ranging from $5 million to $21 million covering the period of June 1, 2005 through August 31, 2006. If approved, the continuation of these reimbursements beyond August 31, 2006 and the level of such reimbursements are largely contingent on the nature of CMS's disposition of the state plan amendment.

In 2004, the Texas Health and Human Services Commission ("Commission") implemented rules that offset negative Medicaid shortfalls in the hospital-specific cap formula, and included third-party and upper payment limit payments in the shortfall calculation. These changes have resulted in reduced payments to our hospitals located in Texas that have significant Medicaid populations.

We operate two freestanding psychiatric hospitals in the Dallas, Texas region that operate under the Lone Star Select II prospective per diem payment program. We were notified by the Commission that this per diem payment program will terminate on August 31, 2006. If the Commission is unable to develop an alternate prospective payment methodology effective for September 1, 2006, these affected facilities would be paid based on a TEFRA cost based payment system.

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

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

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

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

State Medicaid Disproportionate Share Hospital Payments: Hospitals that have an unusually large number of low-income patients (i.e., those with a Medicaid utilization rate of at least one standard deviation above the

mean Medicaid utilization, or having a low income patient utilization rate exceeding 25%) are eligible to receive a disproportionate share hospital ("DSH") adjustment. Congress established a national limit on DSH adjustments. Although this legislation and the resulting state broad-based provider taxes have affected the payments we receive under the Medicaid program, to date the net impact has not been materially adverse.

Upon meeting certain conditions, and serving a disproportionately high share of Texas' and South Carolina's low income patients, five of our facilities located in Texas and one facility located in South Carolina received additional reimbursement from each state's DSH fund. The Texas and South Carolina programs have been renewed for each state's 2006 fiscal years (covering the period of September 1, 2005 through August 31, 2006 for Texas and July 1, 2005 through June 30, 2006 for South Carolina). Although neither state has definitively quantified the amount of DSH funding our facilities will receive during the 2006 fiscal years, both states have indicated the allocation criteria will be similar to the methodology used in previous years. Included in our financial results was an aggregate of $9 million during each of the three month periods ended March 31, 2006 and 2005 from these programs. Failure to renew these DSH programs beyond their scheduled termination dates, failure of our hospitals that currently receive DSH payments to qualify for future DSH funds under these programs, or reductions in reimbursements, could have a material adverse effect on our future results of operations.

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

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

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

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

Other Operating Results

Combined net revenues from our surgical hospitals, ambulatory surgery centers and radiation oncology centers were $8 million and $9 million during the three month periods ended March 31, 2006 and 2005, respectively. Combined income before income taxes from these entities was $2 million and $1 million during the three months ended March 31, 2006 and 2005, respectively.

Interest expense decreased $2 million to $9 million during the three months ended March 31, 2006 as compared to $11 million during the comparable prior year quarter due primarily to lower average outstanding borrowings.

The effective tax rate was 37.6% and 36.7% during the three month periods ended March 31, 2006 and 2005, respectively. The increase in the effective tax rate during the first quarter of 2006, as compared to the comparable prior year quarter, was due primarily to an increase in the effective state income tax rate.

Discontinued Operations

During 2005, in conjunction with our strategic plan to sell certain acute care hospitals, as well as certain other under-performing assets, we sold the following hospitals and businesses:

- sold a 430-bed hospital located in Bayamon, Puerto Rico during the first quarter of 2005;
- sold a 180-bed hospital located in Fajardo, Puerto Rico during the first quarter of 2005;
- sold a home health business in Bradenton, Florida during the first quarter of 2005;
- sold our 81.5% ownership interest in Medi-Partenaires, an operating company that owned and managed 14 hospitals in France, during the second quarter of 2005, and;
- sold the assets of a closed a women's hospital located in Edmond, Oklahoma in September, 2005.

The operating results of these facilities, as well as the gains resulting from the divestitures, are reflected as "Income from discontinued operations, net of income taxes" in the Consolidated Statements of Income for the three month periods ended March 31, 2006 and 2005. The following table shows the results of operations of these facilities, on a combined basis, for all facilities reflected as discontinued operations (amounts in thousands):

Income from discontinued operations, net of income taxes	Three Months Ended March 31,	
	2006	2005
Net revenues	$ 204	$119,549
Income from operations	940	4,936
Gain on divestitures	—	9,096
Provision for asset impairment	—	(3,105)
Income from discontinued operations, pre-tax	940	10,927
Income tax provision	(348)	(4,208)
Income from discontinued operations, net of income taxes	$ 592	$ 6,719

Impact of Hurricane Katrina

In August, 2005, our facilities listed below were severely damage from Hurricane Katrina. Since the Hurricane, all facilities remain closed and non-operational as we continue to assess the damage and evaluate the likely recovery period for the facilities and surrounding communities.

Methodist Hospital - located in New Orleans, Louisiana consisting of Methodist Hospital ("Methodist"), a six-story, 306-bed acute-care facility and Lakeland Medical Pavilion ("Lakeland"), a two-story, 54-bed acute-care facility.

Chalmette Medical Center - located in Chalmette, Louisiana consisting Chalmette Medical Center ("Chalmette"), a two-story, 138-bed acute-care facility and Virtue Street Pavilion, a one-story, 57-bed facility providing physical rehabilitation, skilled nursing and inpatient behavioral health services.

Since these facilities have been closed since Hurricane Katrina and therefore no revenues are reflected in our Consolidated Statements of Income for the post-hurricane period, we have excluded the financial and statistical results for these facilities from our "same facility" results for the periods of January 1st through March 31st of 2006 and 2005.

Included in our financial results for the three month period ended March 31, 2006 was a combined after-tax charge of $4.1 million ($6.9 million pre-tax and pre-minority interest) consisting primarily of expenses incurred in connection with remediation of the hurricane-damaged properties including removal of damaged property and debris and sealing of the buildings to prevent further weather-related deterioration.

Also included in our financial results for the three month period ended March 31, 2006 was $13.1 million of after-tax, hurricane related insurance recoveries ($22.3 million pre-tax and pre-minority interest). At the time of Hurricane Katrina, we maintained commercial insurance policies with a combined potential coverage of $279 million for property damage and business interruption insurance. As of March 31, 2006, we received total Hurricane Katrina related commercial insurance proceeds of $103 million. During the first quarter of 2006, we filed our formal Hurricane Katrina related insurance claim with a commercial insurer. Although our claims for hurricane-related losses exceeded the recoveries we have recorded as of March 31, 2006, thereby making us entitled to hurricane-related insurance proceeds in excess of those recorded as of March 31, 2006, the timing and amount of such proceeds can not be determined at this time since they will be based on factors such as loss causation, ultimate replacement costs of damaged assets and ultimate economic value of business interruption claims.

Professional and General Liability Claims and Property Insurance

Due to unfavorable pricing and availability trends in the professional and general liability insurance markets, our subsidiaries have assumed a greater portion of the hospital professional and general liability risk as the cost of commercial professional and general liability insurance coverage has risen significantly. Effective January 1, 2006, most of our subsidiaries were self-insured for malpractice exposure up to $20 million per occurrence. We purchased an umbrella excess policy for our subsidiaries through a commercial insurance carrier for coverage in excess of $20 million per occurrence with a $75 million aggregate limitation. Given these insurance market conditions, there can be no assurance that a continuation of these unfavorable trends, or a sharp increase in claims asserted against us, will not have a material adverse effect on our future results of operations.

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

For the period from January 1, 1998 through December 31, 2001, most of our subsidiaries were covered under commercial insurance policies with PHICO, a Pennsylvania based insurance company that was placed into liquidation during the first quarter of 2002. As a result of PHICO’s liquidation, we recorded a $40 million pre-tax charge during 2001 to reserve for PHICO claims that became our liability. However, we continue to be entitled to receive reimbursement from state insurance guaranty funds and/or PHICO’s estate for a portion of certain claims ultimately paid by us.

As of March 31, 2006, the total accrual for our professional and general liability claims was $232.3 million ($224.6 million net of expected recoveries), of which $24.0 million is included in other current liabilities. As of December 31, 2005, the total accrual for our professional and general liability claims was $225.2 million ($216.4 million net of expected recoveries), of which $24.0 million is included in other current liabilities. Included in other assets was $7.7 million as of March 31, 2006 and $8.8 million as of December 31, 2005, related to estimated expected recoveries from various state guaranty funds in connection with PHICO related professional and general liability claims payments.

Prior to 2006, we had commercial insurance policies for a large portion of our property loss exposure which provided coverage with varying sub-limits and aggregates for property and business interruption losses resulting from damage sustained from fire, flood, windstorm and earthquake. The specific amount of commercial insurance coverage was dependent on factors such as location of the facility and loss causation. Due to a sharp increase in property losses experienced nationwide in recent years, the cost of commercial property insurance has increased significantly. As a result, catastrophic coverage for flood, earthquake and windstorm has been limited to annual aggregate losses (as opposed to per occurrence losses) and coverage has been limited to lower sub-limits for named windstorms, earthquakes in certain states such as Alaska, California, Puerto Rico and Washington and for floods in facilities located in designated flood zones. Given these insurance market conditions, there can be no assurance that a continuation of these unfavorable trends, or a sharp increase in uninsured property losses sustained by us, will not have a material adverse effect on our future results of operations.

Liquidity

Net cash provided by operating activities

Net cash provided by operating activities was $110 million during the three months ended March 31, 2006 and $135 million during the comparable prior year quarter. The $24 million net decrease was primarily attributable to the following:

- an unfavorable change of $35 million due to a decrease in net income plus or minus the adjustments to reconcile net income to net cash provided by operating activities (depreciation and amortization, accretion of discount on convertible debentures, gains on sales of assets and businesses, hurricane-related insurance recoveries and provision for asset impairment). This unfavorable change was due, in part, to a decrease in income generated by our acute care facilities during the first quarter of 2006, as compared to the comparable prior year quarter, (as discussed above in "Acute Care Hospital Services") and the $7 million pre-tax hurricane-related expenses incurred during the first quarter of 2006;
- a favorable change of $18 million in accounts receivable, and;
- $7 million of other net unfavorable changes.

Our days sales outstanding ("DSO"), are calculated by dividing our quarterly net revenue by the number of days in the quarter. The result is divided into the accounts receivable balance at the end of each quarter to obtain the DSO. Our DSO were 47 days at March 31, 2006 and 51 days at March 31, 2005.

Net cash provided by/used in investing activities

During the three month period ended March 31, 2006, we used $67 million of net cash in investing activities as compared to $61 million of net cash provided by investing activities during the three months ended March 31, 2005.

During the first three months of 2006, we used $67 million of net cash in investing activities as follows:

- spent $83 million to finance capital expenditures at our facilities, including construction costs related to a new 170-bed acute care hospital in Las Vegas, Nevada, a new 104-bed replacement acute care hospital in Eagle Pass, Texas, a new 120-bed children's hospital in Edinburg, Texas and a new 134-bed replacement behavioral health care facility in McAllen, Texas;
- spent $12 million to acquire the assets of a closed behavioral health care facility located in Florida, and;
- received $28 million of commercial insurance proceeds in connection with damage sustained from Hurricane Katrina.

During the first three months of 2005, we received $61 million of net cash provided by investing activities as follows:

- received $125 million of proceeds from the sale of two acute care facilities located in Puerto Rico and a home health business in Florida;
- spent $59 million to finance capital expenditures at our facilities, and;
- spent $5 million to acquire purchase the membership interests in McAllen Medical Center Physicians, Inc. and Health Clinic P.L.L.C.

We expect to spend approximately $242 million to $252 million for capital expenditures during the remaining nine months of 2006, including expenditures for capital equipment, renovations and new projects at existing hospitals and completion of major construction projects in progress. 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.

Net cash provided by/used in financing activities

During the three month periods ended March 31, 2006 and 2005, we used $43 million and $175 million, respectively, of net cash in financing activities.

During the first three months of 2006, we used $43 million of net cash from financing activities as follows:

- spent $39 million of net debt repayments consisting primarily of repayments under our $500 million unsecured non-amortizing revolving credit agreement ("Revolver"), and;
- spent $4 million to pay an $.08 per share quarterly cash dividend;

During the first three months of 2005, we used $175 million of net cash from financing activities as follows:

- spent $169 million of net debt repayments consisting primarily of repayments under our Revolver;
- spent $5 million to pay an $.08 per share quarterly cash dividend, and;
- spent $1 million of other net cash provided by financing activities.

Capital Resources

Credit Facilities and Outstanding Debt Securities

We have a $500 million unsecured non-amortizing revolving credit agreement, which expires on March 4, 2010. The agreement includes a $75 million sub-limit for letters of credit. The interest rate on borrowings is determined at our option at the prime rate, LIBOR plus a spread of .32% to .80% or a money market rate. A facility fee ranging from .08% to .20% is required on the total commitment. The applicable margins over LIBOR and the facility fee are based upon our debt ratings by Standard & Poor's Ratings Group and Moody's Investor Services Inc. At March 31, 2006, the applicable margin over the LIBOR rate was 0.50% and the commitment fee was .125%. There are no compensating balance requirements. As of March 31, 2006, we had $70 million of borrowings outstanding under our revolving credit agreement and we had $374 million of available borrowing capacity, net of $56 million of outstanding letters of credit.

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

We issued discounted Convertible Debentures in 2000 which are due in 2020 ("Debentures"). The aggregate issue price of the Debentures was $250 million or $587 million aggregate principal amount at maturity. The Debentures were issued at a price of $425.90 per $1,000 principal amount of Debenture. The Debentures' yield to maturity is 5% per annum, .426% of which is cash interest. The interest on the bonds is paid semiannually in arrears on June 23 and December 23 of each year. The Debentures are convertible at the option of the holders into 11.2048 shares of our common stock per $1,000 of Debentures, however, we have the right to redeem the Debenture any time on or after June 23, 2006 at a price equal to the issue price of the Debentures plus accrued original issue discount and accrued cash interest to the date of redemption.

Our total debt as a percentage of total capitalization was 33% at March 31, 2006 and 35% at December 31, 2005. Covenants relating to long-term debt require maintenance of a minimum net worth, specified debt to total capital and fixed charge coverage ratios. We are in compliance with all required covenants as of March 31, 2006.

We expect to finance all capital expenditures, acquisitions and potential stock repurchases with internally generated and additional funds. Additional funds may be obtained through: (i) the issuance of equity; (ii) borrowings under our existing revolving credit facility or through refinancing the existing revolving credit agreement, and/or; (iii) the issuance of other long-term debt.

Off-Balance Sheet Arrangements

During the three months ended March 31, 2006, there have been no material changes in the off-balance sheet arrangements consisting of operating leases and standby letters of credit and surety bonds. See Note 2 to the Consolidated Financial Statements for disclosure related to the following transactions that occurred subsequent to March 31, 2006: (i) an asset exchange and substitution agreement with Universal Health Realty Income Trust (the "Trust"), and; (ii) renewals of leases on hospital facilities leased from the Trust. Reference is made to Item 7. Management's Discussion and Analysis of Operations and Financial Condition – Contractual Obligations and Off-Balance Sheet Arrangements, in our Annual Report on Form 10-K for the year ended December 31, 2005.

As of March 31, 2006, we had outstanding letters of credit and surety bonds totaling $81 million consisting of: (i) $69 million related to our self-insurance programs; (ii) $6 million consisting primarily of collateral for outstanding bonds of an unaffiliated third party and public utility, and; (iii) $6 million of debt guarantees related to entities in which we own a minority interest.

We have various obligations under operating leases or master leases for real property and under operating leases for equipment. The real property master leases are leases for buildings on or near hospital property for which we guarantee a certain level of rental income. We sublease space in these buildings and any amounts received from these subleases are offset against the expense. In addition, after giving effect to the Asset Exchange and Substitution Agreement and lease renewals with the Trust as disclosed in Note 2 to the Consolidated Financial Statements, we lease four hospital facilities from the Trust with terms scheduled to expire in 2011 and 2014. These leases contain up to four, 5-year renewal options.

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, 2006. 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, 2005.

Item 4. Controls and Procedures

As of March 31, 2006, 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. Based on this evaluation, the CEO and CFO have concluded that our disclosure controls and procedures are effective to ensure that material information is recorded, processed, summarized and reported by management on a timely basis in order to comply with our disclosure obligations under the Securities and Exchange Act of 1934 and the SEC rules thereunder.

Changes in Internal Control Over Financial Reporting

There have been no significant changes in our internal control over financial reporting or in other factors during the first quarter of 2006 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Item 1. Legal Proceedings

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

On August 5, 2004, we were named, together with our subsidiary, Valley Hospital Medical Center, Inc., as defendants in a lawsuit filed in Clark County, Nevada, under the caption Deborah Louise Poblocki v. Universal Health Services, Inc., et al., No. 04-A-489927-C. The plaintiff alleged that the hospital overcharged her and other similarly situated patients who lacked health insurance. The complaint sought class action treatment but no class was certified. The matter was settled in February, 2006 on terms favorable to us.

We and our South Texas Health System affiliates, which operate McAllen Medical Center, McAllen Heart Hospital, Edinburg Regional Medical Center and certain other affiliates, were served with a subpoena dated November 21, 2005, issued by the Office of Inspector General of the Department of Health and Human Services. The Civil Division of the U.S. Attorney's office in Houston, Texas has indicated that the subpoena is part of an investigation under the False Claims Act of compliance with Medicare and Medicaid rules and regulations pertaining to the employment of physicians and the solicitation of patient referrals from physicians from January 1, 1999 to the date of the subpoena related to the South Texas Health System. We are cooperating in the investigation and are producing documents responsive to the subpoena. We monitor all aspects of our business and have developed a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards. Because the law in this area is complex and constantly evolving, governmental investigation or litigation may result in interpretations that are inconsistent with industry practices, including ours. This matter is at an early stage and we are unable to evaluate the existence or extent of any potential financial exposure at this time.

On November 1, 2005, our management company and several of our facilities located in California, including Inland Valley Medical Center, Rancho Springs Medical Center, Del Amo Hospital and Corona Regional Medical Center ("Hospitals") were named as defendants in a wage and hour lawsuit filed in Los Angeles Superior Court under the caption Lasko-Hoellinger, et al v. UHS of Delaware, Inc., et al. While two of the four original plaintiffs in that case voluntarily requested that they be dismissed as plaintiffs from that lawsuit, the remaining two plaintiffs are seeking to have the matter certified as a class action. The remaining plaintiffs are alleging, among other things, that they are entitled to recover damages from the Hospitals for missed breaks and other alleged violations of various California Labor Code sections and applicable wage orders for a period of at least one year prior to the filing of the case. The Hospitals have denied liability and are defending the case, which has not yet been certified as a class action by the court. Although we are unable to evaluate the extent of any potential financial exposure at this time, this matter could have a material adverse effect on our future results of operations.

Item 1A. Risk Factors

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, 2005.

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

During 1999, 2004 and 2005, our Board of Directors approved stock repurchase programs authorizing us to purchase up to 11.5 million shares of our outstanding Class B Common Stock on the open market at prevailing market prices or in negotiated transactions off the market. The Board of Directors also gave management discretion to use the authorization to purchase its convertible debentures which are due in 2020. Pursuant to the stock and convertible debenture repurchase program, we may purchase shares or debentures on the open market or in negotiated private transactions. Pursuant to the terms of these programs, we purchased 32,482 shares at an average price of $48.22 per share or $1.6 million in the aggregate during the first quarter of 2006. Pursuant to the stock repurchase programs referenced above, we purchased a total of 7.9 million shares at an average purchase price of $50.05 per share or $396.9 million in the aggregate. As of March 31, 2006, the maximum number of shares that may yet be purchased under the program is 3,570,838 shares.

2006 period	Total number of shares purchased	Number of shares purchased as part of publicly announced programs	Average price paid per share	Aggregate purchase price paid (in thousands)	Maximum number of shares that may yet be purchased under the program
January, 2006	12,434	12,434	$ 47.85	$ 595	3,590,886
February, 2006	2,280	2,280	$ 48.77	$ 111	3,588,606
March, 2006	17,768	17,768	$ 48.41	$ 860	3,570,838
Total January through March	32,482	32,482	$ 48.22	$ 1,566	3,570,838

Dividends

During each of the quarters ended March 31, 2006 and 2005, we declared and paid dividends of $.08 per share.

Item 6. Exhibits

(a) Exhibits:

11. Statement re computation of per share earnings is set forth in Note 6 of the Notes to Condensed Consolidated Financial Statements.

31.1 Certification of the Company's Chief Executive Officer pursuant to Rule 13a-14(a)/15d-14(a) under the Securities and 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 and 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.

All other items of this Report are inapplicable.

Signature

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 9, 2006

/s/Alan B. Miller

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

/s/ Steve Filton

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

Exhibit 31.1

CERTIFICATION - Chief Executive Officer

I, Alan B. Miller, certify that:

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

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this annual 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 officers 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 controls over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and we 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 controls over financial reporting, or caused such internal controls 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 principals;

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

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

5. The registrant's other certifying officers 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 registrant's board of directors (or persons performing the equivalent function):

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 9, 2006

/s/ Alan B. Miller

President and 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 annual 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 officers 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 controls over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and we 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 controls over financial reporting, or caused such internal controls 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 principals;

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

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

5. The registrant's other certifying officers 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 registrant's board of directors (or persons performing the equivalent function):

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 9, 2006

/s/ Steve Filton

Senior Vice President and Chief Financial Officer

EXHIBIT 32.1

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

In connection with the Quarterly Report of Universal Health Services, Inc. (the "Company") on Form 10-Q for the quarter ended March 31, 2006, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Alan B. Miller, President and 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 result of operations of the Company at the end of, and for the period covered by, the Report.

/s/ Alan B. Miller
President and Chief Executive Officer
May 9, 2006

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, 2006, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Steve Filton, Senior Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, and to the best of my knowledge, that:

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

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

/s/ Steve Filton
Senior Vice President and Chief Financial Officer
May 9, 2006

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.